

Using the ecological framework to identify barriers and enablers to implementing Namaste Care in Canada's long-term care system

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Contributions: (I) Conception and design: PV Hunter, S Kaasalainen; (II) Administrative support: None; (III) Provision of study materials or patients: None; (IV) Collection and assembly of data: PV Hunter, S Kaasalainen; (V) Data analysis and interpretation: PV Hunter, S Kaasalainen, KA Froggatt, J Ploeg, L Dolovich; (VI) Manuscript writing: All authors; (VII) Final approval of manuscript: All authors.

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Background: Higher acuity of care at the time of admission to long-term care (LTC) is resulting in a shorter period to time of death, yet most LTC homes in Canada do not have formalized approaches to palliative care. Namaste Care is a palliative care approach specifically tailored to persons with advanced cognitive impairment who are living in LTC. The purpose of this study was to employ the ecological framework to identify barriers and enablers to an implementation of Namaste Care.

Methods: Six group interviews were conducted with families, unlicensed staff, and licensed staff at two Canadian LTC homes that were planning to implement Namaste Care. None of the interviewees had prior experience implementing Namaste Care. The resulting qualitative data were analyzed using a template organizing approach.

Results: We found that the strongest implementation enablers were positive perceptions of need for the program, benefits of the program, and fit within a resident-centred or palliative approach to care. Barriers included a generally low resource base for LTC, the need to adjust highly developed routines to accommodate the program, and reliance on a casual work force.

Conclusions: We conclude that within the Canadian LTC system, positive perceptions of Namaste Care are tempered by concerns about organizational capacity to support new programming.

Keywords: Dementia; aged; long-term care (LTC); palliative care; complementary therapies

Submitted Mar 28, 2017. Accepted for publication Jun 15, 2017.

doi: 10.21037/apm.2017.06.14

View this article at: <http://dx.doi.org/10.21037/apm.2017.06.14>

Introduction

Although long-term care (LTC) is a major end of life setting for older people in Canada (1), palliative care approaches have yet to realize their full potential here. A potential reason for this is that most LTC residents have cognitive impairment (2,3), and poor understanding of the end of life trajectory for these residents among LTC staff (4) continues

to be associated with underuse of comfort care measures (5,6) and invasive non-palliative interventions, such as tube feeding, laboratory tests, and intravenous therapy (4,7,8). Over the last decades, organizations providing LTC have been urged to consider a palliative approach for residents with cognitive impairment (9). Such an approach would ideally emphasize: patient-centred care, optimal symptom management, advance care planning, psychosocial and

spiritual support, family involvement, health provider education, continuity of care, attention to ethical issues, and timely recognition of dying (10).

New approaches to the end of life care of cognitively impaired LTC residents are increasingly being documented (11-13). Among these is a program called Namaste Care, a program tailored for residents who can no longer participate in traditional recreational programming (14) and an approach to end of life care (15). The Hindu greeting namaste, from which the program derives its name, encapsulates the program philosophy: "to honor the spirit within". Namaste Care is most frequently offered as a group program, intended to run seven days per week, twice per day, for two hours each time. The program is usually coordinated by a nursing assistant, with drop-in assistance from other staff, family members, or volunteers. Given the group format, it may be possible to introduce Namaste Care without adjusting staffing levels.

During Namaste Care, program participants visit a room with soft music or nature sounds, lowered lighting, and pleasant scents. Some aspects of personal care (washing face, hands, and feet; grooming; and nail care) are included to facilitate an experience of gentle, caring touch. Continuous hydration and soft, sweet foods are offered to stimulate appetite and raise caloric intake (15). These aspects of Namaste Care align well with recommendations for palliative dementia care, including patient-centred care, continuity of care, optimal symptom management (14,16,17), and psychosocial and spiritual support (16,17). Simard suggests the program also promotes family involvement (15), communication (16), and assessment (17).

This approach to care has now been implemented in LTC homes and hospice organizations throughout the USA, and in the UK, Iceland, and Australia (18). Despite its apparent advantages, some organizations have faced challenges implementing Namaste Care (19,20). For example, among a group of five UK homes that implemented Namaste Care, four saw improvements in participants' pain, behavioural symptoms, and the extent to which behavioural symptoms disrupted staff members' work (17). However, one home saw an increase in unwanted symptoms such as pain and neuropsychiatric symptoms. This unsuccessful implementation was attributed to challenges within the leadership team (17). However, the homes that successfully implemented Namaste Care also reported implementation challenges, including: distributing the work, increasing knowledge of the program, encouraging busy staff to take time to participate, and changing practices that aligned

poorly with the program (19). There is some evidence that similar, surmountable challenges have surfaced in other Namaste Care launches (20). Nevertheless, factors determining the success of Namaste Care programs have not been systematically studied.

The ecological framework

It is challenging to implement innovations in healthcare. A growing body of work aims to understand why some organizations succeed in this while others fail. An increasingly common approach is to classify factors that facilitate or impede successful implementation using an implementation determinant framework (21). One of these, the ecological framework (22), was originally developed to promote implementation success for health promotion and prevention programs. An advantage of this framework is that it is drawn from a review of relevant literature, and is therefore both evidence-based and comprehensive.

According to the ecological framework, the success of a program is influenced by characteristics of the innovation (e.g., compatibility with existing needs), characteristics of the providers responsible for the innovation (e.g., self-efficacy), and characteristics of the wider community, including the health care system. Program success is also influenced by the level of support for implementation (e.g., training and technical assistance) and by characteristics of the system within which the program is implemented, including general organizational factors (e.g., capacity to incorporate the innovation), specific practices and processes (e.g., formulation of tasks), and staffing considerations relevant to promoting program success (e.g., leadership and supervisory support). This broad, multi-faceted approach ensures attention to the various levels at which successful program implementation can be compromised or enhanced.

Something that distinguishes the ecological framework from other determinant frameworks is its sensitivity to the influence of the socio-political environment in which innovations are implemented. Since LTC is a setting in which the socio-political environment is known to influence adoption of knowledge and best practices (23-25) and ultimately quality of care (26,27), we considered the ecological framework well suited to identifying important implementation determinants of Namaste Care in this environment. We used the ecological framework to address the following research question: What are the perceived barriers and enablers to implementing Namaste Care in the Canadian LTC system?

Methods

Design

We used a qualitative interpretive design based on a template organizing style (28,29) to identify implementation determinants specific to the introduction of Namaste Care.

Ethics

The study protocol was reviewed and approved by two university ethics boards (Hamilton Integrated Research Ethics Board, No.15-092; University of Saskatchewan Behavioural Research Ethics Board, No. 15-267), and conforms to the provisions of the Helsinki Declaration as revised in 2013. Study participants provided free, informed, written consent, as further described below.

Context and participants

This study took place prior to an 18-month evaluation of the acceptability and feasibility of Namaste Care in Canadian LTC homes. Two LTC communities (“sites”) participated; one in Hamilton, Ontario and the other in Saskatoon, Saskatchewan. In Ontario, 127 residents lived at the participating LTC home, a non-profit entity owned and operated by a religious organization and affiliated with the regional health authority. Sixty residents lived at the participating LTC home in Saskatchewan, which was a private not-for-profit entity affiliated with the regional health authority.

To recruit, facility managers briefly reviewed the purpose of the study with prospective participants, and then invited them to attend a focus group. To ensure a diverse sample, three groups of participants were interviewed at each site: family members, nurses, and unlicensed health providers (i.e., nursing assistants and one recreation worker). A total of six focus groups were scheduled (3 groups × 2 sites). Prior to each focus group, the interviewer reviewed the purpose of the research, gave participants the opportunity to ask questions, and offered the opportunity to decline. No one declined. Across the two sites, a total of 15 family members participated; a few were spouses (20%) and the remainder, children or other relatives (80%). Most family members were female (80%). A total of 17 registered nurses (82% female) and 12 unlicensed providers (100% female) participated. Most unlicensed providers were nursing assistants (75%) and the remainder, recreation workers (25%).

Interviews

Focus groups were conducted in a private meeting room in each participating LTC home in December 2015. A member of the research team conducted the interviews at one LTC home (“site 1”) and a trained research assistant conducted the interviews at the other (“site 2”). The interviewers first introduced Namaste Care by describing its philosophy, elements, logistics and possible outcomes, noting that the group format ensured a staffing ratio similar to the current nursing assistant to resident ratio (1:8), and stating that additional drop-in support could be recruited from other staff members, volunteers, and family members. As the interview proceeded, participants were asked to describe perceptions of Namaste Care, to discuss their site’s strengths and weaknesses with respect to implementing Namaste Care, and to generate ways to address any identified weaknesses.

Data analysis

A deductive approach to content analysis was employed. In content analysis, transcript statements that convey particular meanings are condensed, interpreted (i.e., coded), and then further abstracted into sub-categories and overarching categories (30). In a deductive approach (31), or template organizing style (28,29), data is evaluated for correspondence with a pre-existing template; in this case, the ecological framework (*Table 1*).

Results

Results are summarized according to the seven major categories of the ecological framework, each summarizing additional factors that could act to enhance or impede implementation success. The categories are: community-level factors, characteristics of health providers, characteristics of the innovation, general organizational factors, specific practices and processes associated with the innovation, staffing considerations, and supports for implementation (*Table 1*).

Community level factors

Community-level implementation determinants operate beyond the organization implementing the program and include health systems factors, such as relevant policies, politics, funding, and related theory or research.

Table 1 Coding guide based on the ecological framework

Category	Code
Community level factors	Policy
	Politics & funding ^a
	Related theory and research
Provider characteristics	Perceived need
	Perceived benefits
	Self-efficacy
	Skill proficiency
Innovation characteristics	Compatibility
	Adaptability
General organizational factors	Positive work climate
	Norms regarding change
	Capacity to incorporate innovations into existing routines/practices
	Shared vision
Specific practices and processes	Shared decision-making
	Coordination with other agencies
	Communication
	Formulation of tasks
Specific staffing considerations	Leadership
	Program champion
	Managerial/supervisory/administrative support
Support for implementation	Training
	Technical assistance

^aIn the ecological framework, politics and funding are two separate determinants. We have combined them here since they were always discussed together by our participants.

Staff members at both sites mentioned several policies that might represent barriers to program implementation. One of these was a requirement for two-person lifts and transfers for some frail residents, which might be more difficult to coordinate if one nursing assistant was diverted to Namaste Care. Another potential barrier was the existence of infection control protocols, which were seen as difficult to observe in a daily group program. A third was a system-wide no-scent (i.e., perfume) policy. Namaste Care was seen as contravening this given a suggestion during the program overview that an essential oil diffuser might be

used to create a pleasant scent in the room.

Family members at both sites also mentioned low government funding support for LTC as a potential barrier to implementation. At both sites, family members did not see it as realistic to implement Namaste Care without funding for additional staff. Nurses and unlicensed staff at both sites also commented that the program would be difficult to implement without additional staff, but did not specifically cite funding levels as a concern. With respect to related theory and research, a potential implementation enabler was that licensed staff at site 2 perceived Namaste Care as consistent with a palliative or comfort care approach. In addition, at both sites, family members suggested that the results of previous implementations of Namaste Care could inform the current implementation. See *Table 2* for supporting quotations from interviewees.

Provider characteristics

According to the ecological framework, it is important to successful implementation that providers perceive the program as needed and beneficial. Namaste Care fared very well in this regard (*Table 3*). All groups at both sites recognized the need for greater attention to LTC residents with late-stage dementia and commented on ways that Namaste Care could help to meet the particular needs of this group. Namaste Care was also perceived as offering several benefits, such as increased comfort and meaning.

Nevertheless, all site 1 groups raised concerns that the group format would undermine benefits. A frequently proffered example was that of someone with dementia becoming agitated during the program, and thereby reducing other participants' psychosocial wellbeing. In addition, family members at site 1 and unlicensed staff at both sites expressed concern that diverting a staff member to Namaste Care would disadvantage residents who were not enrolled in Namaste Care.

Implementation-relevant provider characteristics also include skill proficiency and self-efficacy. With respect to skill proficiency, at both sites, unlicensed staff was concerned about relying on a casual workforce, although the way that this concern was expressed varied across the two sites. At site 1, unlicensed staff worried that coordinating Namaste Care would leave less skilled casually employed staff responsible for other work; in contrast, at site 2, unlicensed staff emphasized that it would be unwise to rely on casual staff to coordinate Namaste Care. Similarly,

Table 2 Community-level factors

Code	Representative statements
Politics & funding	<p>S2-F3: if the government is not willing to add funding, I don't see it working</p> <p>S2-F4: I don't think it can be sandwiched in. There has to be additional funding to make this program work</p> <p>S1-L2: I think staffing is going to be the biggest concern, that nine thirty to eleven thirty is a super busy time; I can see that being a big problem</p> <p>S2-UL5: how would that work with staffing? So if one staff member is in Namaste Care, are they going to schedule more on the floor?</p>
Policy	<p>S1-L1: the only problem with the aromatherapy part is that there is a no scent policy, the health region has a no scent policy and so I'd see that being a possible obstacle or a challenge to doing that program</p> <p>S2-L5: it seems awfully difficult when you need two people to do transfers and such</p> <p>S1-UL2: you would need a lot of supplies that might become contaminated</p> <p>S2-UL8: you don't know what kind of illness is bringing this one down, and then you're going to bring another person who is also equally ill with a different condition?</p>
Related theory and Research	<p>S1-F6: what did Joyce (the program founder) tell you about how realistic it is to run the program without extra staff?</p> <p>S2-F1: it sounds as though it's already been done, right? So they must have it set up and therefore know something about how it's going to function or work</p> <p>S2-L2: but it's promoting more of the comfort. Going back to the foundations of palliative care alleviating their pain</p>

S, site; F, family; L, licensed; UL, unlicensed.

Table 3 Provider characteristics

Code	Representative statements
Perceived need	S2-F1: that group tends to be our most vulnerable group where we as a team struggle to feel like we're doing something meaningful for them beyond the physical care giving aspect
Perceived benefits	<p>S2-UL7: the touch</p> <p>S2-UL8: the one on one interaction</p> <p>S2-UL1: or the music. A lot of them enjoy soft music. Or when you put two or three elements together</p> <p>S1-UL3: the one concern or challenge I'm finding with Namaste is ... for some of them, too much stimuli is no good and depending on their mood, their behaviour, and who is in the program, one might add to the other</p> <p>S2-UL5: or maybe the other way, like some residents may feel excluded because they want to have like that extra attention. ... It's like the VIP club</p>
Self-efficacy	<p>S1-UL4: I think most people are scared of the unknown</p> <p>S1-UL1: at the beginning, I was just kind of like, "Well how are we going to get this going?", right? We were told about it, and then we didn't know how we would put it all together, so I was kind of overwhelmed</p> <p>S2-L1: but the thing is, I think it has to be done with the registered staff</p>
Skill proficiency	<p>S2-L3: if part-time or casual staff come in, they might not know what to do</p> <p>S1-UL3: if she is left alone on my side, what would happen to our residents, when a new staff member doesn't know much?</p> <p>S2-UL1: you don't need somebody really hyper</p> <p>S2-F4: my only concern would be making sure that you're getting someone who can focus on the individual in order to maximize the effectiveness of the program</p>

S, site; F, family; L, licensed; UL, unlicensed.

Table 4 Innovation characteristics

Code	Representative statements
Compatibility	<p>S1-L2: when I first came to this home almost ten years ago, I just saw such acts of kindness between staff and residents that I have never seen in my previous thirty some years of nursing. I think that this program is an extension of that</p> <p>S2-L2: but it's promoting comfort, going back to the foundations of palliative care, alleviating their pain</p> <p>S2-UL4: it's kind of like reassuring them that they're going to die. "You're going to the Namaste Care Room". It's going to be like the tainted room</p> <p>S1-F1: we were quite enamoured with the program and sitting here, listening to more detail about it, we continue to be probably more so, because it does seem to be very much targeted to the individual</p> <p>S2-F4: well I think anything that adds to the quality of life, even if it's short term or for a restricted number of individuals is something. As a group, I think we would support it</p>
Adaptability	<p>S2-UL7: 10:00 to 11:00, because at 9:30 if they just finished in the dining room, some are being transported</p> <p>S2-UL8: we are not even finished the breakfast, the ones who start at nine</p> <p>S2-UL1: a lot of them—some of them go to bed</p> <p>S2-UL7: so 10:00–11:00 for the morning session</p> <p>S2-UL8: and 2:00–3:00</p> <p>S2-UL7: so then could there not actually be twelve people, but six of them could come Monday, Wednesday and Friday and the other six come Tuesday, Thursday and Sunday?</p> <p>S1-F4: so I understand that the participants that are involved will do both the morning and the afternoon shift. It's not divided in two, some in the morning and some in the afternoon?</p>

S, site; F, family; L, licensed; UL, unlicensed.

at site 1, family members were concerned that the most caring staff would be diverted to namaste care, whereas at site 2, it was emphasized that staff in Namaste Care must be caring. With respect to feeling capable of implementing the program, at site 2, licensed staff expressed a high level of self-efficacy, requesting that they be given responsibility for the program. At site 1, unlicensed staff expressed low self-efficacy and feeling overwhelmed by the prospect of implementing Namaste Care.

Innovation characteristics

The ecological framework specifies program compatibility with local interests and adaptability to local needs as additional implementation determinants (*Table 4*). With respect to compatibility, licensed staff from both sites said the program philosophy complemented an existing emphasis on positive relationships with residents and quality palliative care. However, at site 2, unlicensed staff believed the group format would discourage family involvement at the end of life, and perceived the emphasis on the end of life period as stigmatizing. Family members at both sites saw the approach as consistent with resident-centred and

individualized care approaches.

Interviewees generated several adaptations to increase program viability. For example, family members at site 1 suggested offering the program to different residents in morning and afternoon, to reach more people. Unlicensed staff at site 2 suggested offering a shorter program at less busy shift times, running the program fewer days per week, and including some residents in a morning shift and some in an afternoon shift.

General organizational factors

The ecological framework considers the following organizational factors as important implementation facilitators: a positive work climate, openness to change, ease of integration into practice, and a shared vision (*Table 5*).

At site 1, both licensed staff and family members commented positively on recent improvements in a culture of resident-centred care at the home. Nevertheless, each group also mentioned an absenteeism problem among unlicensed staff. Licensed staff expected that the home would have difficulty negotiating a change in practice; in particular, staff absenteeism combined with a generally

Table 5 General organizational factors

Code	Representative statements
Positive work climate	S1-L2: just you know, some of the challenges we have in long term care are people just not showing up, right? S1-F1: I think more of the staff today has bought into what the home is trying to accomplish with the residents. I think a year ago there were a lot of rebels on staff that stood in the way S2-L1: where do we sign up to volunteer?
Norms regarding change	S1-L1: personally, I think it's about attitudes, I don't think this is a home that has embraced change very well in the past and so right away there's a lot of resistance. Really, let's be honest, right?
Capacity to incorporate innovations into existing routines & practices	S1-L1: so, just scenario wise like how does this work, how do we make that work, when you are actually short, when nobody will come? S1-UL1: the work load is very heavy, it's not getting any lighter. So when we throw Namaste in there and you've got three people on the floor and they're sinking, and they go to ask nursing staff for help and if they don't get a positive response again, where's your teamwork? S2-F3: the government doesn't give enough hours and man power anyway. And if you're taking away that one person now they're down to one. And if everyone needs to go to the washroom and stuff you're now down to one again. And that's hard
Shared vision	S1-L1: and how many times do they actually do it already? S1-L2: but we don't call that Namaste S1-UL4: they've accepted this challenge or project, so we need to work with it and deal with it—like, figure it out S2-F4: well I think anything that adds to the quality of life, even if it's short term or for a restricted number of individuals is something. We would support it

S, site; F, family; L, licensed; UL, unlicensed.

high workload in LTC were seen as potential threats to a successful implementation of Namaste Care. Nursing assistants anticipated difficulty reorganizing their work (traditionally done in two-person teams) to accommodate the program, and family members also believed the program required extra staff.

At site 2, there were no explicit comments about organizational climate; nevertheless, interview transcripts gave evidence of a strong sense of camaraderie among both licensed and unlicensed staff. For instance, compared to site 1, there was a great deal of collaborative discussion (e.g., supporting or completing each others' contributions) and humour was used frequently. Licensed staff and family members voiced a willingness to try the program, and all staff actively considered how to best accommodate the program. A few licensed staff members even voiced interest in volunteering time outside of work.

Specific practices and processes

According to the ecological framework, successful implementation is supported by specific organizational

practices and processes. These include a high level of collaboration between managers and staff either prior to or during implementation, which may be manifest in shared decision-making, coordination with other community organizations, effective communication processes, and shared formulation of tasks (*Table 6*).

With respect to shared decision-making, both licensed and unlicensed staff at site 1 expressed concern that they were not involved in the decision to adopt the program and expressed interest in participating in future decisions. At site 1, family members asked to help decide which residents participate in the program; at site 2, they asked to be given the opportunity to describe perceived effects of the program on their own family members.

With respect to coordination with other agencies, family members mentioned the possibility of students and clergy lending support to the program. They also repeated a comment made in the overview of Namaste Care, noting that family members and volunteers could participate in the program.

All staff members highlighted the importance of clear and active communication about the program. At site 1,

Table 6 Specific practices & processes

Code	Representative statements
Shared decision-making	S1-L3: it would have been nice if we would have had time, like information, if somebody came and sat with us and formed a group, and then started implementing
	S2-F3: I think it would be important to—you know, you said the families would participate – but just asking them about what they're seeing—if they're seeing any changes, or the resident is less anxious, or more calm, or anything like that
Coordination with other agencies	S2-F1: although it's staff run, certainly we would probably have volunteers, students, family—it's sort of a flowing kind of thing. It's not like the door is shut and no one else can come in
Communication	S1-L3: so far as the input for the program, who gives suggestions like how does all that work?
	S2-UL5: I think, too, having a good snapshot of the person's care needs. Because if it's different people going in and you're bringing people from different units, you may not have a clear idea that this person has any triggers or behaviours or whether it's a good day or a bad day for them
	S1-F4: can we be kept up to date on the process?
Formulation of tasks	S1-UL2: so there's two care aides for 15 residents, 30 residents on the floor, two teams. So, if I'm disappearing, that leaves the three (two maybe) staying together on one team and then the other one on the other lifts is always a 2-person job
	S2-UL1: 1:30 to 3:30 we might have some obstacles because certain people do go to bed after lunch
	S2-UL5: how would that work with staffing are they going to schedule more in the floor?

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licensed staff expressed questions about feedback processes for the program, and conveyed interest in communicating with the management team and the research team. At site 2, licensed staff suggested creating a staff schedule for Namaste Care, and advised documenting the work done in Namaste Care. Unlicensed staff suggested considering the advantages and disadvantages of listing Namaste Care on the home's activities calendar. They also recommended making a brief "snapshot" of resident care needs available to those working in the Namaste Care room. At both sites, families asked to be informed as the program unfolded.

Concerning formulation of tasks, most participant groups questioned how staff would be assigned to the program. This question seemed to be driven by a perception that staff would be lost to residents not in Namaste Care, only partly assuaged by a reminder that it might be feasible to implement this group program without affecting the staff-to-resident ratio for those not attending program. At site 1, unlicensed staff members were particularly concerned about how 2-person lifts and transfers would be negotiated with one member of the team assigned to work in Namaste Care; at site 2, licensed staff mentioned the same concern on behalf of unlicensed staff members. At site 2, unlicensed staff was particularly concerned about how the program would be negotiated around mealtimes, naptimes, and toileting needs.

Staffing considerations

The ecological framework identifies three leadership-related staffing considerations as important to successful implementation. One is effective leadership, including priority-setting, consensus-making, incentives, and general oversight. A second is the presence of program champions—informal leaders who will rally support and negotiate solutions. Finally, implementation is more likely to be successful with the regular involvement and encouragement of senior employees, such as supervisors and managers (*Table 7*).

Site 1 staff and family members readily identified the director of nursing care as the person responsible for leading the program. Family members at site 1 expressed concern that two key managerial positions were currently unstaffed. Unlicensed staff recommended forming an implementation working group to assist with guiding the program, and requested that licensed staff offer supervisory support by assigning nursing assistants to work in Namaste Care. They further recommended that managers actively support the program by checking on staff and residents during the first weeks of implementation, by encouraging staff, and by facilitating teamwork.

At site 2, staff readily identified the director of nursing care as the leader. A few licensed staff members recommended consistent program staffing to improve

Table 7 Specific staffing considerations

Code	Representative statements
Leadership	<p>S2-L1: but the thing is, I think it has to be done with the registered staff. Interviewer: why do you think it has to be done with the registered staff?</p> <p>S2-L1: because the registered staff has ideas about the care of those residents. They can work with unlicensed staff, too</p> <p>S1-F3 (spiritual care coordinator present at family interview): when our CEO got that phone call, you know, her compassion, she won't say no to anything, this is her belief; that it can work. So, when she got sick, I said to DOC, it's you and I, and we're going to make this happen, we've got to make it happen</p>
Program champion	<p>S1-UL2: I think a core group is a good step ahead and I think that we should have a sheet where we could say who is interested in taking part in Namaste so that we can move forward a little bit easier</p> <p>S1-UL1: if I'm scheduled for Namaste and the staff partner I have been assigned to work with that day is struggling, what can I do?</p> <p>S2-L3: will everyone be trained in Namaste Care? You know what I mean? There will be no consistency depending on who the assigned carer is</p>
Managerial, supervisory, or administrative support	<p>S1-UL3: the RN or LP would designate someone to come into Namaste</p> <p>S1-UL2: I think that's very important, to see management floating around the floor to see how we're doing</p> <p>S1-UL4: absolutely, I think that's very important</p> <p>S1-UL2: I think they both have stressed though, that that will happen</p> <p>S1-UL1: they have</p> <p>S1-UL2: because they really want this program to work well</p> <p>S1-F4: one other question I have, you're down two pretty important members of the administration, is there any news in that regard?</p>

S, site; F, family; L, licensed; UL, unlicensed.

continuity of care. In addition, one licensed staff member thought the program was best led by nurses in cooperation with nursing assistants.

Support for implementation

Adequate training and technical assistance can be vital to the successful implementation of any program. The ecological framework defines technical assistance as a combination of resources offered to providers after implementation begins, including ongoing training, training of new staff, emotional support, and mechanisms for problem-solving. We also considered comments about appropriate space, equipment, and supplies in this category (Table 8). With respect to training, licensed staff at site 1 expressed a need for education, and hoped that all staff would participate. At site 2, advisory council members were aware of a book about Namaste Care and expressed interest in reading it. Concerning the need for space, equipment, and supplies,

unlicensed staff at site 2 commented that the room chosen for Namaste Care was too small. Unlicensed staff at site 1 commented that lack of access to water supply in the identified space might be a barrier to implementing some Namaste Care activities.

Discussion

This study makes an important contribution to an understanding of barriers and enablers to implementing Namaste Care, a program that promotes attention to quality of life in the late stages of dementia and is consistent with a palliative approach to dementia care. In this study, the ecological framework (22) was used to identify a range of factors known to be associated with implementation success, including characteristics associated with the innovation, health providers, and the broader context (the Canadian LTC system), as well as organizational characteristics, including practical supports, capacity for change, work flow

Table 8 Support for implementation

Code	Representative statements
Training	S2-F4: a staff member was saying there was a whole book on this and of course there's going to be a training manual, etc. Will the family members be able to see some of this? S1-L2: I mean I would hope that we get a good turnout from staff when Joyce Simard (the program founder) is here. Honestly, to hear that information from the person that started the program, that's incredible!
Technical assistance	S1-UL1: now that I'm thinking of it more, when we get those people up, we're going to wash their hands and face in their room, because we want running water. We're going to have to do that in their rooms S1-UL-2: yes, we do that all in their rooms S1-UL1: again, running water is there, we don't have running water in here S2-UL4: it might be overwhelming too right? For the resident. You know to have all—like it's a lot of people in the room, and it may just be too much for them S2-UL6: for such a small room, I think the ideal number would be four residents

S, site; F, family; L, licensed; UL, unlicensed.

considerations, and coordination of leadership among the staff cohort.

As we analyzed interviewee statements related to the Canadian LTC context (e.g., policy, politics, and funding) we noted concerns that some existing governmental and regional policies (e.g., 2-person lifts and transfers for some residents, infection control, and no-scent policies) might be difficult to navigate given some program characteristics. Somewhat similar concerns arose in a multi-facility implementation trial in the UK (e.g., difficulty working around a practice norm of wearing gloves during care) (19). When local policies and resulting practice norms are identified as barriers to implementation, any changes to the practices used to meet policy objectives should be introduced and monitored very carefully during implementation to ensure dual attention to policy goals and intervention fidelity.

Still, participant comments also suggested that Namaste Care is perceived as needed and beneficial, consistent with palliative care and resident-centred care philosophies, and likely to improve outcomes such as a sense of relationship and reduced agitation. These perceptions align well with staff perceptions of Namaste Care in other settings (17,20), and initial reports of outcomes associated with Namaste Care. In particular, the program appears to contribute to a number of positive psychosocial outcomes, including improved quality of life and relationships (15), as well as reductions in the need for psychotropic medications, lower rates of psychiatric symptoms, and improved communication (16). On the basis of early research findings

and the response to Namaste Care from LTC staff and families, there may be considerable potential to increase use of Namaste Care in the Canadian LTC system.

Despite liking the program and anticipating benefits, participants were concerned about the resulting demand on resources and an impact on workflow, and suggested more staff would be needed. For example, offering a morning session of Namaste Care was seen as removing resources needed to provide personal care and breakfast. Some were concerned that improving care for some residents would compromise care for others—a concern that has arisen in other LTC studies (32). The workplace dynamics in Canadian LTC homes may offer some explanation for the level of concern that surfaced on this topic. A social network analysis noted that a hierarchical division of labour within LTC teams in Canada results in a very mechanistic approach to work, particularly for nursing assistants (33). Work in Canadian LTC homes has also been described as particularly task-oriented and role-differentiated (34). Nevertheless, resource constraints in LTC are well documented elsewhere (35,36), do appear to create time pressure (23,26,34,37-39), and have operated as a barrier to offering Namaste Care at the recommended intensity in prior studies (20). Indeed, given that similar concerns about LTC workload exist on a global scale, it may be helpful for homes implementing Namaste Care to plan for an additional staff member to cover the part of the day during which Namaste Care is offered. Additional staffing may be especially helpful during the initial implementation period, to facilitate change.

Our interviews with unlicensed staff suggested that both sites were reliant on a casual labour force. This is to be expected, since absenteeism and turnover are persistent problems in LTC (40). However, unlicensed staff also noted that the bulk of their work is coordinated in 2-person teams. They attributed this general practice to a specific requirement to coordinate safe lifts and transfers of many residents by involving two employees, but also noted that this practice facilitates mentorship of casual staff by regular staff. Thus, to unlicensed providers, Namaste Care could be seen as a double threat to a well-established system of work. On this basis, we recommend that homes considering Namaste Care evaluate the stability of their workforce prior to implementation, and engage unlicensed staff actively in the planning process to ensure that these concerns are effectively addressed.

The apparent conflict between perceiving the program as very valuable and being reluctant to accommodate it mirrors other results suggesting that the low resource base and task-oriented nature of work in Canadian LTC settings competes directly with health providers' interests in forging stronger relationships with the residents (41,42). On one hand, Namaste Care is a solution to this problem, since it is promoted as a way to improve care without necessarily increasing staffing, and since it provides a means of systematizing resident-centred care. On the other hand, the comments of unlicensed providers suggest that Canadian LTC homes may need to carefully consider how staff assignment of duties can be reformulated or whether resources may need to be increased to accommodate Namaste Care.

Nursing assistants also raised the possibility that Namaste Care might provoke stigma and fear of participating for residents or their families. For instance, they anticipated that residents might notice that their peers in Namaste Care die within weeks or months of their initial participation in the program, and come to associate the room with death. Since the program is designed for individuals with late-stage cognitive impairment, whose memory impairment is likely to hinder awareness that people who attend the program ultimately pass away, we think this unlikely. Nevertheless, death anxiety and taboos about discussing death are well documented (43-46), including among North American health providers (47-49). Thus, although conceptualizing Namaste Care as end of life dementia care may help to increase engagement in dedicating resources to the least demanding—and arguably most vulnerable—LTC residents (14,50), this message needs to be delivered carefully,

perhaps along with continuing education, in order to avoid creating additional implementation barriers.

A range of specific organizational practices and processes are important to successful program implementation. These include collaboration, shared decision-making, coordination with other organizations, effective communication processes, and shared task formulation. Overall, participant comments about these factors suggested that despite concerns about staffing capacity, staff at both sites were willing to actively participate in the development of communication systems to support Namaste Care, including day-to-day assignment of duties. Family members' comments also suggested their interest in participating in communication about the program. Although engagement in identifying practices and processes was high, in light of other research on the Canadian LTC system, we do anticipate that some implementation barriers might nevertheless be encountered here. For instance, reorganization of work to support Namaste Care is most likely to affect the roles of unlicensed health providers, yet unlicensed providers are least likely to be included in decision-making processes (34,39). Meaningful family engagement is also recognized as an area needing improvement in many Canadian LTC homes (51). Still, given the level of engagement from staff and family participants, to the extent that engagement in collaborative decision-making about work practices and processes is recognized and acted upon prior to implementation, this should operate as an implementation facilitator, as appears to be the case in some previous Namaste Care trials (20).

We were particularly encouraged to find health providers expressed interest in forming a core group of staff to either plan or staff the program. Since staff planning groups are also known to foster informal leadership (52), engaging staff members with interest in planning for Namaste Care should help to facilitate successful implementation. Some staff members also voiced the importance of managers maintaining a consistent early presence in the program. Beyond an active presence, research suggests that leadership should also include direct expressions of recognition or appreciation and support (53,54). Overall, effort to identify and engage formal and informal leaders is likely to be an important enabler, and prior successful implementations of Namaste Care support this (15,20).

Participants were not very concerned about recruiting practical support for implementation, including training, supplies and technology. In particular, participants were pleased that training would be provided and voiced interest

in attending. The only concern voiced about practical support for implementation was related to space. Most Canadian LTC homes are at capacity, and many frail older adults with extensive support needs are on wait lists for placement (55). Without a surplus of space, existing spaces must be shared or repurposed. Both sites were able to repurpose smaller gathering spaces for Namaste Care by moving other activities from underutilised spaces. Overall, the ease with which reasonably suitable spaces for small group programs could be identified and the low reliance of Namaste Care on special technologies and supplies are likely implementation facilitators.

This study had some limitations. First, the ecological framework was not identified a priori, which compromised our ability to more thoroughly assess barriers and enablers to implementation. Secondly, participants' comments were based on a brief summary of the program, rather than direct exposure to it. It is possible that increasing participants' exposure to the program (e.g., by having them read about it, watch video footage, visit an existing program, or plan for implementation) might lead to somewhat different results. Further, since the interviews were completed after both sites had committed to implementing Namaste Care, interviewees may have emphasized communication and work planning issues to a greater degree than if the interviews had been coordinated prior to the sites' commitment. In addition, the predictive value of these results may be limited; for instance, participants were very engaged in the idea of collaborating to launch the program, whereas empirical research demonstrates that collaboration across roles is a weakness of the Canadian LTC system (34). To address these issues, future studies might explore implementation determinants over the course of the first several months of Namaste Care launches.

Conclusions

Namaste Care is an approach to advanced dementia care that has had global impact. Although early results suggest that Namaste Care is a promising model for late-life dementia care, a great deal of research is still needed to ascertain the range of outcomes for residents, the program's impact on LTC resources, and the conditions under which Namaste Care is most likely to be successfully implemented and effective. By employing the ecological framework (22), we were able to consider a range of determinants already known to be relevant in health contexts, including factors associated with the intervention, health providers,

organizational contexts, and health systems. Overall, our results suggest that implementations of Namaste Care in the Canadian LTC system are likely to be enabled by widely shared perceptions that the program is beneficial, needed, and compatible with dominant philosophies of care. On the other hand, a barrier to implementation of Namaste Care in the Canadian LTC system is that interviewees had strong reservations about organizational capacity to accommodate the new program. Thus, support for a high-fidelity implementation across both participating LTC homes was mixed. Our data paint the picture of a well-considered and appealing intervention encountering a health system running near peak efficiency.

Acknowledgements

Funding: This work was supported by Alzheimer Society of Canada (No. 16-09 to Sharon Kaasalainen).

Footnote

Conflicts of Interest: Co-author J Simard is an independent consultant who created the Namaste Care program and has promoted it internationally. A potential conflict of interest is inherent in her collaboration with this research team, formed to study the implementation of Namaste Care in Canada. To guard against excessive influence, Ms. Simard has abstained from participation in data collection and analysis. Her involvement on the team helps to maximize intervention fidelity and knowledge of global research on Namaste Care. The other authors have no conflicts of interest to declare.

Ethical Statement: The study was approved by Hamilton Integrated Research Ethics Board (No. 15-092) and University of Saskatchewan Behavioural Research Ethics Board (No. 15-267), and written informed consent was obtained from all patients.

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Cite this article as: Hunter PV, Kaasalainen S, Froggatt KA, Ploeg J, Dolovich L, Simard J, Salsali M. Using the ecological framework to identify barriers and enablers to implementing Namaste Care in Canada's long-term care system. *Ann Palliat Med* 2017;6(4):340-353. doi: 10.21037/apm.2017.06.14