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Formulation-led care in care homes: Staff perspectives on this psychological approach to managing behaviour in dementia care

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Abstract

Introduction: Many people living with dementia will move to specialist care facilities as the syndrome progresses. Psychological formulation offers a promising non-pharmacological approach to managing behaviours that challenge in dementia care. However, little is known about how formulation is viewed by non-qualified care staff who are responsible for the day-to-day care of residents. Therefore, the present study aimed to explore the experiences of care staff in relation to formulation as an approach to managing behaviour in dementia care.

Design: This was a qualitative design involving semi-structured, individual interviews.

Method: Interviews were conducted with 13 care staff with experience of psychological formulation from five care facilities. Data were analysed using thematic analysis.

Results: Three themes emerged from the data that offer an insight into the factors contributing to care staff's perspectives of formulation-led care. The themes were defined as expectation, working together and understanding.

Conclusion: The findings suggest that formulation-led care approaches are viewed by care staff as a favourable approach to supporting people living with dementia who present with behavioural difficulties. Psychologists can aid care staff's investment within formulation approaches through managing expectations and fostering effective working relationships with care teams to develop understanding of the context around behaviours that challenge.

Implications for Practice: By aiding effective, collaborative communication between nursing and psychology team members and providing clear feedback to aid nurses' understanding of formulations, this study highlights that consideration of biopsychosocial factors when attempting to understand behaviour offers a safe, person-centred alternative to pharmacological approaches.

KEYWORDS
behaviour, dementia, formulation, perspectives, staff

1 | INTRODUCTION

Behavioural and psychological symptoms of dementia such as agitation, aggression and restlessness affect up to 90% of people living with dementia (Brechin et al., 2013). People with dementia are often moved to specialist care homes when behaviours become more pervasive (Brodaty et al., 2015). Pharmacological interventions, such as antipsychotic medication, were routinely utilised in the management of behavioural and psychological symptoms of dementia and continue to be widely used in care home settings for people living with dementia (Corbett & Ballard, 2012). Due to concerns relating to the excessive use of medication and side effects (Banerjee, 2009), current guidelines advocate for the use of non-pharmacological interventions as first-line approaches (American Geriatric Society, 2013; National Institute for Health & Care Excellence, 2018). However, nursing staff have been found to be key drivers for antipsychotic use due to limited understanding and confidence in adopting non-pharmacological approaches (Aerts et al., 2019).

Whilst behaviour analysis methods such as the 'ABC' approach (Antecedents, Behaviour and Consequences) are regularly used in dementia care facilities, these approaches have been criticised for attempting to reduce behaviour to a single explanatory hypothesis (Moniz-Cook et al., 2012). In their overview of systematic reviews exploring treatment options, Dyer et al. (2017) found that interventions that sought to holistically explore the factors underlying behaviours had a significant impact on behaviour, such as the use of formulations. Formulations are hypotheses that are derived from extensive assessment which seek to explain the development and maintenance of presenting difficulties based upon a person's history and experiences and psychological theory (Johnstone, 2017). Behavioural and psychological symptoms of dementia represent a complex manifestation of underlying biological, social and psychological factors that are idiosyncratic to the person (Wolverson et al., 2019). Therefore, approaches that can conceptualise behaviour through an analysis of these factors in the context of dementia are recommended (James et al., 2022) and regarded as good practice (Royal College of Psychiatrists, 2017). James et al. (2020) explored clinician's views of this approach and the results were favourable, suggesting that formulations are perceived as a useful, holistic alternative to pharmacological treatments. However, health-care staff have reported feeling cautious about utilising formulations in the context of dementia care due to confusion about the meaning of the term and the implementation (Reichelt et al., 2019).

Over recent years, the practice of team formulation has grown in the United Kingdom. Team formulation refers to the process of facilitating staff teams to develop a shared understanding of service users' presenting difficulties (Johnstone, 2013). Bealey et al. (2021) conducted a systematic review of team formulations in multidisciplinary teams and concluded that formulation in this way is efficacious in enhancing staff understanding of service users and improving professional confidence. The preliminary positive effects of this approach in older adult services specifically have been documented by Dexter-Smith (2015) through single case studies and staff feedback. However, this approach to formulation is not widely used in care homes at present despite an increase in the use of team formulations in other settings (Geach et al., 2018).

In adult impatient services, the use of formulation has been associated with positive staff outcomes, including the development of more empathic working relationships with service users and increased optimism (Berry et al., 2009, 2015). However, the impact of team formulation on dementia care staff is lesser known (Craven-Staines et al., 2010). There is preliminary evidence to suggest that formulation-led approaches are viewed favourably by care staff. Holle et al. (2016) conducted an integrative review exploring individualised formulation-led interventions in managing the behaviour of people with dementia. Only one of the 34 studies qualitatively explored the

What does this research add to existing knowledge in gerontology?

- Care home staff expressed support for team formulation as an alternative way of understanding and attending to psychological and behavioural symptoms of dementia.
- Staff who had high expectations of formulations were more likely to perceive formulation negatively when immediate intervention outcomes were not realised.
- Staff were more likely to value this biopsychosocial approach when formulations were collaboratively developed with the team and incorporated their own knowledge and understanding of the service user.

What are the implications of this new knowledge for nursing care with older people?

- Providing care staff with a clear explanation to aid their understanding of formulations may help to manage expectations.
- Collaboration between the care team and psychology staff should be encouraged to support a shared understanding of residents' behaviours in order to improve the efficacy of formulations.
- Consideration of biopsychosocial factors underpinning behaviour can support understanding and intervention planning and offers a safe alternative to pharmacological approaches.

How could the findings be used to influence policy or practice or research or education?

- Team formulations offer an opportunity for care staff to co-produce meaningful and appropriate strategies to attend to behavioural and psychological symptoms of dementia.
- However, team formulation should be supported by follow-up input to enable staff feedback and redirection where required.

experiences of care staff in relation to specific formulation-based interventions. Zwijsen et al., (2014) conducted interviews with 51 participants from different caring professions, including 29 nursing staff. The staff were asked about the barriers and facilitators of a structured formulation-led intervention and staffmade reference to organisational aspects, such as workload and staff turnover; the culture of the organisation and specific aspects of the care programme. As the interviews formed an evaluation of a specific formulation-led intervention, the attitudes and beliefs of staff regarding the management of behavioural and psychological symptoms of dementia through this psychological approach were not explicitly explored. Notably, the nursing staff recruited within the study had all received at least 2 years of caregiving training which is not representative of the majority of care staff. Steele et al. (2021) explored a novel approach of training community mental health team staff to carrying out formulations with care home staff. The study found that community mental health staff valued using formulations with care home staff but highlighted a number of different barriers to integrating formulation within their routine practice including time limitations and perceived low confidence in using the approach. The study did not, however, explore care staff members' view of the experience.

Therefore, the current study aims to address a gap in the literature by exploring the experiences of care staff in relation to formulation as an approach to managing behavioural and psychological symptoms of dementia. It focuses on formulations carried out by psychologists as this remains the most common professional group involved in the practice of team formulation (Geach et al., 2018).

2 | MATERIALS AND METHODS

2.1 | Participants

Inclusion criteria were as follows: (a) currently working with people with dementia in care settings; (b) aged 18 and over; (c) able to converse in English proficiently and (d) experience of participating within a team formulation within the past year. Job roles included nursing and health-care assistants, shift leaders, senior carers and managers. Participants were recruited from care homes, nursing homes and assisted living accommodations across the North-West of England using purposeful sampling. This involved contacting managers of homes where a psychological formulation had recently been undertaken with support from the care team using contact information provided by local Community Mental Health Teams. Prior to this involvement, it had been identified that repeat referrals were being made to these teams to request behaviour management support for residents. Therefore, a formulation approach was proposed as a method of exploring the underlying mechanisms for the behaviour(s) from a biopsychosocial perspective in the hope that this way of considering behaviour could be adopted by the care teams. Formulations were based upon the Newcastle Model by James and Stephenson (2007), which is widely used within older adult services to structure formulations (James, 2011).

In total, seven care facilities were contacted and five care managers agreed to meet to discuss participation in more detail. Seventeen staff members expressed an interest in participation. Of these, two people later declined due to reluctance to be audio recorded; one person was unwell at the time of interview and did not want to rearrange and one person asked to withdraw at consent due to lack of availability. A final sample of 13 participants provided written, informed consent to be interviewed.

All participants were female which is broadly reflective of the demographic of care staff (Skills for Care, 2018). The participants were aged between 21 and 63 (mean = 39 years) and their years of experience within care home settings ranged from 3 months to 25 years. The majority of staff had a care-related NVQ qualification and one participant had an undergraduate degree in psychology.

2.2 | Intervention

The Newcastle Model outlines a framework for exploring behaviour through intensive assessment; information sharing sessions and treatment planning through the use of a formulation (James, 2017). In this study, psychologists from each of the community teams took a lead in facilitating this process following receipt of referrals for behaviour management support. Interviews were undertaken with key stakeholders including care staff and family members and the service user where appropriate. Information related to the service user's physical and emotional health, life history, personality, cognitive impairment, social environment and medication use was collated by the psychologist and used to generate a series of hypotheses regarding the service user's behaviour. This information was presented back to the care team through a feedback session in order to facilitate further discussions about possible intervention options.

2.3 | Procedure

The University of Manchester Ethics Committee granted ethical approval for the study and all participants gave written consent to participate. Interviews were undertaken within care home facilities and audio recorded. Interviews lasted between 18 and 46 min (mean = 34 min). The interview schedule consisted of open-ended questions such as 'what were your initial thoughts about this process of understanding behaviour?'; 'how did you use this information in your work?' and 'what effect did this approach have on the service user's behaviour?'. The questions were developed to explore care staff's experiences of formulation-led care, their perceptions of the approach in terms of managing behavioural and psychological symptoms of dementia from both a care staff and resident perspective and opinions regarding barriers and facilitators that affect the utility of this psychological intervention. The schedule was revised and developed throughout the interview process in order to attend to emerging themes within the data. Throughout the interview process, a reflective journal was used to document observations to aid

the coding process and initial analyses. All participants were given a £10 shopping voucher for their involvement.

2.4 | Data analysis

All interviews were transcribed verbatim and then subject to inductive thematic analysis. Thematic analysis was selected for analysing the data as it provides systematic guidelines for exploring qualitative data and is used to summarise, describe and interpret common patterns across the data (Braun & Clarke, 2013). This qualitative method also allows for flexibility to explore emerging themes and is widely used as a method to explore experiences, perceptions and perspectives which can be generalised more broadly (Fugard & Potts, 2015).

Transcripts were first read and descriptively coded by the first author. A subset of initial codes were reviewed by the research team to assess the credibility of coding. Codes were initially grouped into seven concepts following a process of gaining familiarity with the data. The initial concepts were discussed with the research team who focused on ensuring each theme suitably related to the research question, accurately reflected the data and was distinct enough to minimise any overlap between the concepts. Consequentially, the initial themes were revised during the analysis and some of the thinner concepts were collated to form three final themes that the authors felt were more parsimonious in addressing the research question.

Although the idea stems from grounded theory, the concept of data saturation has been used within thematic analysis research to empirically investigate when no further themes are found (Glaser, 1965). It was deemed that data saturation had occurred as no novel codes were arising from the data following the 11th interview (Guest et al., 2006), suggesting that the established codes and the subsequent themes suitably reflected the views of the participants.

2.5 | Epistemology and reflexivity

Whilst recognising the inherent subjectivity of this work, the authors assumed a reality to the participants' experiences that existed beyond this research (Fletcher, 2017). Regarding the analysis of the data, the research team's background in psychology and psychologically driven research in care home settings will have influenced the interpretation of the data. The interviewer's position at the time as a trainee clinical psychologist could also have had an impact upon the participants' reflections as the staff may have felt compelled to portray a favourable view of the approach.

3 | RESULTS

Three key themes were developed from the data: expectation, working together and understanding.

3.1 | Theme 1: Expectation

All of the interviewees reported that they were keen to explore different approaches to managing dementia compared to more traditional methods such as medication:

> ...there'd be a reason why they do, why they're doing what they're doing. Sedating them is not helping the problem; it's just, just basically, do you know, making them more relaxed...
>
> [Participant 7]

> ... [medication is] an easy way out. Like it's not right, it's not helpful [...] it doesn't help anyone. It's sort of like, you know, puts the difficulty over there instead of actually solving it [...] we need to actually help the person figure out what's going on.
>
> [Participant 8]

Staff stated that the process of receiving input from psychology services usually followed lengthy periods of attempting to manage a resident's behaviours without any external input, apart from medication support. Some participants felt that they had exhausted all of the strategies and techniques available to them and therefore hoped a psychological formulation would provide them with effective strategies that could quickly ameliorate behaviours that challenge:

> ...we look at something magic to happen...
>
> [Participant 3]

Other participants reported that they had no expectations of the support and there was a sense that this was associated with the staff's limited understanding of the role of a psychologist. These participants expressed little awareness of the role or how psychological input could support them within their own jobs:

> ...I couldn't tell you what, what psychology means [...] will it change the person? Will it do anything?...
>
> [Participant 7]

It appeared that in the absence of a clear definition of psychological support and formulation, some staff were curious to explore how the approach could benefit them whilst others came to their own conclusions about what the support would involve which affected their expectations:

> ... from a psychologist I would expect them to [give you the answers]...
>
> [Participant 3]

The expectations that care staff held in relation to psychological formulation had an impact on their overall perspectives of formulation-led care. Interviewees who were more hopeful about the perceived benefits of psychological input described a sense of

dissatisfaction with the support provided compared to participants who had little or no pre-conceived ideas about what a formulation-led approach would entail:

> …at first, I was happy, 'cos I was thinking, it's [psychological formulation] gonna really help us…It's just pointless. You're doing, you're doing the jobs…but then the behaviour's still happening, but it's like, you've done the recommendations so everything should be fine…
>
> [Participant 2]

> …well I didn't know what to expect at first, 'cos I didn't really have much experience with it… we didn't know what was on offer so everything that we learnt was a bonus…
>
> [Participant 6]

Furthermore, it appeared that the type of expectations that participants expressed also had an impact on their perspective of the approach. Interviewees who hoped for quick solutions appeared to be disappointed by the support made available to them:

> …you think the problem's gonna be solved…I think, at first you're looking for a quick fix aren't you? You think someone's here that can fix it all […] we're always open to new ideas and that's what you hope for I think when they come - new input. But it doesn't seem to be the case…
>
> [Participant 1]

In contrast, participants who hoped to gain a better understanding of the resident and develop their awareness of how dementia can affect a person offered more positive feedback:

> …to be fair, I thought it were just gonna be like a basic dementia understanding of what dementia is […] but the way they put it across, as how to understand it a little bit more, made it, a lot more easier, in general for us to try different approaches with him…
>
> [Participant 5]

Interviewees' beliefs about capacity for change also had an impact upon their perspectives on the approach. Participants who were optimistic about the perceived impact of the support were more invested in the content of the formulation. However, other participants were less hopeful of positive changes as they believed any capacity for change was outside of their control:

> …not everyone with dementia can be fixed…
>
> [Participant 1]

> …[following the intervention] there was nothing more we could possibly do with her […] we basically can't try anymore…
>
> [Participant 9]

3.2 | Theme 2: Working together

The nature of the relationship between the care staff and the psychologist, in particular the interviewees' perceptions of the psychologist's involvement with the care team, appeared to influence participants' views of formulation-led care. Some participants reported a sense of disconnection between the care team and the psychologist which subsequently affected their beliefs about whether the psychologist had a gained 'a true picture' of the resident's behaviours:

> …I don't know how someone can think they can just observe. I don't know, they need to be here, constant, I think, to, to know…walk in my shoes for a month…
>
> [Participant 1]

Correspondingly, a proportion of participants described a sense of frustration and powerlessness that their knowledge and experience of working with the resident appeared to be undervalued by the psychologist. Some participants indicated that they did not feel able to approach the psychologist to offer their own perspectives and ideas:

> …I work on the floor where she comes, that's my, the floor I work on, and she hasn't spoke to me once…I don't feel like I can approach them, I wouldn't approach them to ask them, any information…like I say they don't really acknowledge, they just come in, do their job and then they go…
>
> [Participant 2]

The absence of joint working appeared to create a divide between the staff and the psychologist in relation to expertise and experience and subsequently had an adverse impact upon the participant's attitudes towards the approach:

> …she [the psychologist] thinks she read it in a book and she'll come and tell us what we're doing wrong or right I think. I've known [the resident] for years and, and you just come and you say, "it's not". I don't say it but some say, like a bit of a kid coming in telling me how to, you know, tell your grandma how to suck eggs…
>
> [Participant 1]

Some participants, however, alluded to the presence of positive working relationships that were characterised by collaboration, information sharing and a sense that the psychologist was present and had an accurate understanding of the resident in question:

> …I think she did that [observation] over two weeks […] so she understood more of how we're seeing him than how, that she's being described of him, without seeing it for herself […] She, asked us, she came and

said, spoke to us, before she did the assessments, how we feel that was an issue and discussed that with us…
[Participant 5]

A benefit of positive working relationships between the care team and psychologist was that interviewees felt acknowledged and validated as they felt that their experiences and opinions were being heard. Interviewees also spoke of the benefit of team working and using their understanding of the resident, presented through a formulation, to develop their own suggestions in relation to how challenging behaviours could be minimised:

…how I see things is not probably how you see things. So it's like, I'm scratching your back and you're scratching my back. So it's like you're telling me things that I, that's helping them, and I'm telling you things like because you don't work on that side of it…
[Participant 7]

…so we all was discussing it as a team kind of thing, and you know inputting what, you know what we could do, do for him…
[Participant 10]

Participants appeared to be more invested in recommendations that were developed in this way through consultation with the psychologist as opposed to being prescriptively told what to do. This sense of team working appeared to increase their ownership of the suggestions, which subsequently aided implementation:

… the rest [of the ideas] was from us. But she was just inputting what could you do to, you know, like steer him away from getting agitated, getting aggressive, and this is what we come up with […] so it should be quite simple, you know to put together…
[Participant 10]

This sense of engagement was offered by participants as a way of overcoming any potential barriers regarding the utility of a formulation-led approach:

…involve like a more, like a two way sort of, questioning between both. The psychologist could say something, and then the staff member could say, "well I've tried this but when I was trying this he or she did this", so we know it's not working this way. So it could be more like a two-way sort of thing…
[Participant 3]

Despite their individual perspectives of the approach, the majority of participants suggested that it would be helpful to receive some follow-up support from psychological services as an opportunity to offer feedback and seek further support if required. Some staff reported feeling 'abandoned' [Participant 1] following involvement from the psychologist, whilst other expressed their concerns about the future:

…it would be good if she was to come back in again and just see if things have altered and, and you know, things have been put in place…
[Participant 11]

3.3 | Theme 3: Understanding

Participants spoke about how their investment within the approach was affected by their understanding of formulation. On the whole, staff gave positive feedback regarding formulations, particularly in relation to the concise presentation of the information, which aided their engagement within the content. Providing staff with context around the resident's experiences allowed them to hypothesise about potential triggers in relation to residents' behaviours:

…when you start looking at all these different things and you can just piece together what has actually set things off…
[Participant 11]

Some interviewees felt that the support facilitated their understanding of how the individual's behaviour was affected by their experience of dementia. This increased understanding had a positive impact upon their investment in the implementation of strategies, including building upon strategies that had already been trialled by the team before psychological involvement:

…so yeah, I understand a little bit, but now I actually know that I can, I can do that, and have the confidence in doing it or saying, it's alright I'll have a go, I'll try…
[Participant 5]

There was a sense that more experienced staff were less invested in the outcome of the formulation as they felt that information did not offer them further understanding or a new perspective. Instead, some staff members felt that the approach would be more useful for newer members of the team:

…this is useful for someone who first comes in…
[Participant 1]

… there's a lot of new staff, and I think sitting down and actually listening to somebody think of why she's actually behaving like this, I think they'd [like to] know…
[Participant 9]

Correspondingly, younger, less experienced staff had more positive attitudes regarding the formulation-led approach and

reported that the experience had been beneficial for them and the resident:

> …things are working and he seems quite happy […] it's made me more confident now that I have more tools to work with…
>
> [Participant 8]

Staff felt confident in being able to interpret the information and implement the strategies that had been suggested by the psychologist in consideration of the formulation. However, interviewees often felt the suggestions lacked originality and were not sufficiently tailored to the individual needs of residents:

> …you do understand what they're saying, but you think, well, we knew that anyway (laughs). I know it's a bit awful to say that, but we always say, well we've known that, that's what we've done…
>
> [Participant 3]

> …she's only told us what we know. She's not told us any other ways to deal with him…
>
> [Participant 4]

These participants were subsequently more likely to report a lack of investment in the formulation, describing the intervention as 'pointless' [Participant 2].

It was noted that many of the interviewees were unable to recall examples of specific suggestions that were developed a result of the formulation, stating that they 'couldn't remember' [Participant 9]. This could suggest that presentation of the formulation and the associated recommendations were not fully accessible or meaningful to the staff to enable them to fully understand the information.

However, written communication was found to support the consolidation of the formulation:

> … it just enhanced all the information, like it really made me like focus, 'cos I knew like a lot of things, things going on to like focus, so then like, ok, and it just made all the information sink in a bit more…
>
> [Participant 8]

4 | DISCUSSION

The present study aimed to explore the perspectives of care staff in relation to formulation as a way of managing behavioural and psychological symptoms of dementia and three themes were identified across the data. The extent to which formulation was perceived to benefit staff was largely based upon their expectations, sense of collaborative working and their understanding of the approach.

Participants' expectations of psychological support were central to their experiences and attitudes towards the approach. Overall, staff expressed support for formulation as an alternative way of attending to symptoms in line with policy in this area (American Geriatric Society, 2013; National Institute for Health & Care Excellence, 2018). This optimism for new ways of working with behavioural difficulties following exhaustive efforts to support residents had an impact on participants' expectations of formulation-led care approaches. Where high expectations of effective, curative strategies were not met, participants alluded to a sense of disappointment in the approach which appeared to strengthen beliefs that nothing could be done to support the people with dementia. Murphy et al. (2013) suggest that dementia continues to be conceptualised within a medical framework by health staff, where behaviour is regarded as part of the condition. Therefore, the perception of dementia in this way may mean that staff are more likely to conclude that challenging behaviours are not amenable to change if strategies informed by a psychological formulation are not perceived to be efficacious. This suggests that the way formulations are introduced and implemented could have a significant impact upon nursing staff perceptions. Formulations offer hypotheses about the development and maintenance of behaviour (Johnstone & Dallos, 2013), thus providing care staff with an understanding of the tentative nature of this approach may help to manage expectations in relation to immediate solutions. Shirley (2010) suggested that socialising staff to the approach in this way can facilitate care staff's investment within formulation. Correspondingly, Raphael et al. (2021) suggest that in order for psychological interventions to be embedded within health-care settings, new ways of working need to be introduced in collaboration with key stakeholders, such as care home managers and community nursing staff. Taken together, this provides evidence that managing the expectations of care staff is an important consideration when attempting to engage care staff within a formulation approach.

Working together formed another pertinent theme within the present study and was also identified within Steele et al.'s (2021) study exploring community mental health staff members' experiences of carrying out formulations with care home staff. Participants within the present study discussed feeling that the psychologist had not attained a true perspective of the resident in question as the care staff had not been suitably involved in the information gathering process. This was evident in the participants' accounts, as it appeared that the presence of power dynamics between the care team and psychologist was linked to disengagement with the approach. Furthermore, experiences of good team working between the staff and psychologist were associated with more favourable views of formulation as an approach and participants reported that sharing information in this way allowed them to feel heard and valued. This finding has been reported in research by Hood et al. (2013) who found that multidisciplinary staff teams in community settings valued formulation work within a team as it facilitated group cohesion and improved team dynamics. This study suggests that effective team working that combines experiential perspectives from the care team with a psychological theory and strategies should be encouraged and was described by participants as a facilitator of this approach.

The majority of care staff reflected that psychological formulation enabled them to foster a more holistic perspective of the resident and an understanding of the resident's subjective experience. This understanding following formulation formed another central theme of this study, which is reflective of the findings of other studies within dementia literature (Craven-Staines et al., 2010; Murphy et al., 2013). Increased understanding through knowledge acquisition can have a positive impact upon staff attitudes towards residents (Hanson, 2014), which has been associated with increased quality of care (Lintern, 2001). The findings provide evidence that contextual information provided through psychological formulations can aid care staff's understanding of behaviour.

Participants' experience of working with people with dementia appeared to affect their understanding and perceived utility of the approach. Experienced care staff reported that formulation did not aid their understanding of the development and maintenance of behavioural difficulties for people with dementia. Therefore, they perceived psychological formulation less favourably when compared to their less experienced counterparts. Caring for people with dementia over long periods of time has been associated with care staff burnout (Duffy et al., 2009) and Todd and Watts (2005) identified that burnout had an adverse impact on optimism, willingness to support people with dementia and responses to challenging behaviour. It could be argued that care staff's prolonged experiences of supporting people with behavioural and psychological symptoms of dementia could have culminated in a sense of burnout, which subsequently affected their willingness to invest within a formulation-led approach. Correspondingly, Zimmerman et al. (2005) found that more experienced care staff are less likely to espouse hopeful and person-centred attitudes to dementia compared to staff with less experience. This could suggest that staff attitudes to dementia could affect staff's motivation to further understand the context behind behaviour. Therefore, the importance of validating and acknowledging care staff's experiences of supporting residents with behavioural and psychological symptoms of dementia and empowering experienced staff to use formulations to predict behaviours and develop appropriate interventions is recommended.

One of the key functions of formulation is to generate ideas for person-centred interventions (Johnstone, 2013, 2017). If staff do not understand the purpose or the nature of the formulation developed, they are unlikely to appreciate the value of recommendations arising within from the process. Previous research has suggested that one of the key barriers to carrying out effective formulation is information generated from formulations not being fed into care planning (Steele et al., 2021). These findings suggest that managing staff expectations and engaging staff in a way that recognises the perspectives that they themselves bring is a way of overcoming this barrier, supported by psychological theory.

4.1 | Limitations

Purposeful sampling resulted in the recruitment of an all-female sample from the North-West of England. Although reflective of the typical demographic of this group (Skills for Care, 2018), the findings may not capture the perspectives of other demographic groups. Furthermore, the participants who were approached for recruitment within the study had either participated in the development of a formulation or had volunteered to attend a feedback session. Therefore, this pool of participants could reflect a biased sample of care staff with an interest in psychological approaches.

As this research was undertaken after the formulation had been developed with the care teams, it was not possible to ensure that the psychologists' approaches to implementing the Newcastle Model were standardised to ensure consistency in the implementation of the approach across each of the sites. In addition, individual differences in the introduction and implementation of the approach by the psychologists may have influenced staff perceptions which could have accounted for the differences in staff perspectives. Some of the participants had limited understanding of formulation, despite the fact that all care homes in the study had previous experience of team formulation within the past year. This suggests that there were either differences in how formulation was implemented across care homes or reflects individual staff members involvement or engagement in formulations that were carried out.

5 | CONCLUSION

There is a paucity of research exploring care staff's perspectives of formulation-led care. Therefore, this study represents an important contribution in advancing the research. In recognition of staff beliefs regarding collaboration and joint working, formulations offer an opportunity for care staff to co-produce meaningful and appropriate strategies to attend to behavioural and psychological symptoms of dementia. Future research might helpfully explore the implementation of team formulations within care home settings with a specific focus on care staff perspectives of this approach to formulation.

6 | IMPLICATIONS FOR PRACTICE

The findings from this research propose that the involvement of nursing staff in the development and implementation of formulations is pertinent to perceived efficacy of the approach. Providing care staff with a clear explanation of formulations may help to manage expectations, with a particular focus on how formulations provide tentative hypotheses that can be explored through intervention. Collaboration between care teams and psychology staff should be encouraged to support a dialogue between the services to facilitate a shared understanding of residents' behaviours. More specifically, it is proposed that by increasing their presence within care facilities at team meetings and through regular formulation sessions/supervision, psychologists can maximise opportunities to feed in to care plans and develop positive working relationships with care staff. Additionally, regular training in relation to understanding the biopsychosocial symptoms of dementia may increase care staff engagement and implementation of formulation-informed interventions.

Whilst best practice guidelines advocate for psychologists to develop formulations with staff teams due to their specialist training (NICE, 2018), Steele et al. (2021) suggest that community health-care professionals can be trained to utilise this biopsychosocial approach in their clinical practice. Therefore, where effective professional relations have been established between community staff and care teams, other health-care professionals such as mental health nurses may be suitably placed to facilitate discussions around formulation.

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CONFLICT OF INTEREST

The authors declare that there are no conflicts of interest.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author upon reasonable request.

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