



Institute of
Psychiatry
at The Maudsley



UNIVERSITY of
BRADFORD



Evaluating the effectiveness and cost effectiveness of **Dementia Care Mapping™ (DCM™)** to **enable person-centred care** for people with dementia and their carers:
A cluster randomised controlled trial
in care homes (DCM EPIC trial).

<http://www.leedsbeckett.ac.uk/pages/epic-trial/>

- Chief Investigator: Professor Claire Surr, Professor of Dementia Studies, Leeds Beckett University, Portland Building, City Campus, Leeds, LS1 3HE
- Authors: Prof Clive Ballard², Mrs Kayleigh Burton⁴, Prof Lyn Chenoweth³, Dr Anne Corbett², Prof Murna Downs¹, Mr Paul Edwards¹, Prof Amanda Farrin⁴, Dr Jane Fossey⁵, Ms Liz Graham⁴, Mrs Ivana Holloway⁴, Mr David Meads⁶, Prof Louise Robinson⁸, Dr Najma Siddiqi⁶, Prof Graham Strokes⁷, Dr Daphne Wallace¹, Dr Rebecca Walwyn⁴
- Co-ordinating Groups: ¹School of Dementia Studies, University of Bradford, UK
²Wolfson Centre for Age Related Diseases, KCL, UK
³University of Technology, Sydney, Australia
⁴Leeds Institute of Clinical Trials Research, University of Leeds, UK
⁵Psychological Services, University of Oxford, UK
⁶Leeds Institute of Health Sciences, University of Leeds, UK
⁷Bupa Care Services, Leeds, UK
⁸Institute for Aging and Health, University of Newcastle, UK
⁹Leeds Beckett University, Leeds, UK

Protocol Version 9.0 06 July 2016
Grant Reference: HTA ref: 11/15/13
ISRCTN: ISRCTN82288852
Research Ethics Committee Reference: 13/YH/0016

The Sponsor and CTRU accept no responsibility for the accuracy of additional documentation or instructions developed by collaboratina or third party organisations, from the content of this protocol.

KEY CONTACTS

Chief Investigator

Professor Claire Surr
Leeds Beckett University
Leeds
LS1 3EH

Tel: 0113 812 4316
Email: c.surr@leedsbeckett.ac.uk

Senior Trial Coordinator (for all regulatory, setup and process queries)

Mrs Amanda Lilley-Kelly
Complex Interventions Division
Clinical Trials Research Unit
University of Leeds
Leeds LS2 9JT

Tel: 0113 343 7987
Email: a.c.lilley-kelly@leeds.ac.uk

Senior Trial Managers

Ms Liz Graham
Complex Interventions Division
Clinical Trials Research Unit
University of Leeds
Leeds LS2 9JT

Tel: 0113 343 9242
Email: e.h.graham@leeds.ac.uk

Mrs Kayleigh Burton
Complex Interventions Division
Clinical Trials Research Unit
University of Leeds
Leeds LS2 9JT

Tel: 0113 343 9242
Email: k.v.burton@leeds.ac.uk

Data Managers (for data collection and eligibility queries)

Ms. Madeline Harms (main contact)
Complex Interventions Division
Clinical Trials Research Unit
University of Leeds
Leeds LS2 9JT

Tel: 0113 343 2771
Email: m.e.l.harms@leeds.ac.uk

Ms. Alison Fergusson
Complex Interventions Division
Clinical Trials Research Unit
University of Leeds
Leeds LS2 9JT

Tel: 0113 343 1480
Email: a.fergusson@leeds.ac.uk

Recruiting Site Leads

Professor Clive Ballard (KCL)
Wolfson Centre for Age Related Diseases
Guy's Campus,
King's College London
London SE1 1UL

Tel: 020 78486568
Email: clive.ballard@kcl.ac.uk

Dr Jane Fossey (Oxford)
Psychological Services
Oxford Health NHS Foundation Trust
Fulbrook Centre
Oxford OX3 7JU

Tel: 01865 738445
Email: jane.fossey@oxfordhealth.nhs.uk

Professor Claire Surr (Yorkshire)
Leeds Beckett University
(see above)

Tel: 0113 812 4316
Email: c.a.surr@leedsbeckett.ac.uk

Treatment Leads

Professor Graham Stokes (UC)
Bupa Care Services
Bridge House
Outwood Lane
Horsforth, Leeds
LS18 4UP

Tel: 0113 3816142
Email: graham.stokes@bupa.com

Juniper West
Norfolk & Suffolk NHS Foundation Trust
S14 St Andrews Lodge
Julian Hospital
Bowthorpe Road
Norwich
NR2 3TD

Tel: 01603 421 850
Email: juniper.west@nhs.net

Patient and Public Involvement

Dr Anne Corbett
Kings College London in association with
Alzheimer's Society
Devon House,
58 St Katharine's Way
London E1W 1LB

Tel: 020 7423 3500
Email: anne.corbett@kcl.ac.uk

Dr Daphne Wallace
% School of Dementia Studies
University of Bradford
Bradford, West Yorkshire
BD7 1DP

Supervising Statistician

Dr Rebecca Walwyn
Complex Interventions Division
Clinical Trials Research Unit
University of Leeds
Leeds LS2 9JT

Tel: 0113 343 5485
Email: r.e.a.walwyn@leeds.ac.uk

Trial Statistician

Mrs Ivana Holloway
Complex Interventions Division
Clinical Trials Research Unit
University of Leeds
Leeds LS2 9JT

Tel: 0113 343 0217
Email: i.holloway@leeds.ac.uk

Health Economist

Mr David Meads
Leeds Institute of Health Sciences
University of Leeds
Leeds LS2 9LJ

Tel: 0113 343 0860
Email: d.meads@leeds.ac.uk

Methodologists / Clinicians

Professor Amanda Farrin (Statistician)
Professor of Clinical Trials &
Evaluation of Complex Interventions
Complex Interventions Division
Clinical Trials Research Unit
University of Leeds
Leeds LS2 9JT

Tel: 0113 343 8017
Email: a.j.farrin@leeds.ac.uk

Professor Lynnette Chenoweth (Clinical)
Faculty of Nursing, Midwifery and Health
University of Technology,
UTS,
Lindfield Campus,
Po Box 222
Lindfield, NSW 2070
Sydney, Australia

Tel: +61 2 93690288
Email: l.chenoweth@unsw.edu.au

Professor Murna Downs (Clinical)
Head of School of Dementia Studies
University of Bradford
Bradford, West Yorkshire
BD7 1DP

Tel: 01274 233996
E-mail: m.downs@bradford.ac.uk

Professor Louise Robinson (Clinical)
Professor of Primary Care and Aging
Institute for Health and Society/
Institute for Ageing and Health
Newcastle University
Medical Sciences New Build
Newcastle upon Tyne
NE2 4AX

Tel: 0191 222 7013
Email: a.l.robinson@ncl.ac.uk

Dr Najma Siddiqi (Clinical)
Consultant Psychiatrist
Leeds Institute for Health Sciences
University of Leeds
Leeds LS2 9LJ

Tel: 0113 343 2740
Email: n.siddiqi@leeds.ac.uk

Sponsor Contact

Professor Richard Hogston
Director of Research
Faculty of Health and Social Sciences
Leeds Beckett University
PD512 Portland Building (City Campus)
Leeds,
LS1 3HE

Tel: 0113 812 4337
Email: r.hogston@leedsbeckett.ac.uk

NOTE: Together, the key contacts form the Trial Management Group

1 CONTENTS PAGE

KEY CONTACTS	2
1 CONTENTS PAGE	5
2 TRIAL SUMMARY	9
TRIAL DESIGN FLOW DIAGRAM.....	10
PATHWAYS FOR IDENTIFICATION AND CONSENT	11
2.1.1 Care Home Identification.....	11
2.1.2 Resident screening and consent	12
3 GLOSSARY OF TERMS	13
4 BACKGROUND	15
INTRODUCTION	15
BEHAVIOURS STAFF FIND CHALLENGING (BSC).....	15
PERSON CENTRED CARE	16
DEMEMENTIA CARE MAPPING™ (DCM™)	17
5 AIMS AND OBJECTIVES	19
6 DESIGN	20
7 CARE HOME ELIGIBILITY, RECRUITMENT AND CONSENT	21
CARE HOME ELIGIBILITY	21
CARE HOME RECRUITMENT.....	22
TRAINING REVIEW AND PROVISION OF DEMENTIA AWARENESS TRAINING	22
8 RESIDENT ELIGIBILITY, RECRUITMENT AND CONSENT	23
RESIDENT ELIGIBILITY (BASELINE).....	23
RESIDENT ELIGIBILITY (16 MONTHS POST RANDOMISATION).....	24
RESIDENT RECRUITMENT (at baseline and at 16 months).....	24
RESIDENT INFORMED CONSENT	25
8.1.1 Consent for those with capacity	25
8.1.2 Consent for those without capacity	26
9 STAFF ROLES, ELIGIBILITY, RECRUITMENT AND CONSENT.....	27
STAFF ROLES	27
STAFF MEASURES	27
10 PROXY ELIGIBILITY, RECRUITMENT AND CONSENT	28
RELATIVE / FRIEND AS INFORMANTS (FOR RESIDENTS RECRUITED AT BASELINE ONLY)	29
STAFF AS INFORMANTS	30
11 REGISTRATION AND RANDOMISATION	30
REGISTRATION OF RESIDENTS	30
RANDOMISATION OF CARE HOMES	31
12 INTERVENTION DETAILS	32

USUAL CARE (BOTH ARMS).....	32
DEMENTIA CARE MAPPING™ (INTERVENTION ARM ONLY).....	32
12.1.1 Mapper identification and consent	32
12.1.2 Training	33
12.1.3 Implementation	33
MONITORING INTERVENTION DELIVERY	35
12.1.4 British Standards	35
12.1.5 Briefing	35
12.1.6 Observation	35
12.1.7 Reporting.....	35
12.1.8 Feedback	35
12.1.9 Action Planning and Implementation	36
WITHDRAWAL.....	36
12.1.10 Withdrawal from trial due to death	37
13 DATA COLLECTION / ASSESSMENTS	37
SCREENING DATA (PRIOR TO BASELINE).....	39
13.1.1 Home manager-completed data	39
13.1.2 Researcher-completed data	39
REGISTRATION AND RANDOMISATION DATA	39
PILOT DATA	39
BASELINE DATA	40
13.1.3 Resident-completed data	40
13.1.4 Home manager-completed data	40
13.1.5 Staff-completed data	40
13.1.6 Relative / Friend-completed data	40
13.1.7 Researcher-completed data	41
FOLLOW-UP DATA (for those recruited at baseline)	41
13.1.8 Resident-completed data	41
13.1.9 Home manager-completed data	41
13.1.10 Staff-completed data	41
13.1.11 Relative / Friend -completed data	42
13.1.12 Mapper-completed data	42
13.1.13 Researcher-completed data	42
FOLLOW-UP DATA (for those recruited at 16 months post randomisation)	43
13.1.14 Screening at 16 months	43
13.1.15 Data collection at 16 months	43
ASSESSMENT INSTRUMENTS	43
DEFINITION OF END OF TRIAL.....	45
14 PROCESS EVALUATION AND ASSESSMENT OF TREATMENT IMPLEMENTATION	

Sampling	46
Resident feedback	47
Staff feedback	47
Mapper feedback.....	48
Relative / Friend feedback	48
Data analysis and storage	48
15 RESIDENT SAFETY	49
GENERAL DEFINITIONS	50
DCM-EPIC OPERATIONAL DEFINITIONS AND PROCEDURES	50
15.1.1 Serious Adverse Events	50
15.1.2 Related and Unexpected Serious AEs.....	50
15.1.3 Deaths.....	51
15.1.4 Responsibilities	51
15.1.5 Safeguarding criteria and procedures.....	52
16 HEALTH ECONOMICS	53
17 ENDPOINTS	54
PRIMARY ENDPOINT	54
HEALTH ECONOMIC ENDPOINTS	54
SECONDARY ENDPOINTS	56
STATISTICAL CONSIDERATIONS.....	56
SAMPLE SIZE	56
ACCRUAL.....	57
18 STATISTICAL ANALYSIS	57
GENERAL CONSIDERATIONS	57
FREQUENCY OF ANALYSES	58
ANALYSIS POPULATIONS	58
PRIMARY ANALYSIS	58
18.1.1 Supportive analyses.....	58
SECONDARY ANALYSIS	58
SUB-GROUP ANALYSES	59
19 TRIAL MONITORING	59
DATA MONITORING.....	59
DATA MONITORING AND ETHICS COMMITTEE	59
TRIAL STEERING COMMITTEE (TSC).....	60
CLINICAL GOVERNANCE ISSUES	60
20 QUALITY ASSURANCE AND ETHICAL CONSIDERATIONS.....	60
QUALITY ASSURANCE	60
SERIOUS BREACHES	60

ETHICAL CONSIDERATIONS	60
RESEARCH STAFF TRAINING	61
20.1.1 Capacity to Consent	61
20.1.2 Data Collection Tools and Scales	61
20.1.3 Good Clinical Practice	61
21 CONFIDENTIALITY	62
ARCHIVING	62
22 STATEMENT OF INDEMNITY	62
23 TRIAL ORGANISATIONAL STRUCTURE.....	63
RESPONSIBILITIES	63
OPERATIONAL STRUCTURE	64
24 PATIENT AND PUBLIC INVOLVEMENT	64
25 PUBLICATION POLICY	65
26 REFERENCES	66

2 TRIAL SUMMARY

AIM: To evaluate the clinical and cost-effectiveness of Dementia Care Mapping™ (DCM™) in addition to Usual Care (UC) versus UC alone for people with dementia living in care homes in England.

DESIGN: Cluster randomised controlled trial (RCT) with follow-up over 16-months, cost-effectiveness analysis and process evaluation, including cohort collection of data at 6 months, and cross-sectional collection of outcomes at 16 months post randomisation.

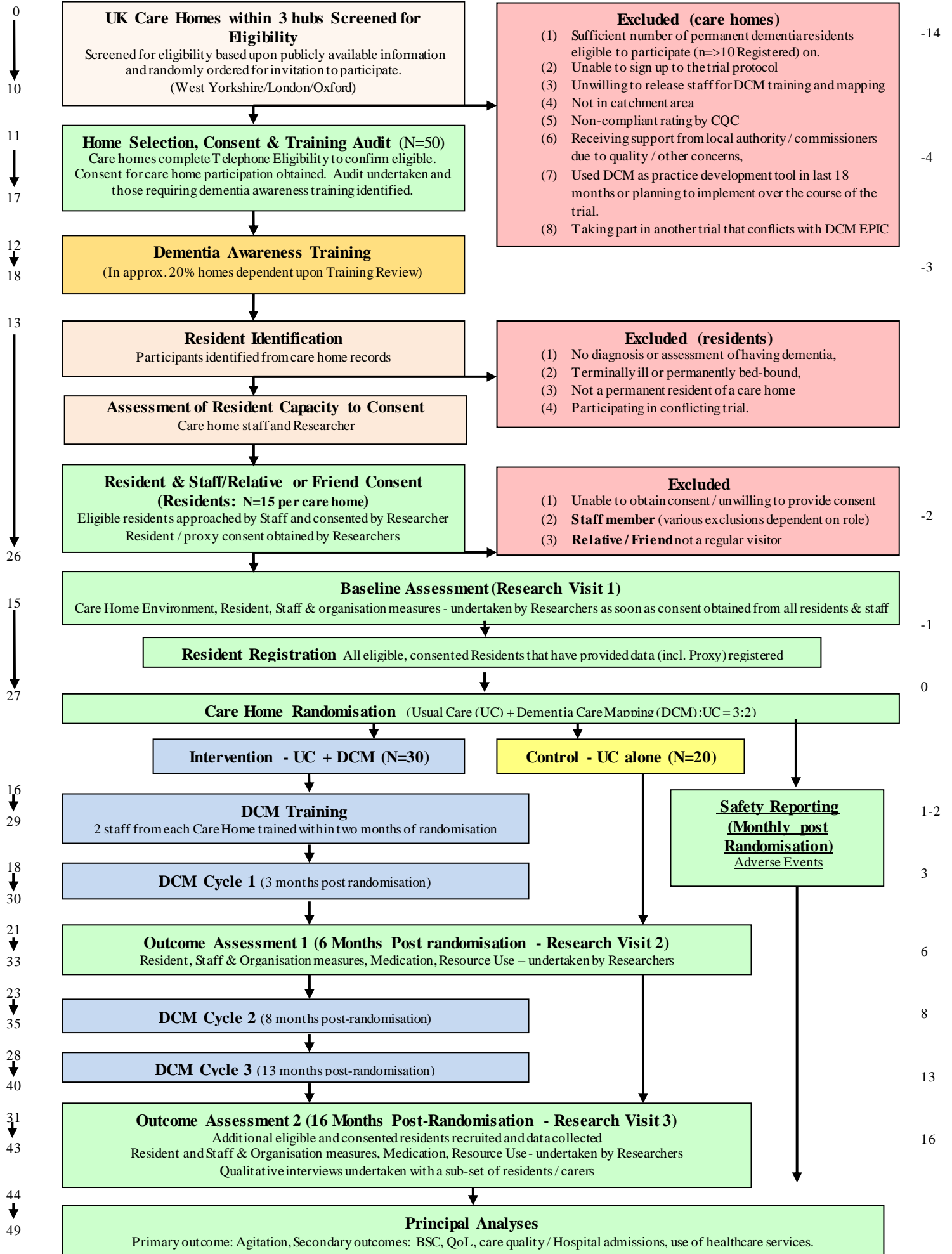
SETTING: Residential, nursing and dementia care homes in England.

TARGET POPULATION: Care homes, residents with dementia, their relatives/friends and care home staff.

HEALTH TECHNOLOGY: Dementia Care Mapping™ (DCM™) is an established care home intervention used to support the implementation of person-centred care (PCC). DCM™ is an observational tool, within a 'practice development cycle'. What this means in practice is that a trained observer (a member of staff in the care home) records the care experience of up to eight people with dementia for up to six consecutive hours. Findings are fed back to staff, who develop individual and group action plans. This is repeated every 4-6 months.

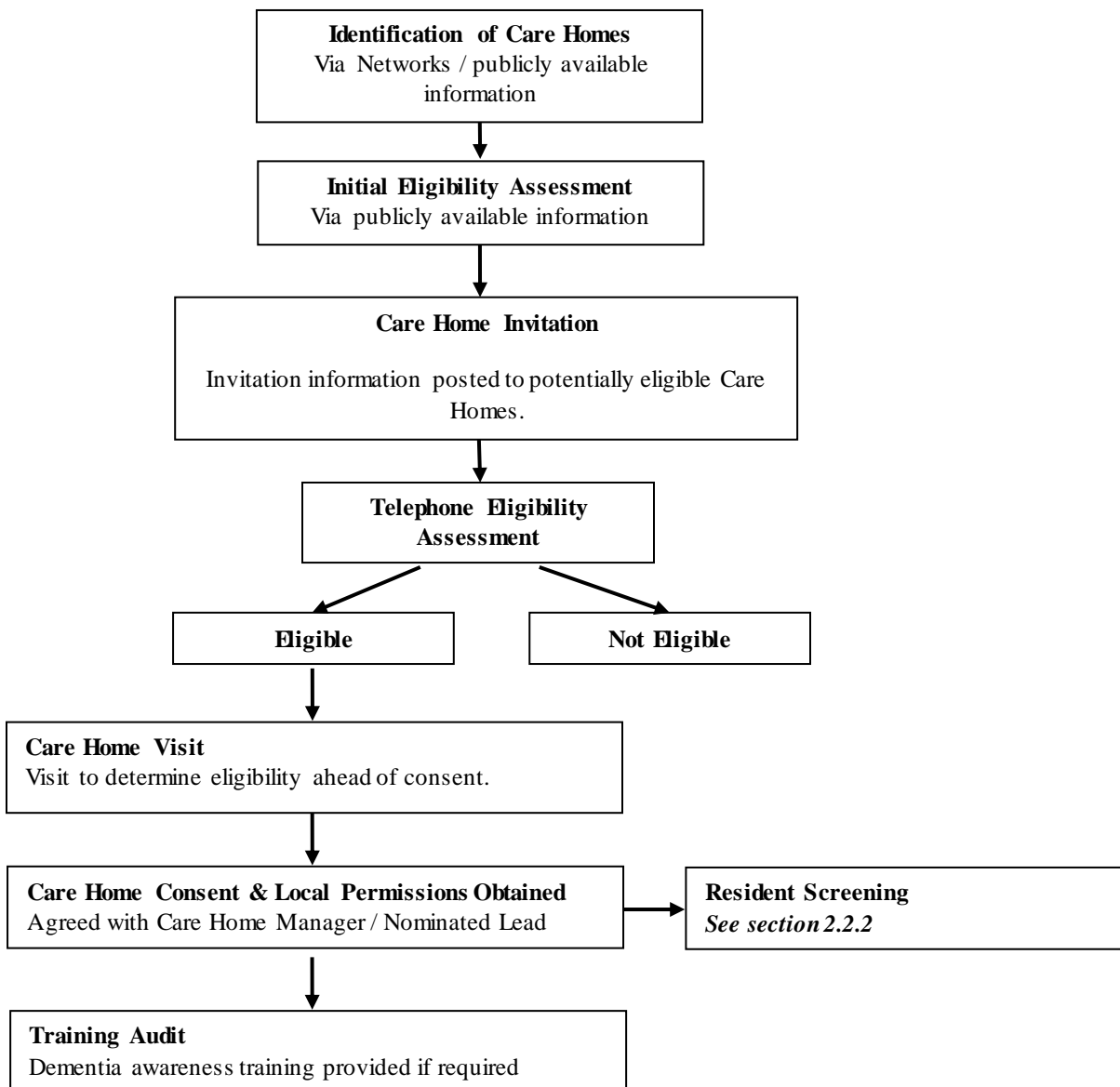
OUTCOMES: The primary endpoint for the efficacy analysis will be based on the Cohen Mansfield Agitation Inventory (CMAI) at 16 months. The primary economic analysis is a cost-utility analysis presenting cost per quality-adjusted life year (QALY) in an incremental cost-effectiveness ratio (ICER). Utility values will be collected using the EQ-5D-5L and the DEMQOL.

SAMPLE SIZE: 50 care homes (750 residents) with 30 (450) and 20 (300) in the intervention and control arms respectively. Additional residents will be recruited at 16 months post-randomisation from each care home to maintain power and minimise bias (due to higher than anticipated loss to follow-up) and ensure the validity of the trial.

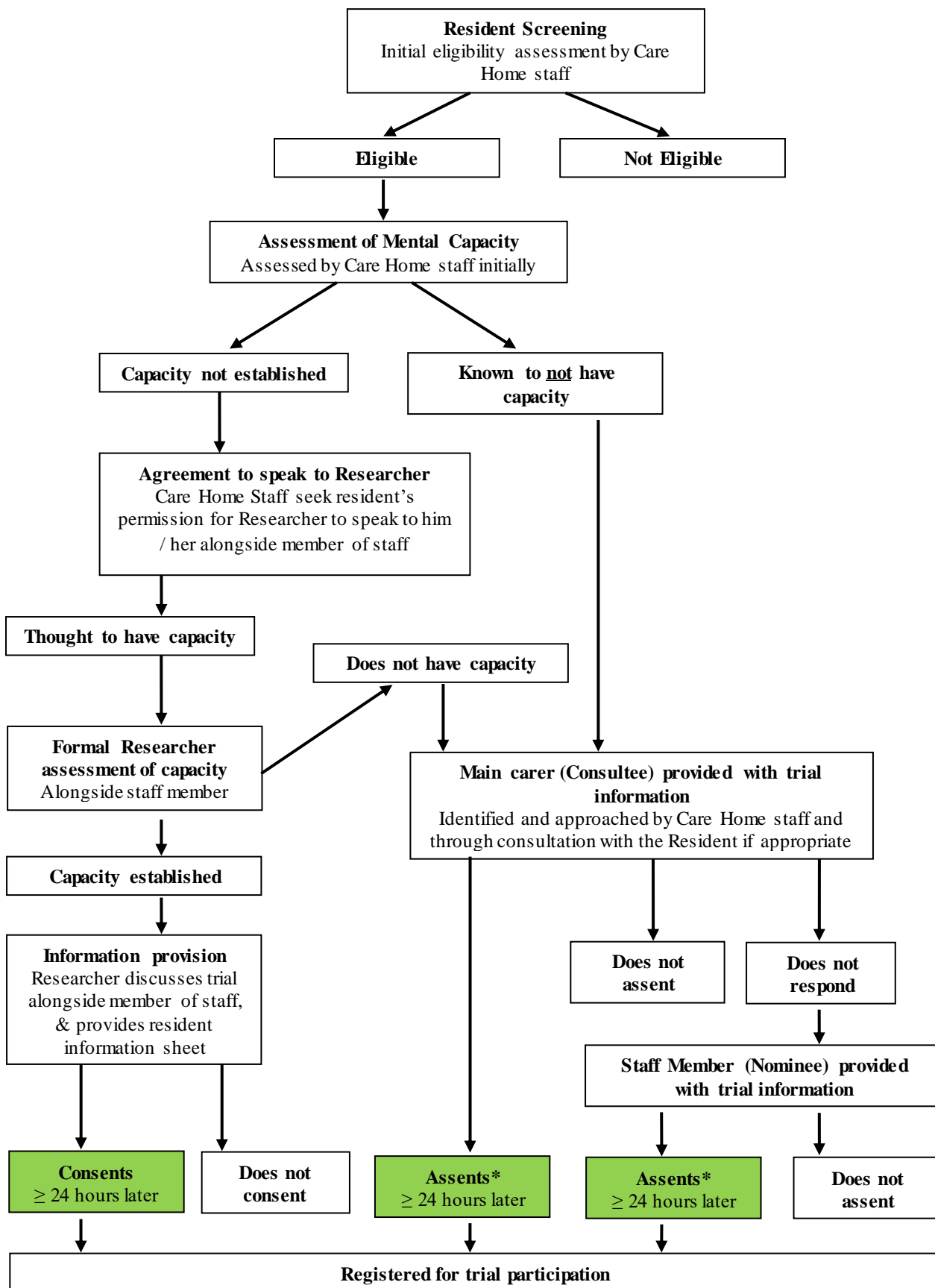


PATHWAYS FOR IDENTIFICATION AND CONSENT

2.1.1 Care Home Identification



2.1.2 Resident screening and consent



* This includes resident consultation

3 GLOSSARY OF TERMS

AE	Adverse Event
BCC	Behaviour Category Code
BPSD	Behavioural and psychological symptoms of dementia
BSC	Behaviours staff find challenging
CACE	Complier Average Causal Effect
CDR	Clinical Dementia Rating Scale
CI	Chief Investigator
CMAI	Cohen Mansfield Agitation Inventory
CQC	Care Quality Commission
CRF	Case Report Form
CTRU	Clinical Trials Research Unit
DCM™	Dementia Care Mapping™
DCM EPIC	Evaluating the effectiveness and cost effectiveness of Dementia Care Mapping™ (DCM™) to enable person-centred care for people with dementia and their carers: A cluster randomised controlled trial in care homes
DEMQOL	Dementia Quality of Life measure
DeNDRoN	Dementia and Neurodegenerative Diseases Research Network
DMEC	Data Monitoring Ethics Committee
DPA	Data Protection Act
EAT	Environmental Audit Tool
ENRICH	Enabling Research in Care Homes (A Research Network Initiative)
FAST	Functional Assessment Staging of Alzheimer's Disease
FITS	Focussed Intervention for Training Staff
GCP	Good Clinical Practice
GHQ-12	General Health Questionnaire
GLHC	Group Living Home Characteristics
HSCIC	Health and Social Care Information Centre
HTA	Health Technology Assessment Programme
ICC	Intracluster Correlation Coefficient
ICER	Incremental cost-effectiveness ratio
ISRCTN	International Standard Randomised Controlled Trial Number
MAGDR	Ministerial Advisory Group on Dementia Research
MAR	Missing at Random
ME	Mood/Engagement Value
MNAR	Missing Not at Random
MRC	Medical Research Council
NICE	National Institute for health and Care Excellence
NIHR	National Institute for Health Research
NMB	Net monetary benefit
NPI	Neuropsychiatric Inventory
NRES	National Research Ethics Service
PAS	Pittsburgh Agitation Scale
PCCT	Person-centred care training
PD	Personal Detractions
PI	Principle Investigator
PIS	Patient Information Sheet
PPI	Patient and Public Involvement
QALY	Quality-adjusted life year
QOL	Quality of Life
QUALID	Quality of Life in Late-Stage Dementia
QUIS	Quality of Interactions Schedule
RCT	Randomised controlled trial
REC	Research Ethics Committee
RGF	NHS Research Governance Framework
RUSAE	Related Unexpected Serious Adverse Event
SAE	Serious Adverse Event

SAP	Statistical Analysis Plan
SCIE	Social Care Institute for Excellence
SMART	Specific, Measurable, Achievable, Realistic, Time limited
SOP	Standard Operating Procedure
TMG	Trial Management Group
TSC	Trial Steering Committee
UC	Usual Care

Note: A cohort cluster-randomised design is usually “closed” in that residents are recruited at baseline and then followed up to trial completion. In an “open” cohort design, these residents are followed up but newly eligible residents are also included at follow-up.

4 BACKGROUND

INTRODUCTION

A third of people who have dementia reside in a care home [1] and at least two-thirds of people living in care homes have dementia [2]. In July 2011 there were over 4,600 nursing homes and over 13,400 care homes in England, the majority of which provide care for older people [3]. Concerns have consistently been raised about care home quality [4, 5]. Improvement in care quality and staff knowledge and skills is identified within the National Dementia Strategy for England [6] and constitutes a Ministerial Advisory Group on Dementia Research (MAGDR) priority [7]. Poor quality care is associated with poor outcomes for people with dementia including an increase in behaviours staff find challenging (BSC) [8, 9]. Developing an informed and effective care homes workforce is a strategic component of improving care quality [6, 10], however, there remains limited robust evidence regarding effective evidence-based staff training interventions for care homes providing care for people with dementia [11]. Furthermore, to date it has not been possible to achieve the widespread implementation into real-world practice, of evidence-based training interventions developed in the context of research. Dementia Care Mapping™ (DCM™) [12, 13] has the benefit of being an existing practice development intervention, that has been widely used in health and social care settings nationally [14] and internationally [15] for over 15 years, to support the embedding of person-centred care in practice. There is good evidence of its use in practice settings as a quality audit and improvement tool [16-25]. The proposed trial will provide robust evidence, through a formal cluster randomised controlled trial, on the effectiveness and cost effectiveness of DCM™ as an intervention to support care homes to sustainably enable the transfer of learning from person-centred care training (PCCT) into care practice. The outcomes of the trial will evaluate whether DCM™ could provide a solution for achieving widespread implementation of an approach to training and practice development, which is practical for use in routine health and social care.

BEHAVIOURS STAFF FIND CHALLENGING (BSC)

BSC also known as ‘neuropsychiatric’ or ‘behavioural and psychological symptoms of dementia (BPSD)’ are a significant therapeutic challenge [26]. We have chosen to use the term BSC within this trial rather than BPSD as it reflects a more person-centred terminology that better emphasises the bio-psycho-social causes of such behaviours and represents the terminology used by relatives and staff in care home settings. BSC include behaviours such as agitation, aggression, restlessness, hallucinations, delusions, depression, anxiety and apathy [26]. Up to 90% of people living with dementia experience one or more of these behaviours during the course of their condition [26] and BSC are reported in up to 79% of care home residents at any one time [27]. BSC also cause distress to the people with dementia experiencing them [28], are associated with reduced quality of life [29, 30] and have a negative impact on the well-being of other residents [31]. BSC also have significant associated costs [32, 33] including increased risk of hospitalisation [34, 35], Accident and Emergency use [33] and production of excess disability; meaning functional abilities of people decline more quickly than is otherwise expected [33]. Therefore, reducing BSC has the potential to improve the quality of life of people with dementia living in care homes as well as reduce costs of providing care to this group.

Agitation is the most common [27, 36], distressing to the person with dementia [28], and the most difficult to manage [37] BSC in care home settings. Agitation includes a cluster of extremely problematic behaviours such as aggressive behaviours, physically non-aggressive behaviours and verbal agitation [38]. These include pacing, spitting, verbal aggression, constant requests for attention, hitting, kicking, pushing, throwing things, screaming, biting, scratching, intentional falling, hurting self and others, making sexual advances and restlessness [39]. The presence of these behaviours puts the person who is agitated at risk of triggering aggressive responses from other residents [40]. The presence of agitation therefore causes potential serious risk of harm to the person who is agitated, other residents and staff. Rates of over 60% of nursing home residents with dementia displaying agitation are reported [41, 42], making it an extremely common as well

as potentially harmful BSC for the people experiencing it, other residents and staff. The presence of agitation is reported as highly challenging, compared to other BSC (such as delusions, depression, apathy or dis-inhibition), in terms of clinical management [37]. Agitation places increased burden on care staff [43, 44] who feel less confident in dealing with situations where residents are agitated than in their management of other BSC [45]. The presence of agitation in a person with dementia is also associated with fewer visits from relatives, poorer quality of life [29] and as it is detrimental to relationships with others, social isolation [44]. The frequency of agitated behaviours, the difficulties staff have in their management and the potential risks they pose to the person, other residents and staff, means that drug treatments such as antipsychotics and other psychotropic medications are prescribed as a first line management approach. However, links of antipsychotics to stroke and excess deaths [46] mean their reduced use is a high government [4] and MAGDR priority [7]. There is a concern that the mandated reduction in antipsychotic prescribing may in turn lead to the prescription of other psychotropic drugs as an alternative [47, 48] despite lack of evidence of their efficacy. Researching psychosocial approaches to support staff with BSC is therefore a MAGDR (7) research priority.

Agitation and other BSC are not an inevitable consequence of dementia. Agitation is often caused by the care practices and environment surrounding the person with dementia [49] as well as by poorly managed physical health and pain [37, 50]. They reflect an expression of unmet needs by a person with dementia in response to poor quality care [4, 50, 51]. This is often caused by lack of stimulation and engagement for the person with dementia [52]. For example, Brodaty et al [53] found significant variability between care homes in terms of the proportions of residents within each setting who displayed BSC, indicating a care home level effect. Likewise, Weber et al [54] report a significant reduction in BSC when people with dementia attended a therapeutic day hospital programme compared to when these same people with dementia were at home, again indicating the impact of the psychosocial environment. Thus, it is now recognised that the presence of agitation within individuals with dementia in care home settings is associated with organisational aspects of care and the care culture within a care home [50]. It is, hence, recommended that agitation is treated through the use of psychosocial interventions that address the quality of care practice [4, 55-57]. Therefore, agitation is a key treatment target area for people with dementia in care homes and treatment approaches need to take a psychosocial, non-drug based approach.

PERSON CENTRED CARE

Person-centred care is an effective psychosocial approach in dementia care [58] and is considered a best practice approach to reducing agitation and other BSC [55]. Person-centred care means providing a supportive social environment within a care setting where people with dementia are valued, treated as individuals, and staff are encouraged to see the world from the person's perspective [55, 59]. Person-centred care, therefore, involves evaluating and responding to the unique needs of each person with dementia and offering an individualised approach to care. NICE/SCIE [55] recommend individualised, holistic or person-centred assessment and care planning, with regular review and individually tailored and monitored psychosocial interventions for BSC. Delivery of care that is person-centred is associated with a reduction in agitated behaviours [60] and BSC more generally [57] and reduced use of anti-psychotics [58, 61, 62]. Bird et al [63] found that multifaceted, individualised interventions lead to significant mean improvements in BSC. Therefore an ability to identify individual causes of BSC and suggest appropriate person-centred solutions is required to effect change [63-65]. This, however, is reliant on staff having the required knowledge, skills and confidence in delivery of person-centred care. Provision of person-centred support is an element of the common induction standards [66] for all social care workers in England. Therefore, provision of at least basic training to staff on person-centred care is expected within all care homes in England [55] and is a regulatory requirement [67]. However, there are no widely accepted, standardised person-centred care training (PCCT) materials available and therefore, content, approaches, quality and efficacy of PCCT vary considerably across the sector [68]. Effective PCCT can produce immediate practice benefits [60, 62], however due to the variability of the amount, content and quality of PCCT staff receive across the sector, knowledge, skills and staff confidence levels in relation to delivery of person-centred care remain generally low

[45, 69]. Raising staff knowledge, skills and confidence levels around person-centred ways to work with BSC is therefore a national priority area [6, 7, 10].

Whilst effective PCCT can produce immediate practice benefits, evidence suggests, that PCCT alone might not sustain change over time [11, 60, 62, 70]. For this reason in many reported studies, PCCT is often accompanied by an additional intervention to support ongoing change. For example, Fossey et al [61] employed PCCT alongside a comprehensive 10-month focussed intervention for training staff (FITS) including ongoing staff training and support. At post-test antipsychotic medication use had decreased by over 40% in the intervention group. Chenoweth et al [58] provided PCCT to two staff members who then disseminated person-centred care practice across the site. Researchers provided additional individualised care planning and ongoing telephone support during a 4-month intervention period. At post-test the benefits were non-significant, while at 10-months post-randomisation, agitation levels were significantly lower than in the usual care control sites. A limitation of both of these studies is that it is unclear whether PCCT, additional support or both caused the effect. Evidence of efficacy of PCCT after a longer follow-up period is limited [11], however, Moniz-Cook et al. [62] found the benefits of PCCT with no additional intervention were not sustained at 1-year. The PCCT programmes evaluated so far, therefore, provide evidence that additional support alongside the training intervention is required in order to facilitate sustained benefits [71]. The use of additional interventions to support the sustained implementation and embedding of PCCT in practice is recommended over an extended period of time [72]. Implementing evidence-based health care interventions in real world practice is a recognised challenge, with barriers to implementation of research designed interventions reported across all areas of practice [73-75]. Current successful interventions that combine staff training with ongoing support such as the FITS [61] are resource intensive and require regular ongoing input from a specialist practitioner and for these reasons have not yet been possible to implement widely in everyday practice. Therefore, interventions that provide staff with knowledge to support BSC, that are cost-effective and that have already been successfully implemented in real world practice are required. Any such intervention will need to accommodate the varying amounts, content and quality of PCCT that is a feature of the sector.

DEMENTIA CARE MAPPING™ (DCM™)

DCM™ [12, 13] is an established and National Institute for Clinical Excellence/Social Care Institute for Excellence (NICE/SCIE) [55] recommended, routine care home/NHS practice development intervention, that is regularly used for ensuring a systematic approach to providing individualised person-centred care. It is used to support the sustained implementation of PCCT in dementia care practice [76]. DCM™ is an observational tool, set within a practice development cycle. It includes five phases: briefing, observation, analysis, feedback and action planning. Briefing involves providing information about DCM™ to staff, residents and visitors so they are aware of the process that will take place, their role/involvement in that process, and have an opportunity to ask questions. During the observation period a trained observer (mapper) records the care experience of up to eight people with dementia for a length of time determined by the purpose of the observation (map). This can be short focussed maps (for example over mealtime periods) up to longer maps of six or more hours to gain a broad picture of the residents' day and night time experience. During feedback findings are provided to staff using a structured report format. Action planning is a joint activity between the mapper and the staff team. Both individual and group level action plans are developed. This cycle is repeated every 4-6 months to monitor and revise action plans. Once initial training and skills development in the method is completed mappers are able to conduct cycles of mapping independently of external input, meaning DCM™ requires no external input over the long term and is therefore potentially less resource intensive and more closely aligned with real world dementia practice than other interventions [61]. Whilst DCM™ has been used in dementia care for nearly 20 years including implementation in care home settings [21, 77-80], and has strong face validity within the practice field [81], there is limited robust evidence of its efficacy in relation to clinical outcomes such as reduction of BSC. Practice implementation reports that the benefits of DCM™ include the improvement of patient well-being [18, 23, 82] and helping staff see care from the point of view of the person with dementia, leading to evidence-based

feedback and action planning that motivates staff and helps them to feel more confident to implement person-centred care [80, 81].

At the point of funding there were only five published studies that examine the benefits of using DCM™ for improving clinical outcomes. A Dutch pilot study [83] found DCM™, used alone, reduced verbal agitation and anxiety in people with dementia and improved care staff feelings of connectedness with residents. An Australian pilot study [84] found improvements in the quality of staff interactions and reductions in agitation and depression through use of DCM™. There are three RCT studies of the efficacy of DCM™ published to date. A cluster RCT conducted in care homes in Australia [58], found that at 10-months post randomisation DCM™, when used alone, was associated with significantly reduced agitation and falls among residents with dementia. A Norwegian cluster RCT [85] in care homes found a significant reduction in neuropsychiatric symptoms as measured by the Neuropsychiatric Inventory (NPI) and on the NPI sub-scales of agitation and psychosis. It also found a significant improvement in quality of life, compared to controls after 10 month follow-up. A cluster RCT study in care homes within the Netherlands [86] found no difference between the DCM™ intervention group and control group on agitation and a significant decrease in neuropsychiatric symptoms in the control group compared to the intervention group. Staff in the intervention group reported significantly less negative emotional reactions and significantly more positive reactions over time than the control group. This study also reported potential intervention fidelity issues within the DCM™ intervention care homes, indicating less than desirable implementation of the intervention in some of the clusters.

Limitations of the studies conducted to date include:

- Relatively small number of clusters (Australia) or small numbers of care homes containing multiple clusters (Norway)
- Use of DCM™ alone rather than alongside PCCT in accordance with best practice guidelines (Australia). This reflects the Australian context where PCCT is the exception rather than assumed good practice;
- Only two full cycles of DCM™ before final follow up limiting the potential for impact, given the length of time that changes within practice can take to implement and see potential benefits (Australia, Norway, Netherlands);
- Follow up period of only 10 months post randomisation again reducing the time for potential change and impact to be realised (Australia, Norway);
- Explanatory trial design (Australia, Norway) involving researcher-led cycles of DCM™ with variable degrees of input from trained care home staff, potentially compromising staff ownership of the DCM™ process including implementation of any action plans. This also restricts generalisability of the results to usual implementation of DCM™ in care practice, which is practitioner-led;
- No analysis of the process of change (Australia, Norway);
- Studies conducted in Australia, Norway and The Netherlands where care funding, regulations and processes are different to the UK.

These trials, therefore, whilst providing promising data on the effectiveness of DCM™ in Australian, Norwegian and Dutch care home settings, does not provide a robust evaluation of effectiveness or cost-effectiveness of DCM™ in UK settings. due to not being able to provide data directly applicable to a UK context, due to lack of comparability of usual care in non-UK care homes prior to DCM™ implementation and the different funding models of dementia care in each country.

In summary, there is a body of practice-based literature and experience that suggests DCM™ is an effective tool for enabling the sustained implementation of knowledge and skills gained through PCCT into care practice and that this may help to reduce BSC. However, there is very limited robust evidence for its effectiveness and no examination of its cost-effectiveness as a UK healthcare intervention. Therefore, a definitive pragmatic RCT of DCM™ in the UK is urgently

needed to inform the implementation of training and development within UK care homes and other clinical settings.

5 AIMS AND OBJECTIVES

Aim:

The aim of the DCM-EPIC trial is to evaluate the clinical and cost-effectiveness of DCM™ in addition to Usual Care (UC) compared to UC alone for people with dementia living in care homes in the UK.

Additional aims are to explore sub-group effects and the process, challenges, benefits and impact of implementing the intervention.

Primary objective:

To determine if DCM™ plus UC (i.e. the intervention) is (i) more effective in reducing agitation as measured by the total Cohen-Mansfield Agitation Inventory (CMAI) score and (ii) more cost-effective than UC alone (i.e. the control), sixteen months after randomisation of care homes.

Secondary objectives:

It is intended that the following are compared with the control:

Impact of the intervention on residents

- (a) To investigate if the intervention is effective in reducing Behaviours Staff find Challenging (BSC) over time as measured by the CMAI and the Neuropsychiatric Inventory (NPI);
- (b) To investigate if the intervention has an impact on the use of antipsychotic and other psychotropic drugs;
- (c) To investigate the effects of the intervention on resident mood (i.e. depression, anxiety and apathy) and quality of life;

Impact of the intervention on staff

- (d) To investigate the effects of the intervention on staff well-being and role efficacy;
- (e) To investigate the quality of staff / resident interactions over time by arm, as measured by the Quality of Interactions Schedule (QUIS);

Safety monitoring

- (f) To assess the safety profile as assessed by the number and types of hospital admissions occurring, by arm;

Potential moderators and mediators of the intervention effect and intervention implementation

- (g) To explore if there are any differential predictors of the effects of the intervention (i.e. treatment-covariate interactions);
- (h) To explore the process, challenges, benefits and impact of implementing the intervention.

6 DESIGN

This trial has been designed to be a pragmatic, multi-centre, cluster-randomised controlled trial of Dementia Care Mapping™ plus Usual Care (DCM™ + UC - 'intervention') versus Usual Care alone (UC - control). It will take place in residential, nursing and dementia care homes across West Yorkshire, Oxfordshire and the Thames Valley, and London, with residents with dementia. There will be an integral cost-effectiveness analysis and process evaluation. Seven-hundred and fifty residents from a random sample of fifty care homes will be registered and baseline assessments undertaken, with care homes then being randomised in a ratio of 3:2 to receive intervention or control. A training review will be conducted within each care home (and training provided as required) to ensure all care homes provide a minimum level of person centred care. Outcome measures will be obtained at 6 and 16 months following randomisation to reflect the effects of the first cycle of mapping and the effects of the full three cycles, respectively. The primary outcome will be agitation as measured by the CMAI. Additional newly eligible and consented residents will be recruited at follow-up 16 months post randomisation.

Following randomisation, care homes allocated to the intervention arm will receive training as soon as able (dependent upon DCM™ course schedule) to complete their first cycle at 3 months (or as soon as practicable), their second cycle at 8 months and their final cycle at 13 months post randomisation.

The pragmatic nature of the trial aims to ensure implementation of the DCM™ intervention reflects what is possible in a typical care home, thus maximising relevance to practice. Training will be provided via a nationally-recognised course given by the University of Bradford. Expert mapper support will be provided to each care home in the intervention group, during completion of their first cycle of mapping. This will maximise intervention fidelity across the intervention homes. Telephone support for DCM™ implementation will be available to all intervention homes thereafter, if required. Since it is not possible to limit the potential effects of using DCM™ in a care home setting to the care provided to a sample of residents only, a cluster design was deemed necessary. This leads to two important sources of clustering: cluster-randomisation and DCM™ treatment provision, with care homes nested within treatment arms. Due to this design we anticipate that the clustering effect will vary across arms, with a higher ICC in the intervention arm, providing the rationale for the unequal allocation of care homes.

Due to the nature of the intervention it will not be possible to blind care homes or staff to the allocation status. To minimise potential for bias the trained mappers will not be involved in providing any outcome measures data. To ensure consistency, where possible the same staff member will be asked to complete measures at each data collection point. All data will be gathered by trained researchers. Proxy completion by a relative / friend will also be sought where possible. Effort will be made to blind all trial researchers to allocation status. Therefore, the researcher doing the observations for the Pittsburgh Agitation Scale and abridged Cohen Mansfield Agitation Inventory will also measure fidelity to allow the outcome assessors to remain blind. The level of any un-blinding will be measured.

7 CARE HOME ELIGIBILITY, RECRUITMENT AND CONSENT

CARE HOME ELIGIBILITY

INCLUSION CRITERIA

A care home meeting all of the following criteria at screening will be eligible for this trial:

- 1) Has a sufficient number of permanent dementia (based on a formal diagnosis or Functional Assessment Staging of Alzheimer's Disease (FAST) score of 4+) residents eligible to participate in the study in order to achieve a minimum of 10 Residents registered to take part prior to Care Home Randomisation;
- 2) Has a manager or nominated person agreeing to sign up to the trial protocol as research lead for the duration of the project, based on appropriate discussions and permissions;
- 3) Agrees to release staff for DCM™ training and subsequent mapping processes;
- 4) Is within catchment area.

* It is expected that Researchers will register a minimum of 10 residents to take part in the DCM EPIC trial data collection at each participating care home. There is no maximum limit on the number of residents able to take part, however the impact upon Researcher workload should be considered.

EXCLUSION CRITERIA

A care home meeting any of the following criteria will not be eligible for this trial:

- 5) In the view of the research team, is not suitable for inclusion due to being subject to CQC enforcement notices, admission bans or relevant moderate or major CQC compliance breaches;
- 6) Is receiving other special support for specific quality concerns, such as being currently subject to, or have pending, any serious safeguarding investigations, or receiving voluntary or compulsory admissions bans, is in receipt of local commissioning special support due to quality concerns;
- 7) Has used* DCM™ as a practice development tool within the 18 months prior to randomisation or is planning to use DCM™ over the course of trial involvement;
- 8) Is taking part, has recently taken part in, or is planning to take part, in another trial that conflicts with DCM™ or with the data collection during the course of their involvement in DCM EPIC.

* Use of DCM™ refers to the completion of DCM™ Mapping Observations.

Eligibility waivers to inclusion and exclusion criteria are not permitted.

Where the care home is a large multi-site or multi-floor establishment, one or two units* within the home may be selected to participate as one home. The chosen units will be identified by the home manager in discussion with the researcher and DCM™ lead using the following criteria:

- i) Dementia units or units with the largest % of residents with dementia;
- ii) Units where DCM™ is considered the most useful to implement.

* A maximum of 2 Units per home can participate due to the impact upon Researcher workload (completion of CH Level data) and the delivery of DCM™ (i.e. 1 Mapper per Unit).

The care home's insurance and indemnity will apply for trained mappers implementing the intervention within the care home setting.

CARE HOME RECRUITMENT

- 7.2.1 Catchment areas will be selected within each recruitment hub (i.e. West Yorkshire, London and Oxford).
- 7.2.2 Care homes in the catchment areas around the recruitment hubs will be screened for initial eligibility via publicly available information (e.g. home type, number of beds, status with CQC).
- 7.2.3 Care homes deemed eligible at this point will be randomly ordered (i.e. care home size, care home postcode, network status (network / non-network)) for further contact.
- 7.2.4 Care home selection will be staggered across the recruitment period to limit the number of homes considered at any one time and minimise the time between first approach and inclusion in the trial.
- 7.2.5 In accordance with the care home recruitment strategy a sample of randomly ordered care homes from each hub will then be sent Invitation Information (i.e. Care Home Information Sheet) to provide details of the trial and outline that a Researcher will contact them to discuss participating. Care homes will be provided with contact details to opt out of further trial contact if they are not interested in participating.
- 7.2.6 Researchers will contact care homes invited to take part within 1-3 weeks of sending Invitation Information to discuss the trial, answer any queries and determine if care homes are interested in taking part at this stage.
- 7.2.7 If a care home expresses an interest in taking part the Researcher will schedule a mutually convenient time to complete eligibility assessments. If a care home is not interested in taking part the Researcher will thank the care home for their time and acknowledge that the trial team will not contact them further.
- 7.2.8 If the Researcher is unable to make contact with the care home following several attempts (i.e. on different date, at varying times) the Researcher will cease attempting to contact the care home.
- 7.2.9 For interested care homes the Researcher will complete initial eligibility screening via telephone ahead of scheduling a mutually convenient time to visit the care home to determine full eligibility (i.e. staff engagement) and complete the recruitment process (i.e. written agreement at the care home level and appropriate management permissions). Care homes will be asked to determine the management permissions required ahead of the care home visit.
- 7.2.10 Once all care homes within a sample have been contacted the Researcher will move onto the next randomly ordered sample (timelines dependent upon number of interested care homes in a sample and recruitment strategy) until sufficient homes have been recruited. If care homes who are within the catchment area volunteer to take part having received information from another source, they will be subject to the same recruitment process as randomly selected homes.
- 7.2.11 Documented reasons for ineligibility or declining participation at each stage will be closely monitored by the Trial Team as part of a regular review of recruitment process.
- 7.2.12 The target is for four homes to be recruited per month. Should recruitment not progress at expected rates, the research team will use their contacts to approach eligible homes, and may include details about the trial in a publicly available newsletter. Should more eligible homes express an interest in participation than is required; a random sample will be chosen from those interested, to be approached for formal consent. A list of reserve homes will be identified by each recruitment hub, to support swift response to under recruitment of residents or drop out of homes ahead of randomisation.

TRAINING REVIEW AND PROVISION OF DEMENTIA AWARENESS TRAINING

It is known that quality of dementia training is variable across the sector and that lack of training leads to poor quality or sub-standard care. Therefore, in order to ensure that each home in the trial at least meets minimum dementia training standards, a training review designed by the research team and based on national information regarding current minimum standards, will be conducted on recruitment of the home to the trial.

The review will be conducted by the researcher at the time when the care home is recruited, through review of training records, review of Care Quality Commission inspection reports (where available) and discussions with the home manager and/or staff. This will provide data on mandatory training, additional training, type, length and provider(s) of training and the percentage of staff that have completed this training.

If the training review finds that homes would benefit from some additional dementia awareness training (i.e. they fall below a minimum level of training defined by the TMG), staff will be provided with a half-day dementia awareness course. As a minimum care homes will be expected to deliver dementia awareness training to 20% of permanent direct care staff. The course, modified in consultation with service users, from an existing resource developed by Bupa and the University of Bradford [87] will be delivered by a trained mentor within each care home. Using a modified version of an existing dementia awareness package reduces development costs and ensures the package is reflective of a basic awareness package being implemented by one of the large, national care home providers. Based on CQC data [88], we expect up to 20% of homes to require this dementia awareness package.

8 RESIDENT ELIGIBILITY, RECRUITMENT AND CONSENT

Residents will be recruited to the trial at baseline. Further residents will be assessed for eligibility and approached to take part at the 16 month follow-up time point in each care home.

RESIDENT ELIGIBILITY (BASELINE)

INCLUSION CRITERIA

Residents meeting all of the following criteria at screening will be eligible for this trial:

- 1) Is a permanent resident within the care home - defined as a person residing in the care home and not present for receipt of respite or day-care;
- 2) Has a formal diagnosis of dementia or score 4+ on FAST [89] rated by the home manager or another experienced member of staff;
- 3) Is appropriately consented (in accordance with Mental Capacity Act [90] and clinical trials guidance on informed consent [91-93]);
- 4) Has an allocated member of staff willing to provide proxy data;
- 5) Has sufficient proficiency in English to contribute to the data collection required for the research.

Note that residents will NOT be excluded if they lack capacity to consent. Guidance on consent will be followed for residents assessed to lack capacity.

EXCLUSION CRITERIA

Residents meeting any of the following criteria will not be eligible for this trial:

- 6) Is known by the care home manager and/or relevant senior staff member to be terminally ill, e.g. formally admitted to an end of life care pathway;
- 7) Is permanently bed-bound/cared for in bed.
- 8) Is taking part, has recently taken part in, or is planning to take part, in another trial that conflicts with DCM™ or with the data collection during the course of their involvement in DCM EPIC.

Eligibility waivers to inclusion and exclusion criteria are not permitted.

RESIDENT ELIGIBILITY (16 MONTHS POST RANDOMISATION)

INCLUSION CRITERIA

Residents meeting all of the following criteria at the 16-month follow-up time point in each care home will be eligible to join the trial:

- 1) Is a permanent resident within the care home or unit(s) taking part in the trial - defined as a person residing in the care home and not present for receipt of respite or day-care;
- 2) Has a formal diagnosis of dementia or scores 4+ on FAST [89] rated by the home manager or another experienced member of staff;
- 3) Is appropriately consented (in accordance with Mental Capacity Act [90] and clinical trials guidance on informed consent [91-93]);
- 4) Has an allocated member of staff willing to provide proxy data;
- 5) Has sufficient proficiency in English to contribute to the data collection required for the research.

Note that residents will NOT be excluded if they lack capacity to consent. Guidance on consent will be followed for residents assessed to lack capacity.

EXCLUSION CRITERIA

Residents meeting any of the following criteria will not be eligible to take part:

- 6) Is already a DCM EPIC Trial participant
- 7) Declined (personally or via consultee) trial participation at the baseline time point
- 8) Moved to the care home (or participating EPIC unit) less than three months prior to screening
- 9) Is known by the care home manager and/or relevant senior staff member to be terminally ill, e.g. formally admitted to an end of life care pathway;
- 10) Is permanently bed-bound/cared for in bed.
- 11) Is taking part in or has recently taken part in another trial that conflicts with DCM™ or with the data collection for the DCM EPIC trial.

Eligibility waivers to inclusion and exclusion criteria are not permitted.

RESIDENT RECRUITMENT (AT BASELINE AND AT 16 MONTHS)

8.3.1 The researcher will meet with the care home manager and/or relevant senior staff to start the process of identification of all eligible residents to be approached to take part in the trial.

8.3.2 The manager or nominated lead will provide an up-to-date list of all residents in the care home and identify staff members who know each resident well, for example their key worker if such a system is in place.

8.3.3 The home will be allocated a range of Resident Screening Numbers by the CTRU ahead of the eligibility assessment process, with one Screening Number assigned to each resident by the home. The names of residents will remain confidential to the manager and care home staff for the purposes of eligibility screening, with details of resident names linked to screening numbers and nominated staff members maintained by the care home.

8.3.4 Each resident will be reviewed for eligibility and basic demographics, and this data will be recorded by the Researcher through discussions with the manager / senior staff, identified only by their screening number. Reasons for ineligibility will be recorded.

8.3.7 All residents listed by care homes and on whom eligibility screening was completed, will be entered onto a linked-anonymous Resident Screening Database hosted by CTRU. The data will include:

- Date of screening;
- Resident age;
- Resident gender;
- Resident ethnicity;
- Resident length of stay;

- Staff assessment of capacity to consent at screening;
- Reasons for ineligibility (where applicable);
- Reasons for not consenting (where applicable);
- Reasons for non-registration (where applicable);
- Resident Identification Number (Resident ID) (where registered).

Documented reasons for ineligibility or declining participation will be closely monitored by the Trial Team as part of a regular review of recruitment processes.

RESIDENT INFORMED CONSENT

Once all eligible residents are identified, the home manager or senior staff member will undertake a documented initial assessment of the capacity of each eligible resident to consent to take part in the trial. All residents will be assumed to have capacity to consent unless assessed to lack capacity in accordance with Mental Capacity Act 2005 [90] guidance. If it is believed that a resident does not have the capacity, the care home will contact the main carer on the researcher's behalf in the first instance. If they are uncertain about a resident's capacity, the home manager or senior staff member will approach the resident and ask their permission for the researcher to speak with them alongside a member of staff who knows them well. If at this point the staff member deems the resident has the capacity to make the decision to speak to the researcher and they give verbal consent, this will be documented and the researcher will gain access to the resident name. If the staff member deems the resident does not have the capacity to make this decision then they will be deemed to lack capacity to consent to participate in the trial.

The researcher will then approach each resident who was deemed to have capacity and whom agreed to speak to the Researcher. The researcher will be supported by a relevant member of staff, and undertake a further documented assessment of capacity.

If the resident is deemed not to have capacity to consent, the care home will contact the main carer on the researcher's behalf as a next step. See section 8.4.2.

Where a resident is deemed to have capacity the member of staff supported by the researcher will discuss the trial with the resident and provide them with the Resident Information Sheet (these will differ, dependent on the time point at which residents are recruited). At least 24 hours later, at a follow-up meeting with the researcher-staff dyad at which a relative or close friend of the resident may be present, the resident will be given the opportunity to ask any further questions they might have. Formal consent to participate in the trial will then be sought by the researcher.

There will be a nominated person within each care home (usually a senior member of staff), whom residents can approach with any questions or concerns. Residents will also be provided with the name of a contact person (their recruitment hub lead) whom they can contact during their participation in the trial if they have a question or concern.

8.1.1 Consent for those with capacity

Residents who are able to give informed consent will sign, or make a mark on the trial consent form. Where a resident is unable to sign, or make a mark, s/he will be asked to indicate his/her consent verbally. This will be witnessed by an independent observer (staff member, relative or friend) and recorded on the trial consent form. In the case of residents who lose capacity during the course of the trial, appropriate guidance on consent in the light of changed capacity will be followed [94]. This will include appointment of a personal consultee or nominated consultee at this point, in accordance with the processes adopted for residents who lack capacity at the outset of the trial (see section 7.3.2). The consultee will provide advice on the resident's continued involvement in the trial. A capacity assessment will be conducted at each data collection point by the researcher for residents who have capacity upon initial consent to take part in the trial, to assess continued capacity at each data collection point.

Where a resident has capacity and consents to taking part in the trial at baseline, documented written consent to approach his/her main carer (relative / friend) regarding potential participation as a proxy informant is included in the standard consent form. Relatives / friends will not be approached to take part for those residents joining the trial at 16 months post-randomisation.

8.1.2 Consent for those without capacity

Where a resident is assessed to lack capacity to give informed consent a 'Personal Consultee' will be appointed who can be consulted about what the Resident's wishes would be if they did have capacity. This will normally be a relative or close friend. Where the Resident has no close family or friend able or willing to act as Personal Consultee, another appropriate independent person, usually a member of staff in the care home who knows them well but who is not actively involved in any elements of the research process, will be appointed as a 'Nominated Consultee'.

The following process will be followed to appoint a consultee and gain their advice on the resident's wishes.

Following the capacity assessment, the Researcher will ask the staff member to identify the Resident's main carer.

If the main carer is present, the staff member will ask if s/he would be willing to speak to the researcher, and the Researcher will then provide him/her with a Relative / Friend Personal Consultee Information Sheet, talk through its contents and explain the assent form attached. They will also be asked for written informed consent to hold their personal details on record to enable the Researcher to contact them directly from this point - if they decide not to provide consent for the Resident to participate in the study, these contact details will not be held by the research team. The carer will then be given at least 24 hours to think about it and to talk to the resident and other relatives/friends. They will be provided with a shorter version of the Resident Information Sheet, designed for residents who lack capacity, to help explain the main trial issues in a format appropriate for people with dementia who lack capacity. They can use this to explain the trial to the Resident and to ascertain, where possible, a view on their feelings about taking part. If they are willing to sign the assent form, they will be asked to return it, by post, directly to the researcher, expressing their advice on what they feel the resident's wishes are/would be in relation to taking part in the trial. They will be asked to do this within a week of being given the Relative / Friend Personal Consultee Information Sheet. The Researcher will send a follow up reminder a week later if the form has not been returned. If after a further week the form has not been returned the process of appointing a Nominated Consultee will be followed.

If the main carer is not present in the care home, the Researcher will ask the care home to send the identified person a Relative / Friend Personal Consultee Information Sheet, the associated Resident Information Sheet and Personal Consultee Declaration form and a shorter form of the Resident Information Sheet on his/her behalf, and wait a week for a response. If there is no response, the care home will phone the main carer or speak to them if they visit the care home to check that they have been received. If there is still no response after a further week then an appropriate staff member from the care home will be approached and sent a Staff Nominated Consultee Information Sheet, the Resident Information Sheet and Nominated Consultee Declaration form and a shorter form of the Resident Information Sheet.

In all cases, the carer (Personal Consultee) or staff member (Nominated Consultee) will be given the opportunity to speak to the researcher over the phone about taking on this role. After undertaking appropriate consultation with the Resident (using the short version of the resident information sheet) and their relatives/close friends and colleagues within the home, where appropriate, the consultee will be asked to complete and return the assent form directly to the Researcher.

A Personal or Nominated Consultee can approach the researchers at any time to indicate they feel the person they are representing has changed their mind about participating in the trial, and to withdraw them from participation. Likewise if the researchers feel that during the trial, the wishes of a person who lacks capacity may have changed in regard to participating in the trial, they will seek advice from the personal or nominated consultee about the resident's continued inclusion.

Given the length of the trial there is a possibility Personal Consultees may lose capacity themselves during the trial period. Therefore an annual review of personal consultee capacity will be undertaken by the Researcher during the period each Resident is participating in the trial. Researchers will review PC capacity with the care home manager, or research lead ahead of all follow-up data collection. Researchers will make every attempt to confirm the ongoing capacity of PCs, but will only conduct capacity assessments for those consultees visiting the care home during data collection visits.

9 STAFF ROLES, ELIGIBILITY, RECRUITMENT AND CONSENT

STAFF ROLES

Active involvement of care home staff is crucial to the trial; this will initially be ascertained by the home manager in parallel to the home manager considering participation on behalf of the home. There are five possible staff roles, although some roles are mutually exclusive (see notes below):

- i) To act as a nominated consultee for residents (see section 8.3.2);
- ii) To provide data relating to their role (staff measures) (see section 9.2);
- iii) To provide proxy data relating to residents they know well (proxy informant) (see section 10.2);
- iv) To become trained DCM™ mappers (see section 12.2);
- v) To participate in the process evaluation (see section 14).

Note: that if a staff member acts as nominated consultee for residents they cannot provide staff measures data, proxy informant data, be a trained mapper or participate in the process evaluation. If a staff member is a trained mapper they cannot provide proxy informant data on residents. The below table (table 1) summarises what each role can and cannot do:

Table 1 Role Summary

	Nominated Consultee	DCM™ mapper	Proxy informant
Nominated Consultee		X	X
Staff measures	X	✓	✓
Proxy informant	X	X	
DCM™ mapper	X		X
Process evaluation	X	✓	✓

A text message will be sent to trained DCM™ mappers ahead of data collection (6 and 16months post randomisation) to remind mappers not to provide proxy data relating to residents.

STAFF MEASURES

INCLUSION CRITERIA

Staff meeting all of the following criteria will be eligible to provide data on the staff measures for this trial:

- 1) Is a permanent, contracted, agency or bank member of staff at time of data collection;
- 2) Provides consent to providing data for the trial through return of the Staff Measures booklet;

- 3) Has sufficient proficiency in English to contribute to the data collection required for the research.

EXCLUSION CRITERIA

Staff meeting the below criterion will not be eligible to provide data on the staff measures for this trial:

- 4) Be acting as a Nominated Consultee for any residents participating in the trial.

Eligibility waivers to inclusion and exclusion criteria are not permitted.

Staff recruitment will take place at baseline and at each further data collection point, due to often high turnover rates of staff in care home settings. The home will be provided with copies of the Staff Information sheet and Staff booklet around two weeks prior to each data collection visit and will be asked to distribute one copy of each to each eligible staff member. Staff will have the opportunity to ask any questions they have by contacting the home manager or nominated research lead, through contacting the researcher, or by speaking to the researcher directly during the data collection visit. Staff will be asked to anonymously complete the booklets and return them in a sealed envelope to a box located within the care home or post directly to the research office in the stamped addressed envelope provided.

The researcher will provide the home manager or care home research lead with the number of returned booklets at the start of, and during, the data collection week. The manager or research lead will remind staff to complete the booklet if they have not all been returned.

The Staff Booklet will include the following data:

- Care Home ID;
- Follow-up time point (i.e. baseline, 6 months or 16 months follow-up);
- Date of completion of questionnaires;
- Staff age category;
- Staff gender;
- First language (if not English);
- Length of time spent working in this care home (<6 months, <12 months, <2 years, <5 years, Over 5 years);
- Highest qualification;
- Previous dementia-specific training and timing;
- Previous DCM™ training and / or experience and timing;
- Current job role.
- Current working pattern
- SCIDS questionnaire

For staff completing the staff booklet, completion and return of this will signify their consent to participate. CTRU will assign Staff Identification Numbers upon receipt of the questionnaires.

10 PROXY ELIGIBILITY, RECRUITMENT AND CONSENT

As a significant proportion of residents recruited into the trial will not be able to complete the data relating to them, it is important to collect proxy data from a consistent informant who knows them well. In this trial, Relatives / Friends and staff members will provide data on residents they know well whether or not the resident lacks the capacity to consent or loses the capacity to consent mid trial. In this way Relatives / Friends and Staff will be regarded as informants alongside the resident, where they are able to complete the questionnaires.

The resident may participate without the involvement or assent of their Relative / Friend to provide proxy data about them, and the Relative / Friend may act as personal consultee without providing data on the resident for the trial.

However, the resident may not participate without the identification of a Staff member willing to provide proxy data.

RELATIVE / FRIEND AS INFORMANTS (FOR RESIDENTS RECRUITED AT BASELINE ONLY)

To be eligible to provide proxy data (i.e. Quality of Life data) about a resident, Relatives / Friends must meet all of the following criteria:

- 1) Visit the resident on a regular basis over the past month (i.e. at least once per week);
- 2) Be willing to provide data at a time convenient to them, within the care home, in person, during the data collection week, or by telephone;
- 3) Has sufficient proficiency in English to contribute to the data collection required for the research.

Eligibility waivers are not permitted.

Relative / Friend recruitment will take place at baseline and eligibility will be reassessed at each subsequent data collection point due to the fact that Relatives / Friends may no longer meet eligibility criteria over time.

Where relatives withdraw, new participant relatives will not be identified at follow-up time points, nor will Relative/ Friend informants be recruited for those residents joining the trial at the 16 month time point.

The Resident supported by the home manager or a senior member of staff who knows the Resident well, will be asked to identify one relative or close friend, who visits regularly, to be approached to provide proxy data for the trial. Where the resident lacks capacity to consent to take part in the research, the relative or close friend identified may be the same person identified to act as consultee for the Resident. However, the Resident and/or staff may identify a relative/friend who is not the Personal Consultee, but who may be more appropriate to provide proxy data for the Resident. Therefore, the person providing proxy data may be different from the Resident's Personal Consultee, where one is appointed.

The home will produce and maintain a list of names and addresses of Relatives / Friends linked to Residents. The Researcher will not have access to this initially. Once Relative / Friend informants are identified, the Researcher will provide the home with written information about the trial (i.e. the Relative / Friend Proxy Information Sheet and Consent Form) that the home manager can either give to the Relative / Friend personally on their next visit, or post to them. After a week, the Researcher will inform the care home of the Relatives / Friends who have responded and will ask the home manager to send out one further reminder to the remaining Relatives / Friends. The Relative / Friend will be informed they can withdraw from the trial at any stage without any adverse impact on the care of the Resident, and without affecting the Resident's continued involvement in the trial. Receipt of the consent form will provide the researcher with a list of Relative / Friend names and addresses that they will maintain for the duration of the trial.

CTRU will assign Relative / Friend Identification Numbers upon receipt of the questionnaires.

For each Relative / Friend associated with each resident, data collected will include;

- Relative / Friend age;
- Relative / Friend gender;
- Relative / Friend date of birth;
- Distance to travel to the care home;
- Relationship to resident;
- Number of visits over past month and indication of whether this is representative of usual visiting pattern;
- Visit patterns (weekdays/weekends, mornings/afternoons/evenings).

There will be a nominated person within each care home (usually a senior member of staff), whom

Relatives / Friends can approach with any questions or concerns. They will also be provided with the name of a contact person (their recruitment hub lead) whom they can contact at any time during their participation in the trial if they have a question or concern.

STAFF AS INFORMANTS

INCLUSION CRITERIA

To be eligible to provide proxy data on a resident, staff must meet all of the following criteria:

- 1) Be a permanent or contracted member of staff;
- 2) Know the resident well, as assessed by their key worker status and/or the judgement of the home manager.

EXCLUSION CRITERIA

Staff meeting any of the following criteria will not be eligible:

- 3) Working in the home as agency or bank staff;
- 4) Be a trained DCM™ mapper;
- 5) Have acted as nominated consultee for any residents in the trial.

Eligibility waivers to inclusion and exclusion criteria are not permitted.

In advance of each data collection visit, the home manager will be asked to review the list of staff that knows each recruited Resident well, including the nominated staff member. Where possible the same staff member will provide proxy data throughout the trial. If a new staff informant is required they will undergo the same process of screening and recruitment as the previous informant.

For new residents identified to participate at 16 months, appropriate staff proxies will be identified to provide data.

Staff identified as potential proxy informants, will be approached by the Researcher, who will give them verbal and written information about the trial (i.e. the Staff Proxy Informant Information Sheet relevant to the time point at which they take on this role).

Staff consent to provide data in this way will be verbal, via discussion with the researcher. Receipt of staff proxy data (about the resident) will be taken as implied consent to take on this role. Written consent from staff will not be required; rather the researcher will formally confirm with the staff member that their name only will be held by the research office to facilitate follow-up. Agreement to this (along with confirmation of staff eligibility) will be noted in the data collection booklet by the researcher.

Where the staff member is not willing to provide data about a resident, a new staff member will be identified instead. Staff participants who show their willingness to provide data will be advised that they are free to withdraw from this role at any time without adverse impact.

11 REGISTRATION AND RANDOMISATION

REGISTRATION OF RESIDENTS

Residents recruited at baseline will be registered with the CTRU after care home recruitment and the training review at the care home level, and after confirmation of eligibility, informed consent and collection of baseline data (including Independent Assessments) at the resident level.

Residents recruited at 16 months will be registered with the CTRU after confirmation of eligibility, informed consent and collection of data (including Independent Assessments) at the resident level.

At both time points, registration of residents will be performed using the CTRU automated 24-hour registration system, which will provide each resident with a unique Resident Identification Number. Authorisation codes and PINs, provided by the CTRU and used by researchers, will be required to access the registration system.

The following details will be required at registration:

- Resident Screening Number;
- Resident details: initials, date of birth;
- Name of person undertaking the registration;
- Confirmation of eligibility (including time spent in participating EPIC unit);
- Confirmation of informed consent;
- Confirmation of baseline (or 16 month follow-up) assessment;
- Confirmation of staff proxy informant identification.

The Resident ID number from the registration process will be added to the Screening Form by CTRU or the researcher to enable those providing consent to be linked.

24-HOUR REGISTRATION OF RESIDENTS can take place either:

ONLINE: <https://lictr.leeds.ac.uk/webrand/>

Or by TELEPHONE: 0113 343 2290

RANDOMISATION OF CARE HOMES

Once all Residents have been registered at baseline, care homes will be randomised using the 24-hour automated randomisation system based at the CTRU University of Leeds.

Care homes that fulfil the eligibility criteria, have signed up to the protocol and have signed a written agreement to participate will be randomised, following recruitment of Residents, Staff and Relatives / Friends, and completion of baseline assessments, on a 3:2 basis to receive either DCM™+UC or UC. A computer generated minimisation programme, based on that recommended by Kuznetsova and Tymofyeyev [95], incorporating a random element will be used to ensure treatment arms are balanced for the following care home characteristics, details of which will be required at randomisation:

- Home/unit type (general residential/nursing, specialist dementia care);
- Size (large \geq 40, medium/small $<$ 40);
- Provision of dementia awareness training by research team (yes, no);
- Recruiting Hub (West Yorkshire, London, Oxford)

The following information will also be required at randomisation:

- Care Home ID;
- Use of DCM™ in the home over the last 5 years (yes, no)
- Name of person undertaking the randomisation;
- Number of registered residents in care home (minimum acceptable=10);
- Confirmation of eligibility;
- Confirmation of baseline assessment for all registered residents.

The randomisation call will be performed by CTRU Data Management, following necessary confirmations from the Researcher. As such, personnel within the CTRU will not be kept blind to treatment allocation. Following randomisation, the CTRU will inform the DCM™ lead of those homes allocated to DCM™ + UC, so that arrangements for training can be made. CTRU will inform the Care Home Manager of the treatment allocation by confirmation email or fax. The

Researchers will not be informed and efforts will be made to keep them blinded to the allocation throughout the trial. Other personnel involved in the trial will only be informed of treatment allocation if this is required to undertake their role associated with the trial.

12 INTERVENTION DETAILS

USUAL CARE (BOTH ARMS)

Usual Care (UC), defined as normal care delivered within the setting, will continue in both arms. No restrictions will be imposed on current practices or on homes undertaking additional development or training as part of usual care, with the exception of control arm homes being required not to implement DCM™ during their trial involvement period. As outlined in the background section, person-centred care is considered best practice within dementia care [55] and as such, care homes are expected to provide staff with appropriate training to deliver care of this type [67]. Details regarding any changes in usual care practice during the course of the trial will be documented by the EPIC Researcher at follow-up visits.

A list of GPs that serve the care home and other relevant visiting professionals will be provided by the care home. All GPs and visiting professionals will be provided with generic best practice guidance about the implementation of person-centred care and managing BSC post care home randomisation, irrespective of whether the residents they support are participating in the trial. We will not be informing individuals' GPs about residents who are participating in the trial. This will facilitate a person-centred primary care response where care homes seek support.

DEMENTIA CARE MAPPING™ (INTERVENTION ARM ONLY)

Dementia Care Mapping™ (DCM™) [12, 13, 96, 97] is an observational tool designed to assess quality of care in formal dementia care settings. It is grounded in the philosophy of person centred care and was designed to be used in a series of developmental evaluations over time. Through a process of preparation and feedback, staff members are empowered to consider care from the point of view of the person with dementia. On the basis of these observations and subsequent feedback to the care team, changes can be made to care plans and practice. DCM™ can be used to monitor change and provides positive reinforcement for the provision of person-centred care over time. The use of DCM™ as an evidence based, service user focussed, quality monitoring and improvement tool has been commended by the Audit Commission [98] and the Commission for Health Improvement [99, 100].

The intervention in this trial comprises:

- a) Training in DCM™;
- b) Implementation of three cycles of briefing, observation, feedback and action planning and implementation of action plans, in accordance with the British Standard best practice guideline [31] and additional intervention fidelity guidelines provided by the research team.

12.1.1 Mapper identification and consent

Two staff* in each home will be identified to be trained to use DCM™ (referred to forthwith as trained mappers). Two mappers will be approached and consented at baseline in all homes prior to randomisation (in homes then randomised to the intervention arm, these identified mappers will undertake DCM™ training, as per 12.2.2).

* If two units within a home are taking part one staff member from each unit will be approached and consented to participate.

INCLUSION CRITERIA

To be eligible to be trained, staff must meet all of the following criteria:

- 1) Be a permanent or contracted member of staff;
- 2) Have the right skills and qualities as assessed by the home manager in accordance with guidance provided by the research team;
- 3) Provide consent to becoming a mapper, to implementing the DCM™ process in accordance with the research protocol and to providing intervention fidelity data;
- 4) Provide consent to complete interview and focus group data for the trial (Process Evaluation).

EXCLUSION CRITERIA

Staff meeting any of the following criteria will not be eligible:

- 5) Working in the home as agency or bank staff;
- 6) Acting as a nominated consultee or providing proxy data for any residents participating in the trial.

Staff eligible to become mappers will be identified by the home manager. The staff chosen to undertake DCM™ training will then be identified by the home manager in discussion with the DCM™ lead.

Potential mappers will initially be approached by the home manager who will be provided with written information about the role and responsibility of the mappers. Once verbal consent has been obtained by the home manager, the potential mappers will be approached by the researchers who will again explain the role and responsibility of the mappers before gaining their written informed consent to participate. Should a mapper leave the care home before the end of the trial, where feasible a further suitable member of staff will be identified, consented and trained to ensure continuity of DCM™ implementation within the home.

12.1.2 Training

DCM™ training is only available through licensed DCM™ trainers, delivering courses registered with the University of Bradford. This ensures consistency of training in the tool nationally and internationally. The DCM™ training consists of a standardised four-day course including an assessment of competency in use of the tool on the final day. A pass mark of 60% is required in order to use DCM™ following the training. Resit assessments are available for students not achieving a pass mark at the first attempt.

All mappers will attend a Bradford or London based DCM™ course. The course trainers will report on mappers' successful completion of the course to CTRU to ensure a register is maintained of all qualified mappers taking part in the trial.

12.1.3 Implementation

Implementation of DCM™ involves a practice development cycle of briefing the staff team, observation, data analysis, feedback to the staff team, action planning and remapping. Ahead of each mapping cycle the CTRU will contact each mapper via SMS to remind them of the upcoming cycle.

Briefing

Mappers run one or more briefing sessions 1-2 weeks prior to undertaking the mapping observations. Briefing sessions inform the care home staff about DCM™ and the process of implementation. It provides an opportunity for staff to ask questions about the process and for mappers to address any worries staff may have about what will happen.

Resident consent for mapping

Prior to mapping, appropriate residents are selected to be mapped through discussions between

the care team and mappers. This is usually completed during the briefing session. Residents are usually selected for observation on the basis of being reflective of a range of abilities or having particular care needs or behaviours staff members have difficulties meeting or understanding. DCM™ will be implemented in the intervention homes as part of care quality monitoring and improvement processes. Consent from residents to be observed as part of the intervention implementation will be gained verbally, by the trained mappers, prior to each DCM™ cycle. The process for this will be in accordance with the usual consent process utilised in DCM™. Residents observed as part of the intervention do not have to meet the research eligibility criteria, or be participating in the research. They will be selected for observation, by the trained mappers, according to guidance provided within the DCM™ tool. Any resident data collected as part of the DCM™ process will be owned and used by the trained mappers within the home. Any data used for monitoring intervention fidelity or for any other purposes within the research, will be anonymised at the care home level before being accessed by the research team.

Observation

DCM™ will involve continuous observation of between 5 and 8 people with dementia (depending on the experience of the mapper), over a period of up to 6 consecutive hours, producing what is called a 'map' of the experience of care. Every 5 minutes the observer, or mapper, will record 2 pieces of information about each person they are observing, a Behaviour Category Code (BCC) and a Mood/Engagement (ME) Value. There are 23 possible BCCs for the mapper to choose from, and they capture what the person with dementia is doing within that 5-minute period (or time frame). The ME Value encapsulates the associated mood and engagement level of the person with dementia and is chosen from a 6-point scale. The mapper will also record instances when a person with dementia is 'put down' by a care worker, known as personal detractors (PDs), and examples of excellent care, called personal enhancers (PEs). These will be recorded as and when they occur. When recording and feeding back PDs and PEs, the mapper will be careful not to identify the individual staff members involved.

Since DCM™ is grounded in person-centred care, for reasons of privacy and dignity, observations will only take place in communal living areas, such as the lounge, dining room and corridors. A mapper will not observe in bedrooms or bathrooms. If a resident is at risk of an accident or a fall, or in the case of a medical emergency, a mapper will intervene immediately and offer assistance to staff as required. They will not continue to map in a setting which is experiencing a crisis or other such difficulties. Once data has been collected it will be analysed by the trained mappers and presented in a standardised report format for the purposes of feedback to the care team.

Data analysis

Mappers will analyse the data they produce to present it in a format that the staff team are able to engage with during feedback. There is a standardised set of data a mapper produces for feedback purposes including the percentage of time individuals and the group spend in each behaviour category and ME Value. A summary of PDs and PEs is also produced. The data will be presented in a report format that is used during the feedback session. This includes graphs of the summarised data and some key discussion points to be addressed during feedback.

Feedback and action planning

Mappers will run one or more feedback sessions with as many of the staff team as possible in order to share the DCM™ data with them and to engage them in considering what this means for improving practice within the setting. On the basis of the discussions during the feedback session an agreed, achievable action plan will be produced with short, medium and longer term goals. Progress on these actions is monitored during the next mapping cycle.

The first cycle of mapping will be supported by an expert DCM™ user provided by the research team, to support establishment of inter-rater reliability of DCM™ coding between the trained mappers within each care home and assessment of this across the 30 intervention sites. This will also support intervention fidelity through supported implementation of DCM™ to the required standard during the first mapping cycle.

The care home's insurance and indemnity will apply for trained mappers implementing the intervention within the care home setting. Possession of appropriate insurance will be checked at point of recruitment of the care home to the study.

MONITORING INTERVENTION DELIVERY

Adherence to the prescribed processes for intervention delivery will be monitored at each round of the intervention.

Monitoring will aim to determine:

- 1) Adherence to the processes – are trained mappers delivering the intervention in accordance with training and 'as intended';
- 2) Quality of intervention delivery (fidelity) – are trained mappers delivering the intervention with sufficient quality.

Measurement of Adherence and Fidelity will take the form of a sliding scale, rather than an absolute value, since this is a complex intervention with multiple facets, where giving a rating of compliant or non-compliant will not be possible.

12.1.4 British Standards

PAS 800 [76] sets out a standard for implementing DCM™ within a care provider organisation. It will provide the basis for the principles underpinning the adherence to intervention delivery.

12.1.5 Briefing

Briefing 'adherence' will be measured by achieving the following:

- Use of standardised briefing documentation provided by the research team and adapted to the individual care home;
- At least 50% of the direct care staff on the unit to be mapped to have attended a formal briefing session (at each round of mapping);
- 100% of staff on the unit to be mapped to have received written briefing documentation (at each round of mapping).

12.1.6 Observation

Observation 'adherence' will be measured by achieving the following:

- Two mappers having completed at least 4 hours of observations over a 1 week period;
- At least five residents observed in total with at least 3 hours of available data on each resident;
- Mappers using all four of the coding frames (BCC, ME, PD and PE) and making additional qualitative notes to accompany the mapping data.

12.1.7 Reporting

Reporting 'adherence' will be measured by achieving the following:

- Use of a standardised report template;
- Data analysis and presentation completed using software provided by the research team.

Anonymised copies of all feedback reports will be provided to the Research team at CTRU by the mappers in order to assess intervention fidelity.

12.1.8 Feedback

Feedback 'adherence' will be measured by achieving the following:

- Use of a feedback guideline to ensure required balance of positive and developmental feedback is given during each feedback session;

- At least 25% of the direct care staff on the unit attending a formal feedback session;
- 100% of staff on the unit having access to the final written report and a mechanism for inputting their feedback and ideas into the action planning process.

12.1.9 Action Planning and Implementation

Action planning and implementation 'adherence' will be measured by achieving the following:

- Use of a standardised format for action plans;
- Development of minimum of one and maximum of four action points per resident;
- Development of at least 6 and maximum 12 home level action points;
- Action points to be written as SMART (Specific, Measurable, Achievable, Realistic, Time limited);
- Action points to be developed in consultation with, and agreed by, staff team.

WITHDRAWAL

It is possible that entire care homes, care home staff, mappers, Relatives / Friends and residents could withdraw during the course of the trial. Where the wish to withdraw is expressed, the reasons for this will be discussed with the research team and the type of withdrawal clarified.

Care homes will sign a written consent agreement prior to randomisation detailing their commitment, reducing the likelihood of withdrawal. However, where they choose to withdraw, the options open to them will be for the home to withdraw from treatment only or from both treatment and further data collection (in the case of the latter, the care home will have the consent of all the residents, Relatives / Friends and staff to this).

Where a mapper wishes to withdraw they may withdraw from providing research data (i.e. participation in final interviews for the process analysis) for the trial, but may still wish to continue in their role as mapper, or may withdraw from both. If a mapper does not wish to provide further intervention fidelity data then they will be judged to also be withdrawing from their role as a mapper within the home. In the case of withdrawing from the role of mapper, where feasible a new mapper will be identified and trained from the staff team.

Care home staff may leave their employment or change their caseload mid-trial, altering their status as the nominated staff member to provide data regarding specific residents. If this occurs then a replacement staff member will be identified and the original staff member will no longer provide data for all or specific residents.

Where a Relative / Friend wishes to withdraw, a replacement will not be sought.

At each visit, the resident's willingness to continue, once initial consent has been secured, will be ascertained. During data collection weeks in the home (baseline, 6 months and 16 months) the researcher will, where possible, be gathering quality of life data directly from the person with dementia. When the researcher speaks to the resident they will remind them who they are and why they are visiting the home. They will check the person with dementia is still happy to provide interview data for the trial on that visit. If they are not then the researcher will not collect any direct data from them on that day. If it is appropriate they may approach the resident again later. This permits residents to choose to be 'non-compliant' in providing interview data about their quality of life at any given data collection point, without withdrawing from the trial. It also gives the resident opportunity to express a desire to withdraw from the trial as a whole at each data collection point, making consent an on-going process.

Residents will be advised that they are free to withdraw from data collection at any time without adverse impact. Like their Relatives / Friends, however, they will be encouraged to continue providing data on a subset of measures only (i.e. proxy-completed/resident-completed /notes and records data).

Residents transferred out of the Care Home during the course of the trial will not be considered as a withdrawal but termed as lost to follow-up. Researchers will document the date of transfer, and if transferred to a new Care Home will document the address to confirm if this Care Home is also taking part in the study. If transferred to another Care Home participating in the study the Residents participation will be reviewed and relevant consent obtained (i.e. Staff Proxy Informant).

It is assumed that the implications of withdrawal will take effect from the point of withdrawal.

12.1.10 Withdrawal from trial due to death

All deaths occurring from the date of consent to participate in the trial up to sixteen months post randomisation must be recorded on the Death Form. The original form should be submitted to the CTRU within a week of the researcher becoming aware of the event. The researcher will contact the home and arrange for a convenient time to review the participant's care records.

13 DATA COLLECTION/ ASSESSMENTS

Recruiting hubs (i.e. West Yorkshire, London and Oxford) will be expected to maintain a file of essential trial documentation (i.e. Hub Site File), which will be provided by CTRU. Original CRFs will be sent to the CTRU and stored centrally.

Assessments will be undertaken at the following time points:

- Screening (prior to consent);
- Baseline (prior to resident registration);
- 6-months post randomisation;
- 16-months post randomisation.

Required data, assessment tools, collection time-points and processes are described in detail in sections 13.1 to 13.5. This is summarised in Table 2 below.

Table 2: Summary of Assessments

Assessment	Type	Method of Completion	Timeline			
			Screening	Baseline	6 Months	16 Months
Care Home Eligibility	CRF	Researcher Assessment	X			
Training Review	CRF	Researcher Assessment	X			
Dementia Awareness Training	CRF	Dementia Awareness Trainer	X			
Resident Screening (Demographics)	CRF	Researcher Assessment	X			
Staff Mapper Screening	CRF	Researcher Assessment	X			
Consent (Staff Mapper, Resident (incl. Personal/Nominated Consultee), Staff Proxy Informant, RF Proxy Informant)	Consent Form	Self-completion (Witnessed)	X			X
Participant Eligibility (Staff Mapper, Resident, Staff Proxy Informant, RF Proxy Informant)	CRF	Researcher Assessment	X			X
Participant Contact Details (Resident, Staff Proxy Informant, RF Proxy Informant)	CRF	Researcher Assessment	X			X

Cohen Mansfield Agitation Index (CMAI) abridged	Questionnaire Booklet	Independent Researcher Observations (R)		X	X	X
Pittsburgh Agitation Scale (PAS)	Questionnaire Booklet	Independent Researcher Observations (R)		X	X	X
Care Home Manager Demographics	Questionnaire Booklet	Researcher Interview (CM)		X	X	X
Care Home Demographics	Questionnaire Booklet	Researcher Interview (CM)		X	X	X
Group Living Home Characteristics (GLHC)	Questionnaire Booklet	Researcher Assessment (CH)		X	X	X
Environmental Audit Tool (EAT)	Questionnaire Booklet	Researcher Observations (CH)		X	X	X
QQuality of Interactions Schedule (QUIS)	Questionnaire Booklet	Researcher Observations (R/S)		X	X	X
Staff Proxy Informant Demographics	Questionnaire Booklet	Researcher Interview (SP)		X	X	X
Resident Demographics	Questionnaire Booklet	Researcher Assessment		X	X	X
RF Proxy Informant Demographics	Questionnaire Booklet	Researcher Interview (RF)		X	X	X
Cohen Mansfield Agitation Index (CMAI)	Questionnaire Booklet	Researcher Interview (SP)		X	X	X
Neuropsychiatric Inventory (NPI-NH)	Questionnaire Booklet	Researcher Interview (SP)		X	X	X
Functional Assessment Staging (FAST)	Questionnaire Booklet	Researcher Interview (SP)		X	X	X
Clinical Dementia Rating (CDR)	Questionnaire Booklet	Researcher Interview (SP)		X	X	X
DEMQOL Proxy	Questionnaire Booklet	Researcher Interview (SP/RF)		X	X	X*
EQ 5D 5L	Questionnaire Booklet	Researcher Interview (SP/RF/R)		X	X	X*
QUALID	Questionnaire Booklet	Researcher Interview (SP/RF)		X	X	X*
QOL-AD	Questionnaire Booklet	Researcher Interview (R)		X	X	X
Resident Comorbidities	Questionnaire Booklet	Researcher Assessment		X	X	X
Healthcare Resource Use	Questionnaire Booklet	Researcher Assessment		X	X	X
Prescription Medications	CRF	Researcher Assessment		X	X	X
Resident Registration	Questionnaire Booklet	Researcher Assessment		X		X
Staff Booklet	Questionnaire Booklet	Self-Completed (S)		X	X	X
General Health Questionnaire (GHQ-12)	Questionnaire Booklet	Self-Completed (S)		X	X	
Sense of Competence in Dementia care Staff (SCIDS)	Questionnaire Booklet	Self-Completed (S)		X	X	X

Safety Reporting	CRF	Researcher Assessment		Monthly following Randomisation
RUSAE Report	CRF	Researcher Assessment		As highlighted.

			Mapper Training	Cycle 1	Cycle 2	Cycle 3
Mapper Training	CRF	DCM Trainer	X			
DCM Adherence	Questionnaire Booklet / CRF	DCM Expert / independent reviewer		X	X	X
DCM Briefing Summary	CRF	CH Mapper		X	X	X
DCM Feedback Summary	CRF	CH Mapper		X	X	X

Key: R – Researcher Observations, CM – Care Home Manager, CH – Care Home Observations, R – Resident, S – Staff, SP – Staff Proxy Informant, RF – Relative/Friend Proxy Informant, X* - only for Relative/Friend Informants consented at baseline and still meeting eligibility criteria.

The main informant will be the nominated staff member who knows the resident well. This is to ensure there is a consistent data set available for each resident at each time point. The staff proxy data will be supplemented, where possible, by information provided by the resident (where they are able) and their Relative / Friend carer (where available).

SCREENING DATA (PRIOR TO BASELINE)

Screening data will be collected on care homes and residents. This will allow eligibility and consent to be established and provide basic information that will be helpful in demonstrating generalisability and imputing data where this is missing.

13.1.1 Home manager-completed data

The following data will be collected from the Home Manager at screening, prior to the relevant consents (that is, the written consent agreement for the care home, consent/assent for the resident, staff and Relatives / Friends):

- Care Home Eligibility Checklist;
- Number of residents with dementia including (i) formal diagnosis or (ii) FAST.

This will be collected over two to three interviews: one for the care home data, one for the resident data, and one for the proxy data.

13.1.2 Researcher-completed data

The following data will be collected by Researchers from the home records:

- Training Review.

This will be collected following care home consent.

REGISTRATION AND RANDOMISATION DATA

See Sections 11.1 and 11.2 for data collected at registration and randomisation respectively.

PILOT DATA

Baseline data collection visits will commence approximately two months earlier in two care homes, in order to assess how manageable the data collection burden is. Following this, the data collection schedule will be reviewed by the Trial Management Group and a decision will be made about whether (and how) to reduce the burden on informants. Strategies for obtaining data from staff and Relatives / Friends may also be refined. The data collected during this pilot will be used in the main trial and the usual timelines will be followed for these homes. In effect these homes are

just commencing the trial in 'isolation' before bringing other homes on board.

BASELINE DATA

The baseline data collection visit will be scheduled to last one week in each home with two Researchers present.

The researcher will also get in touch with Relatives / Friends who have consented to take part to arrange appointments to collect data on residents, and will send out staff measures to the home to be distributed to staff. If appointments cannot be made in advance, the researcher will fit these into their schedule during the visit.

13.1.3 Resident-completed data

Residents will complete the following data where they are able, irrespective of whether they have the capacity to consent or not. The FAST rating at each time point will permit analysis of data to be analysed on the basis of dementia severity:

- QOL-AD;
- EQ-5D-5L.

The Resident measures will be completed by researcher interview.

13.1.4 Home manager-completed data

The following data will be collected from the Home Manager during their scheduled meeting:

- Care home demographics;
- Home manager demographics;
- Staffing including turnover, agency/bank use, levels (accessed via home records);
- Group Living Home Characteristics Questionnaire (GLHC).

The home measures will be completed by researcher interview.

13.1.5 Staff-completed data

The researcher will ask managers to remind staff to complete staff booklets during the period of the researcher visit.

If booklets are not completed during this visit they may be posted directly to the CTRU in pre-paid envelopes.

The following will be completed by Staff acting as proxy-informants as part of a researcher interview:

- Cohen Mansfield Agitation Inventory (CMAI);
- Neuropsychiatric Inventory (NPI);
- QUALID;
- DEMQOL-Proxy;
- EQ-5D-5L-Proxy;
- Clinical Dementia Rating scale (CDR);
- Functional Assessment Staging of Alzheimer's Disease (FAST);

13.1.6 Relative / Friend-completed data

The following will be completed by the Relative / Friend as part of a researcher interview:

- RF Proxy Informant Demographics
- QUALID;
- DEMQOL-Proxy;
- EQ-5D-5L-Proxy.

If measures are not completed during this visit they may be;

- a. Completed via telephone interview within 2 weeks of the follow-up time point;
- b. Self-completed and returned directly to the CTRU in pre-paid envelopes. Guidance on self-completion of questionnaire will be provided by the Researcher.

13.1.7 Researcher-completed data

The following data will be collected by researchers from the home records or observation of residents and staff:

- Environmental Audit Tool (EAT);
- Pittsburgh Agitation Scale (PAS);
- Abridged Cohen Mansfield Agitation Index (CMAI);
- Quality of Interactions Schedule (QUIS);
- Resident co-morbidities
- Prescription Medications;
- Healthcare Resource Use from review of care records.

FOLLOW-UP DATA (FOR THOSE RECRUITED AT BASELINE)

The two follow-up data collection visits (at 6 and 16 months) will be scheduled to last one week in each home. Researchers will contact participating Relatives / Friends to arrange appointments at the care home to collect data on residents, and send out staff measures booklets to be distributed to staff. If appointments cannot be made in advance, the researcher will slot these into their schedule during the visit.

13.1.8 Resident-completed data

Residents will complete the following data at 6- and 16-months if they had the capacity to consent when recruited:

- QOL-AD;
- EQ-5D-5L.

The resident measures will be completed by researcher interview.

13.1.9 Home manager-completed data

The following data will be collected from the Home Manager during their scheduled meeting at 6- and 16-months:

- Care home demographics;
- Home manager demographics;
- Staffing including turnover, agency/bank use, levels (accessed via home records);
- Group Living Home Characteristics Questionnaire (GLHC).

The home measures will be completed by researcher interview. Additionally at 16-months the Home Manager will be interviewed as part of the process evaluation (see Section 14).

13.1.10 Staff-completed data

The researcher will ask managers to remind staff to complete staff booklets during the 6- and 16-month visits

If booklets are not completed during this visit they may be posted directly to the CTRU in pre-paid envelopes.

The following will be completed by Staff acting as proxy informants at 6- and 16-months as part of a researcher interview:

- Cohen Mansfield Agitation Inventory (CMAI);
- Neuropsychiatric Inventory (NPI);
- QUALID;
- DEMQOL-Proxy;
- EQ-5D-5L Proxy;
- Functional Assessment Staging (FAST)
- Clinical Dementia Rating (CDR)

Additionally at 16-months staff will form part of the focus groups conducted as part of the process evaluation (see Section 14).

13.1.11 Relative / Friend-completed data

The following will be completed by the participating Relative / Friend at 6- and 16-months as part of a researcher interview:

- RF Proxy Informant Demographics
- QUALID;
- DEMQOL-Proxy;
- EQ-5D-5L-Proxy.

If measures are not completed during this visit they may be;

- a. Completed via telephone interview within 2 weeks of the follow-up time point;
- b. Self-completed and returned directly to the CTRU in pre-paid envelopes. Guidance on self-completion of questionnaire will be provided by the Researcher.

13.1.12 Mapper-completed data

The trained mappers at those homes allocated to the UC + DCM™ arm of the trial will be asked to complete and return data at each cycle of mapping. Data will be collected on:

- Mapping practice at each stage of the mapping cycle (briefing, observation, data analysis, feedback, action planning) including for example number of staff in the care home who received a formal briefing;
 - Number of hours of mapping;
 - Number of residents mapped;
 - Number of staff attending feedback sessions and number of action plans developed.
- Mappers will be provided with a standard reporting template to gather this information.

13.1.13 Researcher-completed data

The following data will be collected at 6- and 16-months by Researchers from the care home records or observation of Residents and Staff;

- Prescription Medication;
- Usual Care data;
- Pittsburgh Agitation Scale (PAS);
- Abridged CMAI;
- Quality of Interactions Schedule (QUIS);
- Resident co-morbidities
- Healthcare Resource Use from review of care records.

The PAS and abridged CMAI will be completed by an Independent Researcher (blinded to care home allocation and completed Proxy Informant Measures). Efforts will be made to maintain blinding of the researchers to the care home's intervention allocation. Occurrences of researcher un-blinding will be documented and reported to CTRU.

FOLLOW-UP DATA (FOR THOSE RECRUITED AT 16 MONTHS POST RANDOMISATION)

13.1.14 Screening at 16 months

At the 16 month visit the Home Manager will be asked to review the eligibility of residents who are not already participating in DCM EPIC, to allow recruitment of additional residents (see section 8.2).

Screening data will be collected prior to written consent/assent for the resident.

The screening data will include:

- Date of screening;
- Resident age;
- Resident gender;
- Resident ethnicity;
- Resident date of arriving to the care home (or participating unit(s));
- Check whether resident has already been registered in the DCM EPIC trial;
- Staff assessment of capacity to consent at screening;
- Reasons for ineligibility (where applicable);
- Reasons for not consenting (where applicable);
- Reasons for non-registration (where applicable);
- Resident Identification Number (Resident ID) (where registered).

13.1.15 Data collection at 16 months

Data collection for residents recruited at 16 months will match that completed at baseline and 16 months combined (without duplication) for residents recruited at baseline, excluding relative friend proxy information and monthly safety data. Safety data for residents recruited at 16 months will be retrospectively collected via the HSCIC from either the date of Care Home Randomisation, or the date the resident resided in a participating unit of an EPIC randomised Care Home (i.e. Safety data collected covers the time Residents have been exposed to trial intervention). Retrospective safety data will not be used for safety reporting purposes, rather to review rates of adverse events by arm for analysis.

ASSESSMENT INSTRUMENTS

Agitation (Cohen Mansfield Agitation Inventory (CMAI) [38, 39]):

The CMAI measures 29 agitated or aggressive behaviours [101]. The frequency of each symptom is rated on a seven-point scale (1-7) ranging from “never” to “several times an hour”, based upon observations over the last two week period. A total score is obtained by summing the 29 individual frequency scores, yielding a total score that ranges from 29 to 203. The CMAI has good psychometric properties [102] including construct validity and factor structure [103], concurrent validity [104] reliability [105] and test-retest reliability [106] when used in a care home setting. There is also available data on expected points change from previous similar studies supporting accurate sample size calculation. The CMAI will be completed in accordance with the CMAI Manual [39].

The abridged CMAI is rated on a four-point scale (1-4) ranging from “never” to “several times an hour”, based upon observations over one day. The abridged CMAI data collection will be standardised to complete observations of registered (consented) residents within communal areas between 10:00 – 17:00.

BSC (Neuropsychiatric Inventory (NPI-NH) [107]):

The NPI-NH records a broader range of BSC including delusions, hallucinations, agitation/aggression, depression/dysphoria, anxiety, elation/euphoria, apathy/indifference, disinhibition, irritability/lability, aberrant motor behaviour, sleep and night-time behaviour disorders and appetite/eating disorders. The NPI-NH is a 12-item version specifically designed for use with nursing home/care home populations. The NPI-NH is both reliable and valid [107].

Quality of life (DEMQOL-Proxy [108]):

The DEMQoL (version 4) is a quality of life questionnaire designed specifically for use in dementia samples. It has 29 items covering mood, behavioural symptoms, cognition and memory, physical and social functioning and general health that are administered by an interviewer. The DEMQoL-proxy has 32 items covering the same dimensions as the DEMQoL. It is completed by a carer of the person with dementia and administered by an interviewer. The DEMQoL and proxy have acceptable psychometric properties for measuring quality of life in dementia [109]. The measures have recently been valued to enable the derivation of preference based indices (utility values). As a result the DEMQoL and DEMQoL proxy measures will provide dementia-specific utility values that will be employed in secondary cost-utility analyses [110].

Quality of life (EQ-5D-5L/EQ-5D-5L Proxy [111]):

EQ-5D is an accepted standardised measure of health outcome that provides a single index value for health status [112, 113]. The EQ-5D is a five-item measure covering the following five dimensions: usual activities, self-care, mobility, pain and anxiety/depression, each with five response options (no problems, slight problems, moderate problems, severe problems and unable to do task).

Quality of life (QUALID) [114]:

The QUALID is an 11-item scale that rates the presence and frequency of behaviours over the previous seven days. It is a reliable and valid scale for rating quality of life in people with moderate to severe dementia and has good internal consistency, test-retest reliability and inter-rater reliability.

Quality of life (QOL-AD) [115]:

The adapted version of the QOL-AD [116] is a 15-item questionnaire developed specifically for use in Care Homes uses simple language and a four-response answer which is consistent across all questions (poor, fair, good, excellent). The QOL-AD has good reported internal reliability, test-retest reliability and convergent validity [115] and is reported to be reliable in use with people with mild to moderate dementia (11 or greater on the MMSE [117]). Subsequent studies have shown it is reliable and valid in people with more severe dementia (MMSE of >2) [118], [119]. The revised version includes minor changes to the QOL-AD scale to ensure relevance to those living in long term care (e.g. amendment of wording of existing items, removal of questions on management of money and marriage status and addition of questions relating to relationships with staff, ability to live with others and ability to make choices) and had good reported internal consistency [116].

Use of healthcare services (healthcare resource use measure):

This measure is adapted from one currently being piloted in a care home feasibility trial.

Clinical Dementia Rating Scale (CDR) [120]:

The CDR is a well utilised, standardised scale for rating the severity of dementia from no cognitive impairment to severe or advanced dementia [121]. Impairment on six cognitive categories is rated and an algorithm used to calculate the overall severity rating. Severity is rated by a trained assessor via informal interview/conversation with the person.

Functional Assessment Staging (FAST)[89]:

The FAST is a scale designed to capture the functional severity of dementia. It is particularly designed for use in more moderate to severe dementia when the MMSE may no longer be useful in capturing clinically meaningful changes in progression of dementia. It is completed by proxy report from a caregiver.

Agitation (Pittsburgh Agitation Scale [122]):

This is an observational rating of agitation. The scale has good reported reliability and validity [122]. Observations are conducted for between 1 and 8 hours. Data collection will be standardised to complete observations of registered (consented) residents within communal areas between 10:00 – 17:00. Observation scales have been shown to have good convergence with informant measures of agitation [123].

Work stress (General Health Questionnaire 12-item) (GHQ-12) [124]:

This is a measure of stress/psychological well-being and is used with the general population. It has good reported psychometric properties [125].

Job or role efficacy (Sense of Competence in Dementia Care Staff (SCIDS) Scale) [123]:

The SCIDS is a user-friendly, self-complete 17-item scale, across four sub-scales. It has acceptable internal consistency and test-retest reliability.

Care quality (Quality of Interactions Schedule (QUIS)) [126]:

The QUIS has reported adequate inter-rater reliability and sensitivity [127]. The QUIS will utilise researcher observations, via a time-sampling technique in each setting. In accordance with QUIS guidelines a sample of interactions over a period of time will be gathered [126, 128]. Observations will record interactions for 15-minute intervals, in communal areas in the care home. Observations will be completed at two time points (AM and PM) over two days within the same week (7 day period) in accordance with Care Home activity (i.e. morning coffee break) in the most populated communal area within the home. Ratings are made at the care home level on the quality and quantity of interactions.

Care home environment, context and organisation (Environmental Audit Tool (EAT) [129]):

This is an organisational climate measure and a questionnaire about additional home (size, type, ownership, geography, staff turnover, staff ratios, resident demographics, etc.), manager (qualifications, length of time in post, leadership style etc.) and staff (qualifications, length of time in post, English as first language etc.) demographics. The EAT is a valid and reliable instrument that can be used to differentiate between the quality of design in various types of dementia care facilities.

Group Living Home Characteristics Questionnaire (GLHC)[130]:

This is a measure of the style of care being delivered in the home. It examines how 'home-like' care delivered is. It includes five-subcales each containing at least three related statements.

DEFINITION OF END OF TRIAL

The end of the trial is defined as the date of collection of the last participant's last data item, where the last data collection is expected 16 months after randomisation of the last care home.

14 PROCESS EVALUATION AND ASSESSMENT OF TREATMENT IMPLEMENTATION

The process evaluation will examine the process, challenges, benefits and impact of the trial, in order to identify the processes and factors associated with degrees of successful and unsuccessful implementation of the intervention.

Formal assessment of treatment implementation will permit monitoring of adherence to the required components of intervention delivery and assess quality (or fidelity) of delivery.

The process evaluation and implementation assessment will support refining and improving of intervention efficacy and the sustainable implementation of the intervention over time, if the intervention is found to be effective [131]. The process evaluation will have quantitative and qualitative components. The quantitative component will involve assessment of levels of

adherence and fidelity in each home utilising data provided by the mappers from each care home at each cycle. This data will include details on the 'dose' of DCM™ in relation to briefing (number of briefing sessions held and proportion of care home staff receiving briefing), mapping cycles (number of mapping sessions, numbers of residents observed, length of mapping period and number of mappers taking part) feedback sessions (number of feedback sessions held and proportion of care home staff receiving feedback) and DCM™ and action planning documentation (were standard mapping documents produced during each phase using the standard templates provided, number of action plans developed per resident and at home level). This quantitative data is being collected as part of the main trial dataset. In addition, researchers will undertake quantitative and qualitative documentary analysis of intervention documents (i.e. mapping documents and action plans) from each intervention home to assess their content and quality (e.g. are the action points SMART, sufficiently detailed, likely to influence outcomes, focused on practical or social actions, and the quality and appropriateness of the mapping and codes used).

Additional qualitative data will be collected from a subset of 18 intervention homes. Homes which have achieved varying degrees of success with DCM™ implementation will be purposefully selected in order to explore factors associated with successful and unsuccessful implementation. In order to sample for degree of implementation success, the qualitative component of the process evaluation will take place after all outcome data has been collected, at the end of the 16 month follow up data collection period. Data will be collected via semi-structured interviews with up to 5 residents, the home manager and mappers, and separate focus groups (or interviews if focus groups are not possible) with key staff and relatives / friends.

To help to make links between the qualitative and quantitative data, researchers undertaking the qualitative data collection will be provided with some implementation data by the CTRU from the 1st two cycles in the home prior to the interviews. They will use this data to identify areas of success and difficulty in relation to implementation in each home so they can probe about those areas during the qualitative data collection.

SAMPLING

Quantitative data from the mapping cycles in all homes will be used to assess dose, adherence and fidelity, and to understand variation in levels of DCM™ implementation across the homes. Purposive sampling will be used to select a sub-set of 18 homes which have achieved varying degrees of success with DCM™ implementation in order to explore factors associated with successful and unsuccessful implementation in greater detail. These homes will take part in the qualitative process evaluation and will be stratified into three equal groups (6 per group) according to whether they are deemed to be 'successful implementers' partial implementers' or unsuccessful implementers' of DCM™. 'Successful' implementation will be determined by timely completion of DCM™ training and all three DCM™ cycles, and return of 3 sets of completed action planning documents and may also include high levels of staff attendance at DCM™ feedback sessions. Homes identified as 'partial implementers' will have either missed one cycle of DCM™ or have completed all cycles but have low levels of attendance at DCM™ feedback sessions. They may also include homes where implementation was poor and then improved, or vice versa where implementation was good initially but then worsened. 'Unsuccessful implementers' will have failed to complete two (or more) DCM™ cycles and may also have low levels of attendance at DCM™ feedback sessions or have failed to provide feedback sessions.

In addition to sampling for degree of implementation success, the purposive sampling will also ensure inclusion of homes that differ according to key characteristics that may affect DCM™ implementation, including; location of homes (6 from each hub – 2 in each group if feasible), size (large ≥ 40 vs medium/small < 40), and type of home (nursing, dementia, general residential).

The selection of homes for the qualitative component will be undertaken by staff in the CTRU at the University of Leeds, in discussion with the Chief Investigator and DCM™ intervention lead. Homes will be assessed for inclusion using the above sampling criteria 2 weeks prior to their final 16 months follow up measures being due. Researchers will be informed which homes have been selected to take part once all final measures data has been collected and they are able to be un-blinded to

allocation.

RESIDENT FEEDBACK

INCLUSION CRITERIA FOR THE QUALITATIVE PROCESS EVALUATION

At the 16 month follow-up residents from homes taking part in the qualitative process evaluation and meeting all of the following criteria will be eligible:

- 1) Deemed by the researcher to be able to communicate verbally sufficiently well to take part in an interview by the researcher at 16 month follow-up;
- 2) Has capacity (established by the researcher) and provides written consent to take part in the interview at 16 month follow-up.

Eligibility waivers are not permitted.

Where there are more than 5 residents meeting the first 2 eligibility criteria, the researcher will select residents to approach until the maximum of 5 have been recruited for interview. The researcher will approach residents they feel may be most able to provide their views on the mapping and its impact (e.g. residents who have resided in the home throughout the study and may be more likely to recall the mapping, if possible).

Resident interviews will be brief, using a conversational style and will follow a standardised interview schedule.

STAFF FEEDBACK

Staff will be recruited for the process evaluation at the 16 month data collection visit.

INCLUSION CRITERIA FOR THE QUALITATIVE PROCESS EVALUATION

Staff from homes taking part in the qualitative process evaluation and meeting all of the following criteria will be eligible to take part:

- 1) A permanent or contracted member of staff;
- 2) Provide consent to participating in a tape recorded interview or focus group.

EXCLUSION CRITERIA

Staff meeting any of the following criteria will not be eligible:

- 3) Working in the home as agency or bank staff.

Eligibility waivers to inclusion and exclusion criteria are not permitted.

Staff eligible to participate in the data collection (i.e. interviews and focus groups) related to the process evaluation will be identified by the care home manager in discussion with the researcher. A sample of up to 10 eligible staff, reflecting the different roles within the care home, will be approached by the researcher to take part in a focus group. The care home manager and other key members of senior staff will be asked to participate in individual interviews. If any homes fail to implement any cycles of DCM™ then a decision will be made about whether it is still useful to run a staff focus group in these homes or whether only interviews with key staff with knowledge of the intervention (e.g. Care Home manager and consented mappers) will take place.

Staff participating in the interviews or focus groups will be provided with verbal and written information about the interview/focus group and if they are willing to participate will be asked to sign an appropriate consent form. They will have at least 24 hours to decide if they are willing to participate.

The interviews/focus groups will be conducted using a semi-structured format based on a standardised topic guide.

MAPPER FEEDBACK

Mappers will consent to taking part in the process evaluation as part of their initial consent to become mappers. Mappers from homes taking part in the qualitative process evaluation and meeting all of the following criteria will be eligible to take part:

- 1) Have completed the DCM training course;
- 2) Provided consent to participating in a tape recorded interview;
- 3) Are still working in the care home at the 16 month follow up

Eligibility waivers are not permitted.

All Mappers will be interviewed in pairs where possible. The interviews will be conducted using a semi-structured format based on a standardised topic guide.

RELATIVE / FRIEND FEEDBACK

Relatives / Friends will be recruited for the process evaluation at the 16 month data collection visit. Relatives / Friends from homes taking part in the qualitative process evaluation and meeting all of the following criteria will be eligible to take part:

- 1) Have visited the home regularly (at least once per month) over the trial period;
- 2) Provide consent to participating in a tape recorded interview or focus group.

Eligibility waivers are not permitted.

Relatives / Friends eligible to participate in the data collection related to the process evaluation will be identified by the care home manager in discussion with the researcher. A sample of up to 5 eligible Relatives / Friends will be approached by the researcher to take part in a focus group held in the care home, or an individual telephone interview.

Relatives / Friends participating in the interviews or focus groups will be provided with verbal and written information about the interview/focus group and if they are willing to participate will be asked to sign an appropriate consent form. They will have at least 24 hours to decide if they are willing to participate.

The interviews/focus groups will be conducted using a semi-structured format based on a standardised topic guide.

DATA ANALYSIS AND STORAGE

The interviews and focus groups will be audio recorded using a digital audio recording device and will be professionally transcribed. During transcription, any potentially identifying information about the participant(s) that may be contained in the interview/focus group discussions will be anonymised or removed. Demographics data (i.e. Age/Gender/Staff Role/Time in role-Staff) will be collected and stored separately to transcriptions. Only the research team and the transcriber will listen to the interview audio files.

Audio files will be securely transferred in encrypted format, and securely stored at the Sponsor offices, accessible to only those members of the trial team requiring such access.

Data analysis will utilise a Framework Analysis approach. Initial data analysis will inform the development of a coding matrix that will guide and create a structure for further data analysis. The focus of the coding matrix (and so the data analysis) will be on experiences of utilising and implementing DCM™ and on identifying patterns and variations in implementation and experiences of this, and barriers and facilitators between homes. The coding matrix will help to assimilate the development of coding categories between the team of researchers undertaking the analysis.

Samples of data will be independently analysed by a member of the research team throughout data analysis to further inform the development of coding categories.

Data analysis will begin alongside data collection in order to refine and develop the topic guides and sampling strategy so that emerging themes can be explored in greater depth. This process will also help to identify when further data collection is unlikely to yield any significant new themes (i.e. 'data saturation' is reached) and so inform the number of interviews and focus groups actually required.

The quantitative data that will inform the process evaluation (measures of adherence and fidelity in each home) will be collected and analysed as part of the main trial dataset (See Section 19 of this protocol). Findings from those quantitative data will be integrated with the qualitative data by informing the data collection process (by informing the topic guides in each home) and the analysis process to inform understanding of implementation, and the issues surrounding that, in intervention homes.

15 RESIDENT SAFETY

The baseline inclusion criteria for participating care homes will ensure that all participating homes are either already providing at least adequate person centred care or will be supported with a dementia awareness training package to enable the provision of adequate person centred care as part of their usual care provision. All participants in all care homes will therefore be receiving good quality usual care over the course of the intervention. All residents in those care homes additionally delivering DCM™ will be exposed to the potential enhancements of care related to the use of DCM™ to improve person centred care practice.

Given the facts that: a) the intervention is at a care home level, b) it is very low risk and is non-invasive, and c) trial consent is purely for collection of data, there will be minimal reporting of safety data to the REC and Sponsor.

It is anticipated that the trial population (elderly care home residents) are likely to experience a number of adverse events (AEs). However, as the trial intervention confers minimal risk to residents, safety reporting will only collect adverse events serious in nature (SAEs). Safety data will only be obtained for residents whom consent to collect trial data has been obtained.

A review of resident safety will be conducted on a monthly basis following resident recruitment (registration) and Care Home Randomisation for residents recruited at baseline. Researchers will liaise with Care Home Managers / Research Leads to determine if any registered residents (excluding deaths/withdrawals) have experienced an SAE in that month, reporting all events highlighted for individual Residents (using resident ID) on a Safety Reporting Form. Safety data will be returned to CTRU and stored centrally. Summaries of SAEs will be reviewed annually by the trial DMEC. Urgent safety concerns will be escalated to DMEC members for interim review if necessary.

To ensure accurate reporting of serious adverse events (SAEs) an annual summary of registered resident hospitalisations will be collected via the Health and Social Care Information Centre's (HSCIC) centrally available datasets. Annual summaries will be timed to combine with the annual review of safety data by the trial DMEC.

Safety data will be collected up to 16 months post randomisation (i.e the duration of care homes' involvement in the trial).

GENERAL DEFINITIONS

An adverse event (AE) is:

- Any unintentional, unfavourable clinical sign or symptom;
- Any new illness or disease or the deterioration of existing disease or illness.

A serious adverse event (SAE) is defined in general as an untoward event which:

- Results in death;
- Is life threatening;
- Requires or prolongs existing hospitalisation;
- Is significantly or permanently disabling or incapacitating;
- Constitutes a congenital anomaly or a birth defect; or
- Is otherwise considered medically significant by a clinician.

Judgement should be exercised in deciding if an AE should be classified as serious in other circumstances. This should include other AEs that are not immediately life-threatening or do not result in death or hospitalisation, but may jeopardise the participant and may require intervention to prevent one or more of the outcomes listed under SAEs above.

DCM-EPIC OPERATIONAL DEFINITIONS AND PROCEDURES

15.1.1 Serious Adverse Events

It is expected that residents will be admitted to hospital in the event of an SAE, therefore the safety reporting form will collect information on hospitalisation, including reason, duration, and outcome of hospitalisation.

Deaths

We expect that around 25% of participating residents will die during the course of the trial. All deaths occurring from the date of consent up to the last data collection visit will be recorded on a trial Death Form **AND REPORTED TO CTRU WITHIN 1 WEEK OF BECOMING AWARE.**

All SAEs should be reported on a trial Safety Reporting form. The Safety Reporting form will be completed by the researcher during discussion with the Care Home Manager/Research Lead on a monthly basis.

15.1.2 Related and Unexpected Serious AEs

An SAE occurring to a resident which, in the opinion of the Care Home Manager / Lead and Chief Investigator, is related to research procedures and is unexpected will be reported to the main Research Ethics Committee (main REC).

The National Research Ethics Service (NRES) defines related and unexpected SAEs as follows:

- 'related' – that is, it resulted from administration of any research procedures; and
- 'unexpected' – that is, the type of event is not listed in the protocol as an expected occurrence.

Care home staff and / or researchers must report all related and unexpected SAEs (RUSAEs) to CTRU within 24 hours of becoming aware of the event. All RUSAEs will be reviewed by the Chief Investigator **within 1 working day** of CTRU becoming aware of the event and will be subject to expedited reporting to the main REC, HTA, DMEC and Sponsor by the CTRU on behalf of the Chief Investigator **within 15 days of being made aware of the event.**

For each RUSAE the following information will be collected:

- full details in medical terms with a diagnosis, if possible;
- duration (start and end dates; times, if applicable);
- action taken;
- outcome.

Any follow-up information should be faxed to CTRU as soon as it is available. Events will be followed up until the event has resolved or a final outcome has been reached.

**CTRU FAX NUMBER FOR REPORTING RELATED/UNEXPECTED SERIOUS
ADVERSE EVENTS: 0113 343 1471**

Expedited reporting of events to the main REC and the Sponsor will be subject to current NRES guidance, CTRU SOPs and Sponsor requirements.

15.1.3 Deaths

All deaths occurring from the date of consent up to the last data collection visit should be highlighted to the study researcher by the care home (within a week of becoming aware).

Once notified the Researcher should complete a death form, and send this to CTRU within one week of becoming aware of the event.

Death reports will be reviewed by the Chief Investigator on a monthly basis. The Trial Steering Committee (TSC), Data Monitoring and Ethics Committee (DMEC), funding body (HTA) and Sponsor will be informed of deaths on a regular basis (to be agreed by the relevant parties).

Reporting of deaths will support avoidance of inappropriate contact by the researchers, with the resident's family following a death. The researcher will contact the care home to ascertain resident status prior to any contact with a Relative / Friend.

As deaths are expected within the trial population they will not be subject to expedited reporting to the main REC, unless the DMEC advises that the frequency of deaths observed within the trial population is significantly higher than that expected in the general population.

15.1.4 Responsibilities

Care Home Manager / Nominated Lead

Care home Managers or the Nominated Lead person at each participating Care Home should be vigilant for residents experiencing SAEs.

The Manager/Lead should ensure all SAEs (see section 15.2.1) are reported to the researchers during monthly discussions.

The Manager/Lead should ensure timely liaison (see section 15.3) with study researchers regarding deaths and RUSAEs to ensure these are reported within specified timelines to CTRU, as per trial specific guidance which will be provided by CTRU.

Researchers

The researchers are responsible for recording all SAEs on the appropriate Case Report Form (CRF) and returning original copies to the CTRU.

Chief Investigator (CI)

The Chief Investigator is responsible for reviewing all events assessed as Related / Unexpected in the opinion of the manager / lead. In the event of disagreement between local assessment and

the CI, the local assessment may be upgraded or downgraded by the CI prior to reporting to the main REC.

CTRU

The CTRU are responsible for:

- Expedited reporting of RUSAEs to the main REC and Sponsor within required timelines;
- Flagging and reviewing deaths with the Chief Investigator on a monthly basis, and escalating these to the DMEC if deemed necessary;
- Preparing annual safety reports to main REC and annual safety reports to the DMEC;
- Notifying participating care homes of Related / Unexpected SAEs which compromise participant safety.

Data Monitoring and Ethics Committee (DMEC)

The DMEC are responsible for:

- Periodically reviewing unblinded overall safety data to determine patterns and trends of events, or to identify safety issues, which would not be apparent on an individual case basis;
- Making recommendations to the TSC on whether there are any ethical or safety reasons why the trial should not continue.

Trial Steering Committee (TSC)

The TSC are responsible for:

- Consideration of recommendations of the Data Monitoring and Ethics Committee and taking appropriate action to escalate issues of concern.

Responsibilities of the Chief Investigator, CTRU, TSC, DMEC, HTA and Sponsor will be detailed in trial specific guidance.

15.1.5 Safeguarding criteria and procedures

It is possible the researchers may observe poor or potentially abusive practice while visiting the care homes participating in the trial. The definition of abuse detailed in the Department of Health [132] guidance on procedures to protect vulnerable adults from abuse will be used to identify when observed practice may potentially be abusive. The definition states abuse is 'a violation of an individual's human and civil rights by any other person or persons ... and may result in significant harm to, or exploitation of, the person' (p9). The consensus guidance on the different forms of abuse will be used by the researchers to identify practices that will be reportable. That is:

- **physical abuse**, including hitting, slapping, pushing, kicking, misuse of medication, restraint, or inappropriate sanctions;
- **sexual abuse**, including rape and sexual assault or sexual acts to which the vulnerable adult has not consented, or could not consent or was pressured into consenting;
- **psychological abuse**, including emotional abuse, threats of harm or abandonment, deprivation of contact, humiliation, blaming, controlling, intimidation, coercion, harassment, verbal abuse, isolation or withdrawal from services or supportive networks;
- **financial or material abuse**, including theft, fraud, exploitation, pressure in connection with wills, property or inheritance or financial transactions, or the misuse or misappropriation of property, possessions or benefits;
- **neglect and acts of omission**, including ignoring medical or physical care needs, failure to provide access to appropriate health, social care or educational services, the withholding of the necessities of life, such as medication, adequate nutrition and heating; and
- **discriminatory abuse**, including racist, sexist, that based on a person's disability, and other forms of harassment, slurs or similar treatment.

Any or all of these types of abuse may be perpetrated as the result of deliberate intent, negligence or ignorance. [132 p9]

Each Local Authority and care organisation has a safeguarding adults policy and process which clearly outlines the reporting process and investigation procedures for any case of suspected abuse. The appropriate local Safeguarding Adults Process documentation will be sourced for each care home upon recruitment into the trial. Given the regional recruitment of centres it is likely the majority of homes will fall under a small number of Local Authorities and so the same processes will apply for multiple homes. Should any cases of suspected abuse be observed during research site visits the appropriate local reporting process will be consulted and implemented by the researcher in consultation with and support from the Recruitment Centre Lead.

16 HEALTH ECONOMICS

The economic evaluation will be conducted by a health economist from the University of Leeds who will be blinded to treatment allocation. The proposed primary endpoint and methods for the economic evaluation follow the reference case set out by NICE [133]. The primary economic analysis will be a cost-utility analysis over 16 months presenting incremental cost-effectiveness ratios (ICER) for intervention (UC +DCM™) versus control (UC), with effects expressed in terms of quality-adjusted life years (QALY). For the primary analysis we will only use data from those consented at baseline. However, we will explore additional analyses where we incorporate the costs and QALYs of those recruited at 16 months, making assumptions about their resource use and quality of life prior to study inclusion. The analysis will adopt the perspective of the service provider including the costs of health and social care. As the clinical efficacy analyses will use agitation as its primary endpoint, a secondary cost-effectiveness analysis based on change in CMAI will also be conducted. Analysis of the uncertainty surrounding the ICER will be undertaken using non-parametric bootstrap simulation (10,000 simulations) and presented on a cost-effectiveness plane. The simulated net benefit values will also allow the generation of the Cost-Effectiveness Acceptability Curve illustrating the probability that the intervention is cost-effective given a value range of NHS willingness to pay values per incremental QALY (which is commonly considered to be £20,000) [134]. Deterministic sensitivity analysis will test the robustness of the results to parameter uncertainty. For example, we will re-run analyses exploring the impact on results of different approaches to handling missing data and by altering the costs and benefits by ±20%. We will also conduct scenario analyses – for example, calculating the ICER assuming that some proportion of the care homes are provided by the private sector.

A net benefit regression approach will also be employed, where possible – adopting methods and the modelling approach employed in the clinical effectiveness analysis [135].

Net monetary benefit (NMB) is derived for each patient thus:

$$\text{NMB} = (\lambda * \text{QALYs}) - \text{Costs}$$

A positive incremental NMB suggests the intervention is cost-effective. NMB regression will allow traditional statistical analyses where it is possible to control for care home, user characteristics and baseline utility and agitation scores. It will also allow a clustered analysis in line with the model employed for the efficacy analysis. Assuming the intervention has no long-term benefit, costs and effects will only be calculated for the trial period with no modelling forward of benefits. Discounting at the NICE preferred rate of 3.5% per annum for costs and effects will be conducted for values post 12 months. No interim analysis is planned unless requested by the Trial Steering Committee (TSC).

Resident- and proxy-reported health-related quality of life data will be reported and analysed separately. However, given that only a proportion of residents will be able to complete the questionnaires, we will compare these two sets of reports and explore whether it is valid to use one source of data as a substitute for the other. This may help deal with missing data and ensure that we have a full set of data-points for each resident. However preference will be given to self-reported data if it is found to be reliable.

Missing values

Missing data is expected at the item, scale and visit levels. Where scales have published scoring protocols, detailing the handling of missing item data, these will be followed. If not, items will be prorated where 75% or more items for a scale are available. Mechanisms for missing data on key scales/variables will be explored and a multiple imputation model built covering the main analyses. Sensitivity analyses will explore the impact of employing different missing data handling strategies.

17 ENDPOINTS

PRIMARY ENDPOINT

The primary endpoint is agitation at 16 months following randomisation. The primary measure of agitation is the Cohen-Mansfield Agitation Inventory (CMAI) rated by staff members who know the residents well. The Pittsburgh Agitation Scale (PAS) and the abridged CMAI, rated by independent researchers, will provide concurrent validity addressing the issue of potential bias of staff responses, based on the inability to blind them to allocation status.

HEALTH ECONOMIC ENDPOINTS

Effects

Health state utilities will come from two sources. In accordance with the NICE reference case, utility will be measured using the EQ-5D and the UK general population time-trade-off tariff [136]. However, the EQ-5D may not be a suitable measure for this population as there are high ceiling effects in reports from persons with dementia and considerable patient-proxy report disparities [137]. Although NICE prefers EQ-5D utilities to be the basis of cost-utility analyses they concede that condition-specific utility may be used if it is thought the EQ-5D may not capture the intervention effects. Considering this and the short-comings of the EQ-5D, utility values will also be calculated using the DEMQOL which has recently been valued in a preference elicitation trial (HTA trial: 08/53/99 [110]). While the main cost-utility analyses will be presented using EQ-5D utility, these will be supplemented by analyses based on DEMQOL utilities. Residents will self-report where able or the EQ-5D-Proxy or DEMQOL-Proxy will be used. Our experience with this tool suggests 25-30% of residents may be able to self-report. Therefore, where possible, both versions will be collected to enable a comparison of patient and proxy reports and to allow adjustments to be made to values.

We will conduct a secondary, cost-effectiveness analysis based on change in the CMAI.

To reduce potential bias of staff who are delivering care also completing outcome measures, we will conduct a sensitivity analysis, substituting data from the resident self-report and Relative / Friend proxy-reports of outcomes measures into the analysis to evaluate whether staff under or over-report agitated behaviour, other behaviours staff find challenging and quality of life. We recognise that self-report and the proxy completion of measures by Relatives / Friends may differ from the proxy reports of staff. Therefore the sensitivity analysis will look at trends rather than utilising or expecting a like-for-like comparison of scores. We will use recommended best practice when consolidating patient and proxy reports on the EQ-5D and DEMQoL and will consult the instrument developers in each case.

Costs

The assumption for the analysis will be that the local authority pays for the provision of care home care for residents. As such these costs would be included in the healthcare provider (NHS) and social care cost perspective which will be the perspective of the main analysis. As some residents (having over a threshold amount of financial assets) will contribute to their care, we will include a sensitivity analysis where a proportion of residents are considered to pay toward their care home costs. Other cost scenarios will be explored - for example, where private care homes cover the

cost of DCM™. On recruitment to the trial each care home will be asked the proportion of residents in the setting who are self-funding and the cost of a self-funded place. An average of this figure from across all care homes recruited will be used for the economic evaluation.

It is assumed that additional staff time will not be required for staff to attend DCM™ briefing and feedback sessions, but that these will be arranged at handover and other convenient times for staff to attend as part of their usual duties. It is assumed that the staff undertaking the DCM™ cycles will need a standard number of working hours to undertake the DCM™ process and that they will not be expected to be included on the care delivery rota during this time. The PAS 800 (BSI 2010) British Standard document, *Use of Dementia Care Mapping for improved person-centred care in a care provider organisation: Guide*, details the estimated amount of time a DCM™ process will take that is based on the experiences of experts using DCM™ in practice settings. This time guide will be used as the basis of the DCM™ implementation protocol provided to care homes in the intervention arm. This will be used to calculate the average staff time needed to deliver the DCM™ intervention. The total cost of DCM™ will incorporate the costs of training staff and staff time spent delivering the intervention as well as travel costs and any other expenditure (e.g. on training materials).

The final definitive resource capture strategy will be determined after discussions with care home managers and staff and after several data capture methods have been explored in the pilot phase. Researchers will collect healthcare resource use data for each resident participating in the trial at month 0, 6 and 16 months using individual care home records and care plans. This will be supplemented by care home level data collection which will enable some validation of individual-level data. Separate resource use questionnaires will be developed to capture this information. The forms will capture hospital-based care (e.g. hospital and A&E visits and stays), community-based care (e.g. GP visits and contact with other healthcare professionals such as physiotherapists and psychiatrists) and any other costs (e.g. adapted beds and other aids). Medication use will be collected as part in the main CRFs for the trial. Finally, we will also explore resource use data capture from hospital episode statistics. Resource use will be averaged out across adjacent measurement points.

A supplementary analysis will adopt a societal perspective where we would capture any resident or family costs and care home that may be incurred, including out-of-pocket expenses and productivity loss, staff turnover and absences, etc. However, our current assessments judge that costs are likely to be low/negligible given the trial location is care home settings. This must be weighed against the burden to resident (or staff proxies) and Relative / Friend participants of completing regular questionnaires about costs and may mean capture of this data is not worthwhile. However, we will consult with our service user and carer (PPI) representative group regarding potential costs to residents and family carers and the potential for capturing this within the trial.

Unit costs for health service staff and resources will be obtained from national sources such as the Personal Social Services Research Unit, the British National Formulary and NHS reference cost database. Should national costs not be available the finance departments of the care homes involved will be requested to provide local cost data. The mean of these costs will be used as the unit cost estimate in the analysis. We will use the National Institute for Health and Care Excellence (NICE) willingness to pay per incremental QALY threshold (λ) =£20,000) to determine cost-effectiveness. Interventions with an ICER below the threshold range of <£20,000 - £30,000 per QALY will generally be considered cost-effective.

SECONDARY ENDPOINTS

Secondary endpoints relating to residents are:

- Behaviours Staff find Challenging;
- Mood (NPI);
- Quality of Life (QUALID, QOL-AD, DEMQOL, EQ-5D-5L);
- Prescribed Medication;
- Safety (SAEs, Safeguarding).

Secondary endpoints relating to staff are:

- Sense of Competence in Dementia Care Staff (SCIDS) Scale.

Secondary endpoints relating to homes are:

- Intervention Fidelity;
- Quality of Interactions Schedule (QUIS).

All other data are potential mediators or moderators of the treatment effect.

STATISTICAL CONSIDERATIONS

SAMPLE SIZE

These calculations assume an average of 40 residents in each care home and that at least 60% of these (i.e. 24) will meet the eligibility criteria. We estimate that 65% of those eligible will be willing to provide informed consent, therefore, we anticipate that 15 participants can be recruited from each care home. The sample size calculation is based on the primary outcome measure - the difference between randomised groups in mean CMAI scores at 16 months. We calculate the number of participants required based on detecting a moderate standardised effect size of 0.4. If we assume the SD will be similar to that observed in a recent trial in UK care home (7.5 points, [61]), the moderate effect size translates to a minimum difference to be detected of 3 points. If we observe greater variation in CMAI scores, such as the SDs ranging from 15 to 20 points as reported by Zuidema [105], then for the same effect size we will be able to detect a difference of 6 to 8 points respectively. A difference of 8 points on the CMAI is seen as indicative of real behavioural change [105]. Fifty care homes, each recruiting 15 participants, will result in 750 participants overall and provide 90% power at 5% significance level to detect a clinically important difference of 3 points (SD 7.5 points). The sample size takes account of 25% loss to follow-up (as seen in Chenoweth et al., [58]) and an inflation factor of 2.0; (i.e. cluster size of 11 participants available for analysis after loss to follow-up and an intracluster correlation coefficient (ICC) no greater than 0.1 [61]). The assumption that the ICC will be no larger than 0.1 is based on an ICC for CMAI reported by Fossey et al. [61] when evaluating the effectiveness of psychosocial care on antipsychotic use in nursing home residents with dementia. If the loss to follow-up is higher than anticipated (but no greater than 35%), the sample size of 750 participants will still provide more than 85% power at the 5% significance level to detect the moderate effect size of 0.4. As provision of care is a further source of clustering, the ICC is anticipated to be higher in the intervention arm, so an allocation ratio of 3:2 will be used, giving 30 (450) and 20 (300) care homes (participants) in the treatment and control arms respectively, 50 (750) overall.

During the course of the trial, the TMG, DMEC and TSC have been monitoring loss to follow-up. This is higher than expected (likely to be above 35%) mainly due to death rates. In order to preserve statistical power close to 90%, and our ability to detect effect size of 0.4 SDs, maintain validity and increase the generalizability of the trial, we will recruit additional, newly-eligible and consenting residents from the randomised care homes at 16 months post randomisation (details of the power calculations undertaken for the extension application will be included as an appendix to the Statistical Analysis Plan).

ACCRUAL

Recruitment hubs will be located in West Yorkshire, London and Oxford facilitating recruitment from Yorkshire, London, the South East and the South West. Selection of care homes will be facilitated by review of publicly available data (i.e. CQC, www.carehomes.co.uk) immediately prior to commencement of recruitment, to ensure appropriate sampling of potentially eligible care homes.

A process of care home recruitment (as described in section 7.2) will be followed and repeated, if necessary, until a sufficient number of care homes are selected. This trial is low risk and therefore we can assume higher consent rates than for higher risk or invasive studies. Sixty per cent is a conservative estimate of the number of residents with probable dementia who will meet the eligibility criteria in most care homes. Dementia specialist homes will have 100% of residents with dementia. The trial hubs have a sufficient care home population and the trial team members have sufficient contacts within their geographical area to support the required recruitment. Therefore, difficulties recruiting the required 50 care homes and 15 residents in each home are not anticipated. However, reserve homes in each locality will be kept on record and approached should recruitment rates fall below those needed. Recruitment will be phased with an estimated 4-5 homes initiated each month. It is anticipated that twenty-one homes will be recruited from the West Yorkshire hub and twenty-nine homes from across the London and Oxford recruitment hubs.

18 STATISTICAL ANALYSIS

GENERAL CONSIDERATIONS

Statistical analysis of the quantitative elements of the trial is the responsibility of the CTRU Statisticians. The analysis plan outlined in this section will be reviewed and a Statistical Analysis Plan (SAP) will be approved before any formal analysis is undertaken. The SAP will be drafted in accordance with current CTRU standard operating procedures and will be finalised and agreed by the trial statistician and supervising statistician, the Chief Investigator, and other appropriate members of the research team. Any changes to the final SAP, and reasons for change, will be documented.

Missing data is expected at the item, scale and visit levels. Where scales have published scoring protocols, detailing the handling of missing item data, these will be followed. If not, items will be prorated where 75% or more items for a scale are available. Mechanisms for missing data on key scales/variables will be explored, with the proportion of missing data to be compared between intervention and control groups, and a multiple imputation model built covering the main analyses. As it is expected that a sizeable proportion of residents will be missing from the main “closed cohort” analyses, and that missing data may be predicted by known variables, the principal method for handling missing scale data will be multiple imputation under the Missing at Random (MAR) assumption. Multiple imputation will be the principal method for the “open cohort” analyses as well to facilitate comparison. Sensitivity analyses will be carried out to assess the impact of the choice of imputation model and of assuming data are Missing Not at Random (MNAR), as appropriate.

As the primary clinical effectiveness analysis involves a single primary outcome and a single treatment comparison, there are no multiplicity considerations for the primary analysis and a 2-sided 5% significance level will be used. To ensure a single primary analysis, this will depend on the rate of loss to follow-up at 16 months (see below). Where results are combined when interpreting the treatment effect (e.g. across secondary outcomes), consideration will be given to the family-wise error rate and appropriate adjustments made.

Randomisation of care homes to treatments and provision of DCM™ to care homes impose clustering effects, whereby resident outcomes are expected to be correlated. The impact of cluster randomisation is expected to be equal across arms but that of treatment provision is not. As such, the principal method for handling clustering effects will be to fit a multilevel model that allows care home and resident level variances to differ across arms. Sensitivity analyses will be conducted

fitting a random intercept model assuming equal total, within- and between-cluster variances.

FREQUENCY OF ANALYSES

No formal interim analyses are planned. Blinded interim reports will be presented to the TSC and DMEC containing descriptive information. This will include data on recruitment, follow-up, adherence, safety and data quality. This will be presented by randomised arm if specifically requested as such. A single final analysis is planned when all follow-up data has been databased, cleaned and locked.

ANALYSIS POPULATIONS

The primary analysis will be carried out on an intention to treat basis, utilising all available follow-up data, comparing allocated treatments. A complier average causal effect (CACE) analysis, comparing treatments received, will be considered if more than 10% of care homes do not implement the intervention as intended. This decision will be made without reference to the effectiveness data.

PRIMARY ANALYSIS

The primary analysis will depend on the rate of loss to follow-up at 16 months. If loss to follow-up is $\leq 35\%$ (in line with original expectations), the resident-level primary outcome of agitation (continuous CMAI score) will be analysed at 16 months post randomisation using a linear two-level heteroscedastic regression model (allowing the care home and resident variances to differ across arms), adjusting for design factors, with a contrast for intervention and control. Only data from residents registered and alive at care home randomisation will be used. The model will be adjusted for the following fixed effects: care home covariates (home type and size, provision of dementia awareness training and recruiting hub) – level 2, and resident level covariates (severity of dementia, age and baseline CMAI score) – level 1. Unadjusted and adjusted ICCs, estimates and corresponding 95% confidence intervals will be presented.

If loss to follow-up is $>35\%$, the primary outcome of agitation (continuous CMAI score) will be analysed at 16 months post randomisation using a linear two-level heteroscedastic regression model (allowing the care home and resident variances to differ across arms), adjusting for design factors, with a contrast for intervention and control. Here, however, data from residents registered at randomisation and at 16 months post randomisation will be used. The model will be adjusted for the following fixed effects (all care home characteristics using baseline data): type and size, provision of dementia awareness training and recruiting hub, average residents' dementia severity, and average residents' baseline CMAI score. Unadjusted and adjusted estimates and corresponding 95% confidence intervals will be presented.

18.1.1 Supportive analyses

Supportive analyses of the primary analysis of the primary endpoint will also be carried out, again depending on the rate of loss to follow-up. This will be the reverse of the analyses described above. So if loss to follow-up is $\leq 35\%$, the model for the open-cohort design will be fitted and if loss to follow-up is $> 35\%$, the model for the original closed-cohort design will be fitted as described in Section 18.4. Both analyses will be presented in the main results paper.

SECONDARY ANALYSIS

Secondary outcome measures (Behaviours Staff find Challenging, mood, use of antipsychotic drugs, and use of other psychotropic drugs, resident quality of life, staff well-being and role efficacy, care quality and the quality of staff/resident interactions) will be analysed using a similar modelling strategy as described for the primary analysis. Where outcomes are continuous, linear models will be fitted; where binary, logistic models will be fitted. Continuous distributions will be transformed where residuals are non-normal.

Change in primary and secondary outcomes over time (6, 16 months) will be analysed under open and closed cohort design analysis strategies. Under a closed cohort design analysis, this will be with three-level multilevel models with contrasts for treatment, time and the treatment-by-time interaction, in which outcomes are nested within residents and care homes. A similar correlation structure will be assumed for care homes and residents, but correlation over time will also be considered at the outcome level using an autoregressive type covariance structure. Under an open cohort design analysis, data must be aggregated at a care home level so outcomes will be nested within time-point, nested within care homes. Details of models to fit will be given in the Statistical Analysis Plan.

SUB-GROUP ANALYSES

A number of exploratory sub-group analyses are planned which will be specified in detail in the Statistical Analysis Plan. These will include care home and resident level factors such as type of care home, severity of dementia and NPI subgroup clusters.

19 TRIAL MONITORING

DATA MONITORING

Data will be monitored for quality and completeness by the CTRU, using established verification, validation and checking processes. Missing data, except individual data items collected via questionnaires, will be chased until they are received, confirmed as not available, or the trial is at analysis.

Inter-rater reliability will be established between researchers prior to commencing the trial. Independent rating of a random sub-sample of interaction quality judgements will be made from researcher notes, by another researcher, to ensure on-going reliability of use of the tool throughout the trial.

The CTRU/Sponsor reserves the right to intermittently conduct source data verification on a sample of residents, staff and care homes. Source data verification will involve direct access to resident notes at participating care homes and other relevant investigation reports.

A monitoring schedule will be defined and agreed by the DMEC, TSC and TMG. This will detail the timing and content of reports to these committees and will include:

- Screening (of care homes and residents including reasons for exclusion and barriers);
- Recruitment (registrations, randomisations, refusals; rates per month);
- Resident, staff and Relative / Friend retention;
- Data quality/completeness (in particular the key data items);
- Protocol adherence (including intervention adherence);
- Safety;
- Losses to follow-up due to death, withdrawal and loss of contact;
- Variance of the primary outcome
- Evidence of training requirements, outliers or bias in relation to the primary outcome, using reference data from the abridged CMAI and the PAS.

A Quality Lead for the trial will be responsible for researcher training and ensuring inter-rater reliability on measures throughout the trial.

DATA MONITORING AND ETHICS COMMITTEE

An independent DMEC will be established to review the safety and ethics of the trial. Contents of the unblinded reports will be agreed between the DMEC and CTRU at the DMEC meeting during set-up. These annual reports will be prepared by the CTRU for the DMEC during recruitment and follow-up and details of these will be specified in the DMEC Analysis Plan.

TRIAL STEERING COMMITTEE (TSC)

A TSC will be established to provide overall supervision of the trial, including trial progress, adherence to protocol, resident safety, and consideration of new information. The committee will meet once during the set-up period and six monthly thereafter for the duration of the trial, unless further meetings are called by the Chief Investigator (CI) where additional advice on trial conduct or management is required.

The TSC will include an independent Chair, at least two independent members with appropriate methodological and clinical expertise (including knowledge of adult safeguarding procedures), two patient and public involvement representatives (ideally a carer and person with dementia), the CI and other relevant members of the Trial Management Group. An observer from NIHR will be invited to attend each TSC meeting. A representative from the host institution (University of Bradford) will attend as an observer.

CLINICAL GOVERNANCE ISSUES

The Sponsor for the trial is Leeds Beckett University. The Sponsor will ensure responsibility and accountability for trial conduct and procedures associated with the protocol. Individual care homes remain responsible for participant care as usual. Trial Researchers will have the opportunity to highlight any safeguarding issues of concern with the TSC and to individual care homes, in line with relevant guidance from the local authority, care home, and the trial team.

20 QUALITY ASSURANCE AND ETHICAL CONSIDERATIONS

QUALITY ASSURANCE

The trial will be conducted in accordance with the principles of the ENRICH toolkit, Good Clinical Practice (GCP) in clinical trials, and through adherence to CTRU Standard Operating Procedures (SOPs) and trial specific guidance implemented to ensure delivery of the trial in accordance with this protocol.

SERIOUS BREACHES

Care Home staff and Researchers are required to promptly notify the CTRU of a serious breach (as defined in the latest version of the National Research Ethics Service (NRES) SOP). This is defined as a breach of the protocol or of the conditions or principles of GCP which is likely to affect to a significant degree the safety or physical or mental integrity of the trial subjects, or the scientific value of the research.

In the event of doubt or for further information, Staff and Researchers should contact the Trial Manager at the CTRU (who will escalate any concerns in line with CTRU Standard Operating Procedures).

ETHICAL CONSIDERATIONS

The trial will be performed in accordance with the recommendations guiding physicians in biomedical research involving human subjects adopted by the 18th World Medical Assembly, Helsinki, Finland, 1964, amended at the 52nd World Medical Association General Assembly, Edinburgh, Scotland, 1996. Informed written consent will be obtained from the care homes, staff and residents prior to entry into the trial. The right of participants to refuse participation, without giving reasons, must be respected. The participant must remain free to withdraw at any time from the trial without giving reasons and without prejudicing the further treatment or involvement of residents or other staff members. The trial will be submitted to, and approved by, a main REC and will obtain appropriate local permissions for each participating care home prior to entering residents into the trial. The CTRU and / or Chief Investigator will provide the main REC with a copy of the final protocol, resident, Relative / Friend and staff information sheets, consent forms and all

other relevant trial documentation.

RESEARCH STAFF TRAINING

All staff collecting research data will complete a comprehensive training program which will cover good clinical practice (GCP) for research, mental capacity and consent, training in the specific instruments used in the trial, safeguarding and ethical issues. The training will be supported by standardised guidance, summarising the key issues covered in the training program and stating the key rating rules for each of the instruments. The training programme will also include DVDs showing each of the assessment instruments being completed. Inter-rater reliability checks between the researchers, for completion of the outcome measures, will be undertaken using case studies and DVD training materials for the primary outcome and key secondary outcome measures. The training sessions will also be filmed so that refresher sessions can be undertaken at each centre and to enable the training of any new researchers who join during the trial.

20.1.1 Capacity to Consent

All researchers will receive appropriate training on the consent processes and protocols prior to recruitment of residents with dementia and their Relatives / Friends to the trial. Where they do not already have prior expertise in this area, the researchers will receive specialist training on assessing capacity to consent in accordance with the Mental Capacity Act [90], from clinical experts, as well as training in advanced communication techniques that can help to facilitate the consent process with people with dementia.

20.1.2 Data Collection Tools and Scales

Training will be provided to all the researchers on correct use of all tools and scales by the KCL recruiting site lead. This will include achieving appropriate levels of inter-rater reliability on each tool.

20.1.3 Good Clinical Practice

Researchers should work to the principles of MRC Good Clinical Practice.

Should researchers observe any potentially harmful or abusive practice in any of the settings during the research, they will follow required reporting procedures.

21 CONFIDENTIALITY

All information collected during the course of the trial will be kept strictly confidential. Information will be held securely on paper and electronically at the CTRU. The CTRU and the trial researchers will comply with all aspects of the 1998 Data Protection Act and operationally this will include:

- Consent from participants to record personal details including name, date of birth, address and telephone number (for all participants), GP name and address (for resident participants).
- Appropriate storage, restricted access and disposal arrangements for participant personal and clinical details.
- Consent from residents to access their medical records by responsible individuals from the research team, where it is relevant to trial participation.
- Consent from participants for the data collected for the trial to be used to evaluate safety and develop new research.
- All Resident data collection forms (baseline, 6 months, 16 months) will be transferred to or from the CTRU with identification numbers and two other identifiers, usually the participant's initials and date of birth.
- All Staff and Relative / Friend data collection forms completed at Baseline will be transferred to or from the CTRU with two identifiers, usually the participant's initials and date of birth. Follow-up (6 / 16 months) data collection forms will be coded with identification numbers in addition to the two identifiers.
- Where anonymisation of documentation is required care homes and researchers are responsible for ensuring only the instructed identifiers are present before sending to CTRU. Any identifiable data will be sent separately to trial data.
- Researchers must ensure that data sent to CTRU and to the Sponsor organisation is done so in line with trial specific guidance provided, and in line with the principles of the 1998 Data Protection Act.

ARCHIVING

At the end of the trial, data collected for the purposes of the trial will be securely archived at the CTRU for a minimum of 5 years (arrangements for confidential destruction will then be made).

22 STATEMENT OF INDEMNITY

This trial is sponsored by Leeds Beckett University and Leeds Beckett University will be liable for negligent harm caused by the design of the trial. The Care Home organisation has a duty of care to residents, whether or not the resident is taking part in a clinical trial, and the Care Home remains liable for clinical negligence and other negligent harm to residents under this duty of care.

Further details regarding Sponsor Indemnity please contact the Sponsor (details listed under Key Contacts).

23 TRIAL ORGANISATIONAL STRUCTURE

RESPONSIBILITIES

Detailed responsibilities are outlined in relevant Organisational sub-contracts, below provides a summary of general responsibilities.

Sponsor

The Sponsor (Leeds Beckett University) is the organisation that takes responsibility for arrangements to initiate, manage, monitor and finance the trial. The Chief Investigator is based at Leeds Beckett University.

Chief Investigator

The Chief Investigator is responsible for the design, management and reporting of the trial.

Clinical Trials Research Unit (CTRU)

The CTRU are responsible for the day to day conduct of the trial in accordance with the Research Governance Framework, where applicable, MRC GCP standards and the principles of CTRU SOPs.

Recruitment Centre Leads

Recruitment Centre Leads will be responsible for management of the researchers, recruitment of the care homes within their locality and ensuring accurate and effective implementation of the research protocol within their recruitment centre.

Health Economists

The Health Economics collaborators will assist the TMG in protocol and CRF development and will be responsible for the selection and/or design of the economic questionnaires, collation of unit costs, and the conduct, interpretation and writing up of the economic evaluation.

Care Homes

Care Homes will be the key collaborators for this trial. Each home will have close links with the researcher and CTRU via the Trial Manager. They will be responsible for adhering to this research protocol including identifying appropriate staff to be trained in DCM™, maintaining lists of staff, residents and Relatives / Friends prior to consent being obtained for trial participation, allowing staff time to complete data with researchers, implementing DCM™ in accordance with the research protocol.

Researchers

Trial-specific researchers will have responsibility (alongside the relevant care home staff) for the identification, consent, assessment and follow-up of residents, Relatives / Friends and staff in the trial.

DCM™ Experts

Experts in use of DCM™ will be responsible for helping trained mappers in each intervention arm home to undertake their first round of mapping in accordance with the standards set out within the research protocol and additional guidance. This will include establishing an adequate level of inter-rater reliability and supporting completion of the DCM™ process in accordance with specified intervention fidelity indicators.

Trial Manager

The Trial Manager will be responsible for the day to day co-ordination of the trial. He/she will be based within the CTRU and his/her role will include administrative tasks for gaining ethical approval, ensure sites and researchers have relevant essential documents and guidance, liaison with the trial team and trial recruitment hubs.

KCL Recruiting Site Lead

The KCL Recruiting Site Lead (or delegate) will be responsible for training of the researchers to use the data collection tools and scales and ensuring initial and on-going inter-rater reliability of scoring.

Treatment Leads (UC and DCM™)

Standardisation of UC and DCM™ will be overseen across the trial by the Treatment leads for UC and DCM™ respectively.

OPERATIONAL STRUCTURE

Trial Management Group (TMG)

The TMG, comprising the Chief Investigator, CTRU team and co-investigators will be assigned responsibility for the clinical set-up, on-going management, promotion of the trial, and for the interpretation of results. Specifically the TMG will be responsible for (i) protocol completion, (ii) CRF development, (iii) obtaining approval from the main REC, and supporting the care home approvals process, (iv) completing cost estimates and project initiation, (v) appointing and facilitating the TSC, (vi) reporting of serious adverse events, (vii) monitoring of screening, recruitment, consent, and follow-up procedures, safety, data quality and compliance, and (viii) interpretation of results and contribution to publications.

Clinical Trials Research Unit (CTRU)

The CTRU will provide set-up and monitoring of trial conduct to CTRU SOPs and MRC GCP standards including randomisation design and implementation, database development and provision, protocol development, CRF design, trial design, monitoring schedule and statistical analysis of clinical endpoints for the trial. In addition the CTRU will support main REC and care home approval submissions and set-up, ongoing management including training, monitoring reports and promotion of the trial (in collaboration with Hub Leads and Researchers). The CTRU will be responsible for the database administrative functions, data management, safety reporting, all statistical analyses of clinical endpoints and drafting of publications. The CTRU will have responsibility for the conduct of the trial in accordance with the Research Governance Framework and CTRU SOPs.

Trial Steering Committee (TSC)

The Trial Steering Committee, with an independent Chair, will provide overall supervision of the trial, in particular trial progress, adherence to protocol, patient safety and consideration of new information in accordance with the TSC Terms of Reference.

Data Monitoring and Ethics Committee (DMEC)

The DMEC will review the safety and ethics of the trial by reviewing data during the recruitment and follow-up periods in accordance with the DMEC Terms of Reference.

24 PATIENT AND PUBLIC INVOLVEMENT

Service users and carers will play an integral role throughout this programme of research to ensure the work is based on the principles of Patient and Public Involvement (PPI). PPI will be fulfilled in partnership with the Alzheimer's Society via involvement of members of their Research Network, and via inclusion of PPI representatives (relatives and persons with Dementia) on the Trial Management Group. Specifically PPI representatives will be involved in the review of participant information and general aspects of trial design. They will input to the content of the basic dementia awareness package for care home staff and have involvement in all decisions made by the TMG. Where recruitment issues are identified they will be consulted regarding barriers and opportunities to improve recruitment, as well as advising on appropriate researcher approaches to residents and their family and friends. The intention is to involve service users in the interpretation of results and appropriate dissemination of information at the end of the trial.

25 PUBLICATION POLICY

The trial will be registered with an authorised registry, according to the International Committee of Medical Journal Editors (ICMJE) Guidelines, prior the start of recruitment.

A detailed publication policy will be developed and agreed by the Trial Management Group (TMG) and Trial Steering Committee (TSC) in line with the funding body (NIHR HTA) and Sponsor requirements.

The success of the trial depends upon the collaboration of all participants. For this reason, credit for the main results will be given to all those who have collaborated in the trial, through authorship and contributorship. Uniform requirements for authorship for manuscripts submitted to medical journals will guide authorship decisions. These state that authorship credit should be based only on substantial contribution to:

- conception and design, or acquisition of data, or analysis and interpretation of data;
- drafting the article or revising it critically for important intellectual content;
- and final approval of the version to be published;
- and that all these conditions must be met (www.icmje.org).

In light of this, the Chief Investigator, Recruitment Centre Leads and relevant senior CTRU staff will be named as authors in any publication. In addition, all collaborators will be listed as contributors for the main trial publication, giving details of roles in planning, conducting and reporting the trial. Authorship of other publications associated with the trial will be decided taking into account the above authorship and any additional funder requirements.

To maintain the scientific integrity of the trial, data will not be released prior to the first publication of the analysis of the primary endpoint, either for trial publication or oral presentation purposes, without the permission of the Trial Steering Committee. In addition, individual collaborators must not publish data concerning their participants which is directly relevant to the questions posed in the trial until the first publication of the analysis of the primary endpoint.”

NIHR Health Technology Assessment (HTA) programme requirements

In accordance with the NIHR HTA programme’s requirements, all materials to be submitted for publication (written, audio/visual and electronic) should be sent to the NIHR Co-ordinating Centre for HTA (NCCHTA) at the time of submission or at least 28 days before the publication date, whichever is earlier. This applies to all publications regardless of whether or not the primary results have been published.

All publications must acknowledge NIHR HTA as the trial’s funding source and include an appropriate disclaimer regarding expressed views and opinions (example text is provided on the HTA website).

26 REFERENCES

1. Knapp, M., et al., *Dementia UK: Report to the Alzheimer's Society*. 2007, Alzheimer's Society: London.
2. National Audit Office, *Improving services and support for people with dementia*. 2007, The Stationary Office: London.
3. Care Quality Commission, *The state of health care and adult social care in England. An overview of key themes in care 2010/11*. 2011, The Stationary Office: London.
4. All-Party Parliamentary Group on Dementia, *Always a last resort. Inquiry into the prescription of antipsychotic drugs to people with dementia living in care homes*. 2008, The Stationary Office: London.
5. Department of Health, *Quality outcomes for people with dementia: building on the work of the National Dementia Strategy*. 2010, Department of Health.
6. Department of Health, *Living well with dementia: A National Dementia Strategy*. 2009, Department of Health: London.
7. MAGDR, *Final report from the MAGDR Subgroup 1 on priority topics in dementia research*. 2011, available online from <http://www.ccf.nihr.ac.uk/PGfAR/Documents/MAGDR%20S-group%201%20final%20report.pdf>.
8. Bowie, P. and G. Mountain, *The relationship between patient behaviour and environmental quality for the dementing*. *International Journal of Geriatric Psychiatry*, 1997. **12**: p. 718-723.
9. Ballard, C., et al., *Quality of life for people with dementia living in residential and nursing home care: The impact of performance on activities of daily living, behavioural and psychological symptoms, language skills and psychotropic drugs*. *International Psychogeriatrics*, 2001. **13**: p. 93-106.
10. All-Party Parliamentary Group on Dementia, *Prepared to Care. Challenging the dementia skills gap*. 2009, The Stationary Office: London.
11. Kuske, B., et al., *Nursing home staff training in dementia care: a systematic review of evaluated programmes*. *International Psychogeriatrics*, 2007. **19**(5): p. 818-41.
12. Bradford Dementia Group, *Evaluating Dementia Care. The DCM Method. 7th Edition*. 1997, Bradford: University of Bradford.
13. Bradford Dementia Group, *DCM 8 User's Manual*. 2005, Bradford: University of Bradford.
14. Cox, S., *Developing quality in services*, in *A Handbook of Dementia Care*, C. Cantley, Editor. 2001, Open University Press: Buckinghamshire.
15. Innes, A., *Dementia Care Mapping: Applications across cultures*. 2003, Maryland: Health Professions Press.
16. Bredin, K., T. Kitwood, and J. Wattis, *Decline in quality of life for patients with severe dementia following a ward merger*. *International Journal of Geriatric Psychiatry*, 1995. **10**: p. 967-973.
17. Brooker, D., *Auditing Outcome of Care in in-patient and day patient settings using Dementia Care Mapping. Can it be done?* *PSIGE Newsletter*, 1994. **51**(Dec/Jan): p. 18-22.
18. Brooker, D., et al., *The efficacy of Dementia Care Mapping as an audit tool: report of a 3-year British NHS evaluation*. *Aging and Mental Health*, 1998. **2**(1): p. 60-70.
19. Clare, M., *Spreading DCM far and wide in Suffolk*. *Journal of Dementia Care*, 2006(6): p. 10-11.
20. Edwards, P. and S. Brotherton, *DCM 8 in Cheshire*. *Journal of Dementia Care*, 2006(2).
21. Jacques, I., *Evaluating care services for people living with dementia*. *Elderly Care*, 1996. **8**(3): p. 10-13.
22. Martin, G.W. and D. Younger, *Anti oppressive practice: a route to the empowerment of people with dementia through communication and choice*. *Journal of Psychiatric and Mental Health Nursing*, 2000. **7**: p. 59-67.

23. Martin, G.W. and D. Younger, *Person-centred care for people with dementia: A quality audit approach*. Journal of Psychiatric and Mental Health Nursing, 2001. **8**: p. 443-48.
24. Wilkinson, A.M., *Dementia Care Mapping: A pilot study of its implementation in a psychogeriatric service*. International Journal of Geriatric Psychiatry, 1993. **8**: p. 1027-1029.
25. Williams, J. and J. Rees, *The use of 'Dementia Care Mapping' as a method of evaluating care received by patients with dementia - an initiative to improve quality of life*. Journal of Advanced Nursing, 1997. **25**: p. 316-323.
26. Ballard, C. and A. Corbett, *Management of neuropsychiatric symptoms in people with dementia*. CNS drugs, 2010. **24**(9): p. 729-39.
27. Margallo-Lana, M., et al., *Prevalence and Pharmacological Management of Behavioural and Psychological Symptoms Amongst Dementia Sufferers Living in Care Environments*. International Journal of Geriatric Psychiatry, 2001. **16**(1): p. 39-44.
28. Davison, T.E., et al., *An individualised psychosocial approach for 'treatment resistant' behavioural symptoms of dementia among aged care residents*. International Psychogeriatrics, 2007. **19**(5): p. 859-873.
29. Banerjee, S., et al., *Quality of life in dementia: more than just cognition. An analysis of associations with quality of life in dementia*. Journal of Neurology, Neurosurgery and Psychiatry, 2006. **77**(2): p. 146-48.
30. Liperoti, R., C. Pedone, and A. Corsonello, *Antipsychotics for the treatment of behavioural and psychological symptoms of dementia (BPSD)*. Current Neuropharmacology, 2008. **6**: p. 117-124.
31. Deudon, A., et al., *Non-pharmacological management of behavioural symptoms in nursing homes*. International Journal of Geriatric Psychiatry, 2009. **24**: p. 1386-1395.
32. Herrmann, N., et al., *The contribution of neuropsychiatric symptoms to the cost of dementia care*. International Journal of Geriatric Psychiatry, 2006. **21**(10): p. 972-976.
33. Finkel, S., *Introduction to behavioural and psychological symptoms of dementia (BPSD)*. International Journal of Geriatric Psychiatry, 2000. **15**: p. S2-S4.
34. Majic, T., et al., *The pharmacotherapy of neuropsychiatric symptoms of dementia. A cross-sectional study in 18 homes for the elderly in Berlin*. Deutsches Arzteblatt International, 2010. **107**(18): p. 320-327.
35. Tunis, S.L., et al., *Characterizing behavioural and psychological symptoms of dementia (BPSD) among geropsychiatric inpatients*. Journal of the American Medical Association, 2002. **3**(3): p. 146-51.
36. Ballard, C., et al., *A 1-year follow-up study of Behavioral and psychological symptoms in dementia among people in care environments*. Journal of Clinical Psychiatry, 2001. **62**(8): p. 631-636.
37. Husebo, B.S., et al., *Efficacy of treating pain to reduce behavioural disturbances in residents of nursing homes with dementia: cluster randomised clinical trial*. BMJ, 2011. **343**: p. 193.
38. Cohen-Mansfield, J., M.S. Marx, and A.S. Rosenthal, *A description of agitation in a nursing home*. The Journal of Gerontology, 1989. **44**(3): p. M77-M84.
39. Cohen-Mansfield, J., *Instruction manual for the Cohen-Mansfield agitation inventory (CMAI)*. 1991, The Research Institute of the Hebrew Home of Greater Washington: Maryland.
40. Hindley, N. and H. Gordon, *The elderly, dementia, aggression and risk assessment*. International Journal of Geriatric Psychiatry, 2000. **15**: p. 254-59.
41. Burgio, L.D., et al., *Agitation in nursing home residents: the role of gender and social context*. International Psychogeriatrics, 2000. **12**(4): p. 495-511.
42. Zuidema, S., R.T.C.M. Koopmans, and F. Verhey, *Prevalence and predictors of neuropsychiatric symptoms in cognitively impaired nursing home patients*. Journal of Geriatric Psychiatry and Neurology, 2007. **20**(1): p. 41-49.

43. Miyamoto, Y., T. Hisatenr, and I. Hiroto, *Formal caregiver burden in dementia: Impact of behavioral and psychological symptoms of dementia and activities of daily living*. Geriatric Nursing, 2010. **31**(4): p. 246-53.
44. Cohen-Mansfield, J., *Agitated behavior in persons with dementia: The relationship between type of behavior, its frequency, and its disruptiveness*. Journal of Psychiatric Research, 2008. **43**: p. 64-69.
45. Hughes, J., et al., *Care staff working with people with dementia. Training, knowledge and confidence*. Dementia, 2008. **7**(2): p. 227-238.
46. Banerjee, S., *The use of antipsychotic medication for people with dementia: Time for action*. 2009, Department of Health: London.
47. Bishara, D., et al., *Expert opinion on the management of behavioural and psychological symptoms of dementia (BPSD) and investigation into prescribing practices in the UK*. International Journal of Geriatric Psychiatry, 2009. **24**: p. 944-954.
48. Raju, J., S. Sikdar, and T. Krishna, *What happened to patients with behavioural and psychological symptoms of dementia (BPSD) after the committee on safety of medicines (CSM) guidelines?* International Journal of Geriatric Psychiatry, 2005. **20**: p. 898-99.
49. Cohen-Mansfield, J., P. Werner, and M.S. Marx, *The social environment of the agitated nursing home resident*. International Journal of Geriatric Psychiatry, 1992. **7**: p. 789-798.
50. Testad, I., et al., *Nursing home structure and association with agitation and use of psychotropic drugs in nursing home residents in three countries: Norway, Austria and England*. International Journal of Geriatric Psychiatry, 2010. **25**: p. 725-31.
51. Stokes, G., *Challenging behaviour: a psychological approach*, in *Handbook of the clinical psychology of ageing*, R.T. Woods, Editor. 1996, Wiley: Chichester. p. 601-628.
52. Cohen-Mansfield, J., et al., *Can agitated behavior of nursing home residents be prevented with the use of standardized stimuli?* Journal of the American Geriatrics Society, 2010. **58**(8): p. 1459-1464.
53. Brodaty, H., et al., *Psychosis, depression and behavioural disturbances in Sydney nursing home residents: prevalence and predictors*. International Journal of Geriatric Psychiatry, 2001. **16**: p. 504-512.
54. Weber, K., et al., *Longitudinal assessment of psychotherapeutic day hospital treatment for neuropsychiatric symptoms in dementia*. Aging and Mental Health, 2009. **13**(1): p. 92-98.
55. NICE/SCIE, *Dementia. Supporting people with dementia and their carers in health and social care. NICE clinical guideline 42*. 2006, British Psychological Society and Royal College of Psychiatrists: London.
56. Salzman, C., et al., *Elderly patients with dementia-related symptoms of severe agitation and aggression: consensus statement on treatment options, clinical trials methodology, and policy*. Journal of Clinical Psychiatry, 2008. **69**(6): p. 889-98.
57. Moniz-Cook, E., G. Stokes, and S. Agar, *Difficult behaviour and dementia in nursing homes: five cases of psychosocial intervention*. Clinical Psychology and Psychotherapy, 2003. **10**: p. 197-208.
58. Chenoweth, L., et al., *Caring for Aged Dementia Care Resident Study (CADRES) of person-centred dementia care, dementia-care mapping, and usual care in dementia: a cluster-randomised trial*. The Lancet - Neurology, 2009. **8**(April): p. 317-25.
59. Brooker, D., *What is Person Centred Care for people with Dementia?* Reviews in Clinical Gerontology, 2004. **13**(3): p. 215-222.
60. Chrzescijanski, C., W. Moyle, and D. Creedy, *Reducing dementia-related aggression through a staff education intervention*. Dementia, 2007. **6**(2): p. 271-86.
61. Fossey, J., et al., *Effect of enhanced psychosocial care on antipsychotic use in nursing home residents with dementia: cluster randomised controlled trial*. BMJ, 2006. **332**(7544): p. 756-8.
62. Moniz-Cook, E., et al., *Can staff training reduce behavioural problems in residential care for the elderly mentally ill?* International Journal of Geriatric Psychiatry, 1998. **13**: p. 149-

- 158.
63. Bird, M., R.H. Llewellyn-Jones, and A. Korten, *An evaluation of the effectiveness of a case-specific approach to challenging behaviour associated with dementia*. *Aging and Mental Health*, 2009. **13**(1): p. 73-83.
 64. Turner, J. and J. Snowdon, *An Innovative Approach to Behavioral Assessment and Intervention in Residential Care: A Service Evaluation*. *Clinical Gerontologist*, 2009. **32**(3): p. 260-275.
 65. Bird, M., et al., *A controlled trial of a predominantly psychosocial approach to BPSD: treating causality*. *International Psychogeriatrics*, 2007. **19**(5): p. 874-891.
 66. Skills for Care, *Common induction standards (2010 'refreshed' edition)*. 2010, Skills for Care: Leeds.
 67. Care Quality Commission, *Guidance about compliance. Essential standards of quality and safety*. 2010, Care Quality Commission: London.
 68. CSCI, *See me not just the dementia. Understanding people's experiences of living in a care home*. 2008, CSCI: London.
 69. Furaker, C. and A. Nilsson, *The competence of certified nurse assistants caring for persons with dementia diseases in residential facilities*. *Journal of Psychiatric and Mental Health Nursing*, 2009. **16**: p. 146-52.
 70. Lintern, T., R.T. Woods, and L. Phair, *Training is not enough to change care practice*. *Journal of Dementia Care*, 2000(March/Apr): p. 15-17.
 71. Visser, S.M., et al., *Managing behavioural symptoms of dementia: effectiveness of staff education and peer support*. *Aging and Mental Health*, 2008. **12**(1): p. 47-55.
 72. Ballard, C., et al., *Can psychiatric liaison reduce neuroleptic use and reduce health service utilization for dementia patients residing in care facilities*. *International Journal of Geriatric Psychiatry*, 2002. **17**: p. 140-145.
 73. Andrews, S., F. McInerney, and A. Robinson, *Realizing a palliative approach in dementia care: strategies to facilitate aged care staff engagement in evidence-based practice*. *International Psychogeriatrics*, 2009. **21**(Suppl. 1): p. S64-S68.
 74. Brodribb, W., *Barriers to translating evidence-based breastfeeding information into practice*. *Acta Paediatrica*, 2011. **100**(4): p. 486-490.
 75. Godley, S., et al., *A Large-Scale Dissemination and Implementation Model for Evidence-Based Treatment and Continuing Care*. *Clinical Psychology - Science and Practice*, 2011. **18**(1): p. 67-83.
 76. BSI, *PAS 800:2010. Use of Dementia Care Mapping for improved person-centred care in a care provider organization. Guide*. 2010, BSI: London.
 77. Innes, A., *Changing the culture of dementia care. A systematic exploration of the process of culture change in three care settings*, in *School of Health Studies*. 2000, University of Bradford: Bradford.
 78. Innes, A. and C. Surr, *Measuring the well-being of people with dementia living in formal care settings: the use of Dementia Care Mapping*. *Aging and Mental Health*, 2001. **5**(3): p. 258-268.
 79. Wylie, K., I. Madjar, and J.A. Walton, *Dementia Care Mapping. A person-centred, evidence-based approach to improving the quality of care in residential care settings*. *Geriaction*, 2002. **20**(2): p. 5-9.
 80. Mansah, M., L. Coulon, and P. Brown, *A mapper's reflection on Dementia Care Mapping with older residents living in a nursing home*. *International Journal of Older People Nursing*, 2008. **3**: p. 113-20.
 81. Beavis, D., S. Simpson, and I. Graham, *A literature review of Dementia Care Mapping: methodological considerations and efficacy*. *Journal of Psychiatric and Mental Health Nursing*, 2002. **9**: p. 725-736.
 82. Brooker, D., *Dementia Care Mapping: A Review of the Research Literature*. *Gerontologist*, 2005. **45**(Special Issue 1): p. 11-18.

83. Kuiper, D., et al., *The influence of Dementia Care Mapping (DCM) on behavioural problems of persons with dementia and the job satisfaction of caregivers: a pilot study*. Tijdschrift voor Gerontologie en Geriatrie, 2009. **40**(3): p. 102-12.
84. Chenoweth, L. and Y.H. Jeon, *Determining the efficacy of dementia Care Mapping as an outcome measure and process for change: A pilot study*. Aging and Mental Health, 2007. **11**(3): p. 237-45.
85. Rokstad, A.M., et al., *The Effect of Person-Centred Dementia Care to Prevent Agitation and Other Neuropsychiatric Symptoms and Enhance Quality of Life in Nursing Home Patients: A 10-Month Randomized Controlled Trial*. Dementia and Geriatric Cognitive Disorders, 2013. **36**: p. 340-53.
86. van de Ven, G., et al., *Effects of Dementia-Care Mapping on Residents and Staff of Care Homes: A Pragmatic Cluster-Randomised Controlled Trial*. PLoS ONE, 2013. **8**(7): p. e67325.
87. Bupa, *Person First ... dementia second The Essentials Workbooks*. 2010, Bupa: Leeds.
88. Care Quality Commission, *The state of health care and adult social care in England. An overview of key themes in care 2009/10*. . 2010 The Stationary Office: London
89. Reisberg, B., *Functional assessment staging (FAST)*. Psychopharmacology Bulletin, 1988. **24**: p. 653-59.
90. *Mental Capacity Act, in c.9*. 2005.
91. Medical Research Council, *MRC guidelines for good clinical practice in clinical trials*. 1998, Medical Research Council: London.
92. University of Leicester and University of Bristol, *Adults lacking capacity toolkit*, available on-line from <https://connect.le.ac.uk/alctoolkit/>, Editor. 2010.
93. Department of Health and Welsh Assembly Government, *Guidance on nominating a consultee for research involving adults who lack capacity to consent*. 2008, Department of Health: London.
94. Medical Research Council, *Medical research involving adults who cannot consent*. 2007, Medical Research Council: London.
95. Kuznetsova OM, T.Y., *Preserving the allocation ratio at every allocation with biased coin randomisation and minimisation in studies with unequal allocation*. Statistics in Medicine, (2012) (31): p. 702-723.
96. Kitwood, T. and K. Bredin, *A new approach to the evaluation of dementia care*. Journal of Advances in Health and Nursing Care, 1992. **1**(5): p. 41-60.
97. Brooker, D. and C. Surr, *Dementia Care Mapping: Principles and Practice*. 2005, Bradford: University of Bradford.
98. Audit Commission, *Forget Me Not: mental health services for older people*. 2000, Audit Commission: London.
99. Commission for Health Improvement, *Oxfordshire Mental Health Care NHS Trust: Clinical Governance Review Report*. 2002, Commission for Health Improvement: London. p. www.chi.nhs.org/organisations/south_east/oxford_mht/2002/conclusions.shtml.
100. Commission for Health Improvement, *South Birmingham Mental Health Care NHS Trust: Clinical Governance Review Report*. 2002, Commission for Health Improvement: London. p. www.chi.nhs.org/organisations/west_mid/sth_brm_mht/2002/conclusions.shtml.
101. Cohen-Mansfield, J. and N. Billig, *Agitated behaviours in the elderly. I. A conceptual review*. Journal of the American Geriatrics Society, 1986. **34**(10): p. 711-21.
102. Shah, A., H. Evans, and N. Parkash, *Evaluation of three aggression/agitation behaviour rating scales for use on an acute admission and assessment psychogeriatric ward*. International Journal of Geriatric Psychiatry, 1998. **13**: p. 415-420.
103. Rabinowitz, J., et al., *Factor Analysis of the Cohen-Mansfield Agitation Inventory in Three Large Samples of Nursing Home Patients With Dementia and Behavioral Disturbance*. The American Journal of Geriatric Psychiatry, 2005. **13**(11): p. 991-998.
104. Miller, R.J., J.S. Snowden, and R. Vaughan, *The use of the Cohen-Mansfield Agitation*

- Inventory in the assessment of behavioral disorders in nursing homes.* Journal of the American Geriatrics Society, 1995. **43**(5): p. 546-549.
105. Zuidema, S., et al, *Assessing neuropsychiatric symptoms in nursing home patients with dementia: reliability and Reliable Change Index of the Neuropsychiatric Inventory and the Cohen-Mansfield Agitation Inventory.* International Journal of Geriatric Psychiatry, 2011. **26**: p. 127-34.
 106. Koss, E., et al, *Assessing patterns of agitation in Alzheimer's disease patients with the Cohen-Mansfield Agitation Inventory.* Alzheimer Disease and Associated Disorders, 1997. **11**(Suppl 2): p. S45-S50.
 107. Cummings, J.L., et al, *The Neuropsychiatric Inventory. Comprehensive assessment of psychopathology in dementia.* Neurology, 1994. **44**(12): p. 2308.
 108. Smith, S.C., et al, *Development of a new measure of health-related quality of life for people with dementia: DEMQOL.* Psychological Medicine, 2007. **37**(5): p. 737-46.
 109. Smith, S.C., et al, *Measurement of health-related quality of life for people with dementia: development of a new instrument (DEMQOL) and an evaluation of current methodology.* Health Technology Assessment, 2005. **9**(10): p. 1-93.
 110. Rowen, D., et al, *Estimating preference-based single index measures for dementia using DEMQOL and DEMQOL-Proxy.* Value Health, 2012. **15**(2): p. 346-56.
 111. EuroQol Group, *EuroQol - a new facility for the measurement of health-related quality of life.* Health Policy, 1990. **16**(3): p. 199-208.
 112. EuroQol Group. *What is EQ-5D?* Accessed 29.11.11]; Available from: <http://www.euroqol.org/eq-5d/what-is-eq-5d.html>.
 113. Herdman M, G.C., Lloyd A, Janssen M, Kind P, Parkin D, Bonsel G, Badia X., *Development and preliminary testing of the new five-level version of EQ-5D (EQ-5D-5L).* . Qual Life Res. , 2011. **10**: p. 1727-36.
 114. Weiner, M.F., et al, *The Quality of Life in Late-Stage Dementia (QUALID) Scale.* Journal of the American Medical Directors Association, 2000. **1**(May/June): p. 114-116.
 115. Logsdon, R.G., et al., , *Quality of Life in Alzheimer's Disease: Patient and Caregiver Reports.* . Journal of Mental Health and Aging, 1999. **5**(1): p. 21-32.
 116. Edelman, P., et al, *A comparison of three methods of measuring dementia-specific quality of life: perspectives of residents, staff and observers.* The Gerontologist, 2005. **45**(S1): p. 27-36.
 117. Logsdon, R.G., et al.,, *Assessing quality of life in older adults with cognitive impairment.* . Psychosomatic Medicine, 2002. **64**: p. 510-519.
 118. Hoe, J., et al, *Use of the QOL-AD for measuring quality of life in people with severe dementia—the LASER-AD study.* Age and Ageing, 2005. **34**(2): p. 130-35.
 119. Thorgrimsen, L., et al, *Whose quality of life is it anyway? The validity and reliability of the Quality of Life - Alzheimer's Disease (QOL-AD) Scale.* . Alzheimer Disease and Associated Disorders, 2003. **17**: p. 201-8.
 120. Hughes, C.P., et al, *A new clinical scale for the staging of dementia.* The British Journal of Psychiatry, 1982. **140**: p. 566-572.
 121. Morris, J.C., *The Clinical Dementia Rating (CDR): Current version and scoring rules.* Neurology, 1993. **43**(11): p. 2412-2414.
 122. Rosen, J., et al, *The Pittsburgh Agitation Scale: A user-friendly instrument for rating agitation in dementia patients.* American Journal of Geriatric Psychiatry, 1994. **2**(1): p. 52-59.
 123. Cohen-Mansfield, J. and A. Libin, *Assessment of agitation in elderly patients with dementia: correlations between informant rating and direct observation.* International Journal of Geriatric Psychiatry, 2004. **19**: p. 881-91.
 124. Goldberg, D.P. and P.A. Williams, *User's guide to the General Health Questionnaire.* 1988, NFER-Nelson: Windsor.
 125. Penninkilampi-Kerola, V., J. Meietunen, and H. Ebeling, *A comparative assessment of the*

- factor structures and psychometric properties of the GHQ-12 and the GHQ-20 based on data from a Finnish population-based sample.* Scandinavian Journal of Psychology, 2006. **47**: p. 431-40.
126. Dean, R., R. Proudfoot, and J. Lindsay, *The Quality of Interactions Schedule (QUIS): development, reliability and use in the evaluation of two domus units.* International Journal of Geriatric Psychiatry, 1993. **8**: p. 819-826.
 127. Coates, C.J., *The Caring Efficacy Scale: nurses' self-reports of caring in practice settings.* Advanced Practice Nursing Quarterly, 1997. **3**(1): p. 53-9.
 128. Lindsay, J. and D. Skea, *Gender and interactions between care staff and elderly nursing home residents with dementia.* International Journal of Geriatric Psychiatry, 1997. **12**: p. 344-48.
 129. Smith, R., et al., *Validation of the Environmental Audit Tool in both purpose-built and non-purpose-built dementia care settings.* Australasian Journal on Ageing, in press.
 130. Te Boekhorst, S., et al., *The ideals of group living homes for people with dementia: do they practice what they preach?* International Psychogeriatrics, 2011. **23**(9): p. 1526-1527.
 131. Linnan, L. and A. Steckler, *Process evaluation for public health interventions and research.* 2002, San Francisco: Jossey-Bass.
 132. Department of Health, *No secrets: Guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse.* 2000, Department of Health: London.
 133. NICE, *Guide to the methods of health technology appraisal.* 2008, NICE: London.
 134. Fenwick, E., K. Claxton, and M. Sculpher, *Representing uncertainty: the role of cost-effectiveness acceptability curves.* Health Economics, 2001. **10**(8): p. 779-87.
 135. Hoch, J.S., A.H. Briggs, and A.R. Willan, *Something old, something new, something borrowed, something blue: a framework for the marriage of health econometrics and cost-effectiveness analysis.* Health Economics, 2002. **11**(5): p. 415-30.
 136. Dolan, P., *Modeling valuations for EuroQol health states.* Medical Care, 1997. **35**: p. 1095-08.
 137. Hounsome, N., M. Orrell, and R.T. Edwards, *EQ-5D as a quality of life measure in people with dementia and their carers: evidence and key issues.* Value Health, 2011. **14**(2): p. 390-9.