Enduring Power of Attorney (EPA) - implementing and sustaining discussions

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Enduring Power of Attorney (EPA) – implementing and sustaining discussions

Agbata I N

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Declaration Form

Declaration:

“I hereby certify that this material, which I now submit for assessment for the Project Dissertation Module on the MSc in Health Care Management is entirely my own work and has not been submitted as an exercise for assessment at this or any other University.”

Student’s Signature: IAGBATA

Date: 20/05/13

Student’s Number: 11110180
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<td>Advanced Care Planning</td>
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<td>AD</td>
<td>Advance Directive</td>
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<td>ABI</td>
<td>Acquired Brain Injury</td>
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<td>CI</td>
<td>Cognitive Impairment</td>
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<td>CMHN</td>
<td>Community Mental Health Nurses</td>
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<td>CP</td>
<td>Consultant Psychiatrist</td>
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<td>CUA</td>
<td>Cost Utility Analysis</td>
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<td>DPA</td>
<td>Durable Power of Attorney</td>
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<td>EBM</td>
<td>Evidence Based Medicine</td>
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<td>EPA</td>
<td>Enduring Power of Attorney</td>
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<td>FFA</td>
<td>Force Field Analysis</td>
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<td>GP</td>
<td>General Practitioner</td>
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<td>HCP</td>
<td>Health care professionals</td>
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<td>HCPA</td>
<td>Health Care Power of Attorney</td>
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<td>HSE</td>
<td>Health Service Executive</td>
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<td>LPA</td>
<td>Lasting Power of Attorney</td>
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<td>MCA</td>
<td>Mental Capacity Act</td>
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<td>MCB</td>
<td>Mental Capacity Bill</td>
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<td>Mental Health Team</td>
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<td>MMSE</td>
<td>Mini Mental State Examination</td>
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<td>NCHD</td>
<td>Non Consultant Hospital Doctor</td>
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<td>NHS</td>
<td>National Health Service</td>
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<td>OT</td>
<td>Occupational Therapist</td>
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<td>PAD</td>
<td>Psychiatric Advance Directive</td>
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<td>PDCA</td>
<td>Plan Do Check Act</td>
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<td>POA</td>
<td>Psychiatry of Old Age</td>
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<td>SR</td>
<td>Senior Registrar</td>
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<td>SW</td>
<td>Social Worker</td>
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<td>SWOT</td>
<td>Strengths Weaknesses Opportunities Threats</td>
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<td>TC</td>
<td>Team Co-ordinator</td>
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<tr>
<td>TQM</td>
<td>Total Quality Management</td>
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<tr>
<td>Abbreviation</td>
<td>Full Form</td>
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<td>UK</td>
<td>United Kingdom</td>
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<td>USA</td>
<td>United States of America</td>
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<td>WRAP</td>
<td>Wellness Recovery Action Plan</td>
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<td>WOC</td>
<td>Ward Of Court</td>
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Abstract

This change project focused on increasing the awareness and understanding of the Enduring Power of Attorney among members of a regional Mental Health Team, patients and carers. In 2011, 1405 Wardship orders, a provision under the outdated Lunacy Regulations Ireland Act, 1871, were signed in Ireland as opposed to 440 appointed Enduring Powers of Attorney, under Irish Power of Attorney Act 1996. This suggests a probable lack of awareness or understanding and uptake of the provisions for advance care instructions. A pre-audit revealed less than half of a selected population of the Psychiatry of Old Age patients were aware of the Enduring Power of Attorney. The project entailed developing guidelines for implementing discussions on the Enduring Power of Attorney, developing an information booklet on the Enduring Power of Attorney, facilitating training and information sessions and incorporating measures for regular reviews of the implementation into existent organisational structures. Kotter’s eight step change model was utilised to guide the change process implementation. Also, SWOT analysis was integrated prior to, during and after the implementation of the change process. The change objectives were attained, as evidenced by the development of information booklet, and approval of standard guidelines for Enduring power of attorney discussions with inclusion and exclusion criteria. Increased EPA awareness was demonstrated by staff, and patients and carers feedbacks. Also, most staff felt confident or supported after change was implemented. Post Audit of practice after implementation of the change showed 100% compliance by the second contact with the patient.
Acknowledgements

My sincere thanks go first to my Supervisor Philippa Withero for her invaluable guidance. Her support and advice through the process of carrying out and writing up this project was always given with patience.

I say a big thank you to all the staff of the RCSI Leadership Institute for making this journey possible. Each module completed, prepared me for this final chapter of my MSc crossing and to each of the dynamic lecturers who made those gruelling days so enjoyable and motivating, I say thank you.

My appreciation also goes to every member of the Psychiatry of Old Age (POA) Team for their support and contributions towards the project. It would all never have been done without you. My especial thanks go to the Consultant POA for her mentorship in this and other aspects of my passage through last year and this year.

Finally, I thank my husband Eric for being my best friend and buffer and my three beautiful children Maya, Eric and Rian for always trying their best. We never stopped listening to each other. Thank you.

With God everything is possible.
Chapter 1: Introduction

1.1 Introduction
The change project entitled ‘Enduring Power of Attorney (EPA) – implementing and sustaining discussions’, was aimed at changing the status quo on the awareness and understanding of the Enduring Power of Attorney; and sustaining this change among patients and their carers and staff of the Psychiatry of Old Age (POA) team. The EPA is a topical subject and the need to initiate change followed an audit of the POA service. This chapter discusses the nature of the change process undertaken, reviews the rationale for the change and sets out the context in which the change was carried out. The aims and objectives of the change project are also stated.

1.2 Nature of the change
The EPA project was planned and intended as continuous and transitional. In contrast to an emergent change which is spontaneous and largely subject to external and internal influences, a planned change is typically calculated and hinged on a predetermined course of action (Iles & Sutherland, 2001). The EPA project assumed a project management model with specific, action focused and time bound objectives within the constraints of the dissertation; and a planned approach was preferred. The emergent nature of change which occurs in reality (Dawson, 1996) was acknowledged and steps were taken to limit the scope of the project to minimise this.

A degree of flexibility was factored into the process to enable already vastly experienced team members adapt aspects of the change to different circumstances, applying old and new experiences. The process itself was presented as an ongoing practice with a cumulative and evolving component which delineated the change as continuous, distinct from an episodic change which by definition is intermittent and sporadic (Iles & Sutherland, 2001). The change was focused on an aspect of the organisation’s function, involved a shift from an existent to a desired state through
the improvement of specific processes and so was transitional as opposed to developmental or transformational.

1.3 Rationale for carrying out the change

In Ireland, capacity legislation is outdated. The Lunacy Regulations Ireland Act, 1871 remains the major legislation which informs care of adults who lack capacity. The Irish Mental Capacity Bill (MCB), 2008 proposed reforms aimed at introducing more appropriate and modern directives. It identified the elderly, persons with acquired brain injuries (ABI), persons with mental illness and persons with intellectual disabilities as categories of adults who may lack capacity. The POA service deals with elderly (65 years and above) people who have mental illnesses whether chronic or new onset. Patients also present with dementia and delirium, and may have concomitant diagnosis of Stroke, ABI, Parkinson’s disease or Huntington’s chorea. All of these presentations are associated with temporary or permanent loss of capacity which may be progressive in nature (Saxon, 2008).

There are about 200 active patients in the POA service in any given month, with an excess of 500 referrals every year. The service has a Day Hospital where relatively acute patients are assessed and managed. The bulk of assessments and management activity undertaken by the POA service is however community based.

Capacity is often described in relation to a specific issue e.g. finances or treatment choices, and a person is said to have capacity if they can understand information relevant to an issue, retain that information, and weigh up pros and cons in the process of decision making (MCA, 2005). Mental illness may lead to a permanent loss of capacity, but it is also characterized by alternating periods of capacity and incapacity (Fazel et al, 1999). Advance directives which enable people express treatment choices when they do have capacity, are being incorporated more and more into care planning for persons with mental illness (the Wellness Recovery Action Plan – WRAP). Dementia with or without concurrent mental illness, is linked directly to gradual loss of capacity (Hotopf, 2005). Given the progressive nature of most dementias, it is likely that people, who subsequently progress to an advanced stage of the illness where they lack capacity, would have had contact
earlier on in the illness, at a point when they still retained capacity; with a health care professional (HCP).

The EPA under the Irish Powers of Attorney Act, 1996, is a legal document which empowers an individual or more (the Attorney(s)) to act on another person’s behalf (the Donor) in the event of mental incapacity in the Donor. If capacity is lost in the absence of an EPA, the responsibility of acting on behalf of the person falls on the state through the courts via a process known as the ‘Ward of Court’ (WOC). Families often find the prospect of making a loved one a WOC distressing, as care related decisions are outside their control. 1405 Wardship orders were signed in 2011 as opposed to 440 appointed Enduring Powers of Attorney (Courts Service, 2011). The proportion of persons who don’t create an EPA because they are unaware of or don’t fully understand the EPA is uncertain. There is scope to address this gap with the support of HCPs.

1.4 Context of the change
The Irish Mental Capacity Bill was proposed in 2008 but is yet to be deliberated in Oireachtas (Irish National Parliament) and passed as Law. Given the link between dementia and incapacity, the need for appropriate capacity legislation will grow as the prevalence of dementia climbs. While the state of incapacity is not age specific, with increasing age, the incidence of dementia and consequently, incapacity will increase. In 2012 an estimated 42,000 people in Ireland were living with dementia, with a projected increase to 67,493 by 2026 and 140,580 by 2041 (Cahill et al., 2012). Similarly in the United Kingdom (UK), 1.8 million people are expected to have dementia by 2050 (Gregory et al., 2007). In the UK, under the Mental Capacity Act (MCA), 2005, Advanced Care Planning (ACP) covers three decisions: an advance statement (of wishes and preferences), an advance decision to refuse treatment (ADRT) and a Lasting Power of Attorney (LPA). National guidelines recommend that ACP should be initiated with people with long term conditions or in receipt of end-of-life care; during routine clinical care. There are no similar guidelines available in Ireland and the above document serves as the gold standard.
An audit of the practice of EPA discussions in the POA service was carried out on all active case notes in August 2012. The main findings were that the EPA had only been discussed with about 10 patients (less than 5%) and there was no documented evidence of EPA related discussions in any of the 258 active case notes. At the same time, 57 patients were surveyed to determine how many knew of the EPA. These 57 patients were part of a convenience sample based on clinical reviews in the time period. 25 of them (44%) had heard of the EPA and of these 6 (10% of patients surveyed) had heard of the EPA through the POA team. Traditionally, EPA discussions were considered the role of the Social Worker (SW) who only had a proportion of patients on her caseload. Involving every professional member of the team in EPA discussions would increase the likelihood that every patient had access to this information. The need for training and information sessions on EPA was identified in the course of consultations with the Consultant Psychiatrist (CP) and team co-ordinator (TC) both of whom were engaged in supervisory roles within the team. The benefit of a health information booklet on this topic, which may expose patients and their carers to the EPA in the course of their involvement with the service, was additionally highlighted.

1.5 Aims & objectives
Aims and objectives of the change project include:

a. Develop a patient focused health information booklet on EPA which is concise and easy to read and understand in the last quarter of 2012.
   - Develop booklet which covers key aspects of EPA
   - Present information in a way that is easy to read and understand

b. Develop written guidelines for health care professionals initiating discussions on EPA with patients in the last quarter of 2012.
   - Determine standard recommendations for discussions on EPA
   - Identify patient inclusion and exclusion criteria
c. Enhance awareness and knowledge of EPA among staff in the last quarter of 2012 and the first quarter of 2013.
   - Present lecture on EPA to the POA team
   - Provide guidance on EPA at weekly team meetings

d. Implement discussions on EPA with patients and carers based on developed guidelines, in the first quarter of 2013, to enhance awareness of EPA among patients and carers.

1.6 Summary
Best practice recommendations in relation to EPA should be implemented by health service providers pending new capacity legislation. The awareness of EPA may result in an increase in the utilization of the document. EPA discussions are relevant, but not limited to the elderly or people with mental illness. Diagnoses linked with incapacity including ABIs and learning disabilities are represented across medical disciplines. For the purposes of the change initiative, the POA service was the focus.
Chapter 2: Literature Review

2.1 Introduction

A search of the literature in relation to the EPA was carried out in order to access information already available and reveal relevant areas of debate; a function asserted by Mays et al., 2001. Key words and phrases generated included: Enduring Power of Attorney; Power of Attorney; Capacity; Capacity legislation and Advance directives. The key words were passed through a search strategy and the materials generated were studied and classed in keeping with predominant themes. In this chapter, the search strategy employed is described, emerging themes are discussed and implications for the change project are highlighted.

2.2 Search strategy

The literature search was conducted using seven search platforms including the PROQUEST, Sage, SCOPUS, Emerald, the High wire Stanford University platform, Oxford journals, Cambridge journals and Google scholar. Pubmed publications were accessible via the High wire Stanford University platform. The search was limited to publications as from 1990. There were no limitations based on country of publication. Google scholar was subsequently omitted as a search platform, as it generated large numbers of non-specific material. The phrase ‘Advance directives’ was also subsequently omitted as it generated several hundred articles centred on euthanasia and this was outside the focus of interest. 444 materials were generated. The title of each paper was reviewed, and materials centred on Mental Health legislation were excluded as were duplicate papers. Abstracts of the remaining papers were reviewed and subsequently, 30 papers were selected. The references on these selected articles were reviewed to determine if other key words or articles might be generated. No new search phrases or articles of interest were generated using this strategy.
2.3 Review themes
Several themes were identified as a result of the literature review and are discussed below using each theme as a sub topic.

2.3.1 Legislation relevant to capacity
The following legislation were identified:

a. The Lunacy Regulations Ireland Act, 1871 (Ireland)
b. The Powers of Attorney Act, 1996 (Ireland) – (EPA)
c. The Mental Health Act, 2001 (Ireland)
d. The Mental Capacity Bill, 2008 (Ireland)
e. The Mental Capacity Act, 2005 (UK) – (LPA)
f. The Mental Health Act, 1983 (amended in 2007) (UK)
g. The Adults with Incapacity Act, 2000 (Scotland)
h. The Mental Health (Care and Treatment) Act, 2003 (Scotland)
i. The Patient Self-Determination Act, 1991 (United States of America (USA)) – Durable Power of Attorney (DPA)

2.3.2 Determining Capacity
The MCA, 2005 (UK) is often referenced in Ireland. The underlying principles of this Act are as follows

a. Capacity is presumed: a person is assumed to have the capacity to make relevant decision unless this is proved to be wrong

b. Decision-making should be supported appropriately: appropriate support should be given (e.g. improving eyesight or hearing) before a conclusion is reached that a person does not have the capacity to make a relevant decision

c. Unwise decisions do not indicate incapacity: a person with capacity may make an unusual, eccentric or unwise decision and yet have capacity

d. Best interests: anything done for or on behalf of a person without capacity must be in his or her best interests;
e. Least restrictive alternative: anything done for or on behalf of a person without capacity should be the least restrictive of his or her basic rights and freedoms.

Temporary and reversible incapacity may result from treatable conditions such as delirium. For the purposes of the LPA (similar to the EPA in Ireland) however, incapacity must be deemed permanent and irreversible.

Incapacity is linked to cognitive impairment (CI) on account of dementia, delirium, learning disability or ABI (Hotopf, 2005); and psychopathology especially that related to psychosis and affective (mood) disorders (Hotopf, 2005; Latif & Malik, 2001). Communication is crucial as difficulties may cause capacity to be masked and people who cannot superficially indicate that they understand and appreciate the information being given e.g. post stroke; may be considered to have lost capacity (Carling-Rowland & Wahl, 2010). Although capacity assessments are subjective, most research have found no strong associations between loss of mental capacity and socio-demographic variables; and no clear associations with gender, ethnicity, educational status or social class (Hotopf, 2005).

The Mini Mental State Examination (MMSE) (Appendix 1) is a highly sensitive and specific 30-point questionnaire for screening cognitive function which can be used to support a clinical capacity assessment, as scores correlate with expert assessments of capacity to consent to treatment (Gregory et al., 2007). Dementia may be mild, moderate or severe. Cut off points for these broad classes of dementia vary. A score of less than 20 however indicates that CI is no longer ‘mild’. MMSE scores of between 18 and 20 are required to make an ACP (Fazel et al., 1999) but Dening et al. (2012) noted that their participants in their study had a mean MMSE of 24.2 (range = 20–29) and yet most experienced difficulty with the concept of ACP, despite being educated to a higher level.
2.3.3 Capacity and health care needs

The form of Advance Directives (ADs) often referred to as ‘living wills’, varies depending on the decisions to be made. At one end of the spectrum it may be presented as an informal directive recorded in a medical case note by a medical professional and at the other end, a formal document requiring a solicitor’s input (LPA, EPA) (Das & Mulley, 2005). In relation to treatment choices, the validity and applicability of an AD however ultimately remains the responsibility of the involved healthcare professional (Carling-Rowland & Wahl, 2010). Problems may arise with the use of ADs in relation to the formality of the documentation, relevance in futuristic scenarios which were not anticipated and length of time of validity (Maclean, 2008). In the USA, Psychiatric Advance Directive (PAD) statutes are intended primarily for people with severe mental illnesses who anticipate loss of capacity in connection with their illness relapse. An appointed person takes over making decisions for mental health care, under the provisions of the Health Care Power of Attorney (HCPA); in the event of incapacity (Kim, et al., 2008).

The EPA empowers the Attorney to make decisions in one or all of the following aspects of care (Powers of Attorney Act, 1996): where and with whom the Donor should live; whom the Donor should see and not see; training and rehabilitation the Donor should get; diet and dress; inspection of the Donor’s personal papers and housing, social welfare and other benefits. The LPA (UK), includes in addition, healthcare and treatment decisions and this is its main distinction from the EPA. The Durable Power of Attorney (DPA) – USA similarly, includes healthcare decisions in the event of incapacity (Rissimiller et al., 2001). In relation to assets, financial decisions can be made by an Attorney under the EPA and accountability is needed to eliminate culpability (Setterlund et al., 2007).

In one study, 56% of Geriatricians had cared for patients with ADs; had positive experiences and supported the use of living wills by older people in spite of the potential for problems (Schiff et al., 2006). In another study 38.3% of SWs agreed that ADs were helpful, while 42.5% believed the HCPA law for mental health care
was helpful (Kim, et al., 2008). A third study found that both people with dementia and their carers had difficulty with some concepts often encountered in ACP discussions e.g. dignity and respect. In addition, people with dementia even at an early stage, exhibited concrete thinking in relation to futuristic scenarios (Dening et al., 2012).

### 2.4 Implications for the change project

Generally, the literature reviewed were either experiential reviews based on qualitative data, or reviews of publications on the topic. Findings informed the following aspects of the EPA project:

a. Content of the information sessions
b. Cut off point of MMSE scores: discussions were implemented with patients if score was more than 20
c. Feedback was not sought from patients with chronic mental illness in spite of MMSE scores above 20 because of the possibility that there could be other concurrent factors which may imply incapacity

### 2.5 Summary

The overall knowledge base on the topic increased as a result of the literature review. Topical discussions were highlighted and gaps in knowledge and practice were exposed. All the findings lent credence to the rationale for the EPA project. Some findings informed aspects of the project.
Chapter 3: Change Process

3.1 Introduction
The organisation for the purposes of the EPA project was considered to be the POA team as opposed to the broad hospital organisation. In this chapter, the steps taken to plan for the EPA project are summarised, approaches to change are critically reviewed, change models are discussed and the EPA project is described in detail using the selected change model. The strengths and limitations of the project and its impact on the organisation are also highlighted. A summary of the findings on review of change literature are presented when discussing approaches to change. Issues such as culture, resistance and power are also touched on when describing the EPA project.

3.1.1 Planning for change
Several management tools propose guides for exploring organisations and in 2001, Iles and Sutherland derived a figure which clustered these management tools, models and approaches under four headings/questions (Appendix 2). That summary provided a framework which guided a baseline review of the POA team, and set the focus for the EPA project (Figure 1).

Figure 1: Change management tools selected for review of the POA Team (adapted from Iles & Sutherland, 2001)
The McKinsey 7S model (Appendix 3) was used to visualise the components of the organisation and a SWOT analysis was applied to each ‘S’ to further explore these components (Table 1). The 7S model is a useful tool, for analysing and diagnosing organisational issues, and planning interventions and change (Peters & Waterman, 1990). Advocates praise the simplicity of the tool and highlight the gain in the visual model with its interlinking relationships, as it allows change to be seen as a systemic process with change in one ‘S’ likely triggering change in another ‘S’ (Peters & Waterman, 1990; Pascale & Athos, 1986).

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<th>Weaknesses</th>
<th>Opportunities</th>
<th>Threats</th>
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<td>‘salient features of the organisational chart (e.g. degree of hierarchy) and interconnections within the organisation’</td>
<td>Degree of autonomy</td>
<td>Isolation</td>
<td>Role development</td>
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<td><strong>Systems</strong></td>
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<td>‘procedures and routine processes, including how information moves around the organisation’</td>
<td>Updated regularly with emerging standards</td>
<td>Regular reviews leads to bulk in documentation</td>
<td>Introducing process is possible once there’s buy in</td>
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<td><strong>Style</strong></td>
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<td>‘characterisation of how key managers behave in order to achieve the organisation’s goals’</td>
<td>Supervision time utilised effectively as one to one time</td>
<td>Silo effect</td>
<td>Buy in from Lead roles</td>
</tr>
<tr>
<td><strong>Staff</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>‘personnel categories within the organisation, e.g. nurses, doctors, technicians’</td>
<td>Multi Disciplinary Team; ‘Cherry picked’ team</td>
<td>Staff numbers; Work overload</td>
<td>Expanding roles</td>
</tr>
<tr>
<td><strong>Skills</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>‘distinctive capabilities of key personnel and the organisation as a whole’</td>
<td>High level of specialisation</td>
<td>Over specialisation – new process may be viewed as outside remit</td>
<td>Willing to embrace new roles to expand expertise</td>
</tr>
<tr>
<td><strong>Strategy</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>‘plan or course of action leading to the allocation of an organisation’s finite resources to reach identified goals’</td>
<td>Limited resources</td>
<td></td>
<td>Budgetary allocation decisions made outside organisation</td>
</tr>
<tr>
<td><strong>Shared values</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>‘the significant meanings or guiding concepts that an organisation imbues in its members’</td>
<td>Best practice at the heart of service provision</td>
<td>Hard to introduce interests which are not typical to existing concepts</td>
<td>New best practice guidelines well received</td>
</tr>
</tbody>
</table>

Table 1: SWOT analysis (1st) – Preparation for initiating change
Kotter suggests that successful change efforts should begin with an evaluation of the organisation’s ‘competitive situation, market position, technological trends and financial performance’ (Kotter, 1996), arguably a SWOT analysis. Change at a group level was considered suitable for the organisation in this case given the need to involve all the members of the POA team. A project management approach was selected for implementing the EPA project. Several authors concede that project management is a powerful and flexible management approach for applying organisational change (Hebert, 2002; Pinto & Rouhiainen, 2001; Laszlo, 1999)

3.2 Critical review of approaches to change

3.2.1 Background
Change within organisations is constant (Burnes, 2004a). In the same way that people have to adapt to their social environment, by altering appearances, beliefs and behaviours (culture); so also do organisations (Kanter et al. 1992). Organisational change may be achieved through change in strategy, structure, systems, processes and culture (Balogun, 2001; Quattrone & Hopper, 2001; Buchanan & Badham 1999). Change is seen as being loaded with difficulties (Macfarlane et al., 2002; Salauroo & Burnes, 1998; Parkin 1997), doomed to fail (Balogun 2001; Ferlie & Shortell, 2001) or headed for ‘initiative decay’ in which case even the gains that had been achieved are lost as newer initiatives come up (Buchanan et al., 2005). About 70% of change management programmes will fail (Balogun & Hope Hailey, 2004).

3.2.2 Approaches to change

In 2001, Iles and Sutherland after carrying out an extensive review of change literature, concluded that there was a dearth of empirical research in the area and in its place, a significant influence from so called gurus in the field; and a predominance of ‘descriptions of models and approaches, prescriptive advice and anecdotal accounts of organisational change’. Based on their findings, they summarised approaches to change as planned or emergent; continuous or episodic; and developmental, transitional or transformational.
3.2.2.1 Planned and Emergent change

Bamford and Forrester (2003) assert that the concept of planned change was introduced by Lewin in the 1940’s and has remained viable in change literature since. Planned change represents a deliberate attempt to alter a situation either by introducing new skills or technology or modifying behaviour and attitudes in order to improve existing systems; typically through a change agent (Iles & Sutherland, 2001; Bennis & Nanus, 1985; Brooten et al 1978). Emergent change in contrast focuses on exploring the possible complexities of a given system and consequently sourcing out various ways of managing these (Bamford & Forrester 2003).

More than 30 models of planned change can be identified on reviewing change literature (Bullock & Batten, 1985), including Lewin’s three stage model (Todnem, 2005). Advocates of the planned approach claim that it is very effective (Burnes, 2004b; Bamford & Forrester, 2003) but critics suggest that the basic assumption made in planned change that organisations are in a stable state prior to the initiation of the change is flawed in the face of an ever changing environment (Burnes, 2004b, 1996; Wilson, 1992). Burnes (1996) criticised the prescriptive approach of planned change and Bamford and Forrester (2003) echoed this sentiment. Other criticisms focus on the pre-determined nature of planned change and state that not only should organisational change be an open-ended and continuous process (Burnes, 2004b, 1996), but by setting timetables, objectives and methods beforehand, the onus of implementation falls on senior managers who may not fully grasp the process (Wilson, 1992). In addition, Burnes (2004b, 1996) and Kanter et al., (1992) criticize the inherent inflexibility of planned change in the event of a crisis within the organisation.

Conversely, emergent change reflects the unpredictable nature of change and the notion that change processes should follow a continuous and adaptable approach to evolving circumstances (Burnes, 2004b, 1996; Dawson, 1994). It emphasises change readiness and facilitation of change as opposed to specific pre-planned change initiatives (Todnem, 2005). Emergent change is often seen as being bottom
up (Burnes, 2004b, 1996; Bamford & Forrester, 2003), and it is recognised that senior managers would not be able to anticipate and plan for all organisational change in a rapidly changing environment (Kanter et al., 1992). It encourages organisations to employ open learning systems where strategy development and change emerge as the organisation utilises information gained from its environment (Dunphy & Stace, 1993).

Advocates of the emergent approach to change, state that it is more relatable than the planned approach because of the variability in external and internal environments (Bamford & Forrester, 2003). Burnes (1996) claims that ‘the emergent model is suitable for all organizations, all situations and at all times’, whereas Dunphy and Stace (1993) disagree. Furthermore, critics maintain that there is a lack of coherence and diversity of techniques (Bamford & Forrester, 2003; Wilson, 1992). Bamford and Forrester (2003) as well as Dawson (1994) have gone as far as to claim that emergent change models have no central framework and only appear to be unified in their rebuff of the planned approach.

3.2.2 Episodic and Continuous (Incremental) change

Change can be delineated as episodic or continuous (Weick & Quinn, 1999). Episodic (discontinuous) change refers to change processes which result in rapid, time limited alterations of the status quo (Luecke, 2003); involving shifts in the strategy, culture or structure of an organisation (Grundy, 1993); triggered by internal or external factors (Senior, 2002). In contrast, continuous change refers to evolving change processes (Burnes, 2004b). Burnes (2004b) differentiates continuous from incremental change which he defines as change processes which occur continuously but in problem/objective determined shifts. Luecke (2003) however argues that for simplicity, both continuous and incremental change should be considered the same and he suggests that continuous change which allowed for ongoing detection and reaction to factors (internal and external) which could affect the organisation, was better. Furthermore, Orgland (1997) was of the view that people were more likely to be proactive if they saw change as a continuous process; and he proposed that this would lead to greater success and lasting outcomes.
Critiques of the episodic (discontinuous) change suggest that it leads to defensive behaviour and contentment at new status quo and ends up creating situations which would subsequently necessitate major change incentives (Luecke, 2003). In other words, the effects of episodic (discontinuous) change don’t last (Holloway, 2002; Taylor & Hirst, 2001; Bond, 1999; Love et al., 1998; Grundy, 1993). Advocates of the episodic (discontinuous) change in contrast, argue that it creates less stress than a continuous change process and curtails cost inherent in continuous change initiatives (Guimaraes & Armstrong, 1998).

3.2.2.3 Developmental, Transitional and Transformational change
In terms of extent and scope, change can be defined as developmental, transitional or transformational (Ackerman, 1997). Developmental change centres on the improvement of skills or processes which would improve or correct existing aspects of an organisation with change occurring in small incremental steps (Anderson & Anderson, 2001). Transitional change on the other hand, shifts one or more aspects of an organisation from an existing state to an identified desired state which is different from the existing one. It is seen as the foundation of many models of change and has its basis on the work of Lewin (Iles and Sutherland, 2001). Here, change occurs in a series of transition steps (Anderson & Anderson, 2001). Finally, transformational change involves a significant (radical) shift in an organisation’s structure, processes, culture and strategy. This change occurs when there is discontinuity from an old state and a fundamental paradigm shift (Anderson & Anderson, 2001). There is continuous learning and improvement as part of this process and according to Anderson and Anderson (2001), the change has to involve the organisation and its vision for itself; the people who are part of that organisation and the services which the organisation delivers; as well as the processes which are involved in the delivery of the services.

3.3 Rationale for the change model selected
Cheung (2010) reviewed change models published between 1989 and 2009 and identified twenty five models (Appendix 4). He subsequently labelled models ‘widely cited’, based on his study criteria and in this way, selected ‘six widely cited
change models’ (Appendix 5). While his review provides an informative summary of change models, it did not provide an exhaustive reflection of change models within the stated time frame. It did not include the Health Service Executive (HSE) model which is relevant especially in the Irish context. In addition by limiting models to time of publication, he omitted influential change models including Lewin’s model (published 1951) which is widely recognised and referenced in the field. For the purposes of this discussion, three change models have been selected as follows:

- a. Lewin’s model
- b. HSE model
- c. Kotter’s eight steps

### 3.3.1 Lewin’s change model (Lewin, 1951)

Lewin’s model of change follows three progressive steps: unfreezing, moving to a new level and freezing. The first step involves altering the equilibrium of the status quo by increasing the driving forces that direct behaviour away from the existing status quo, decreasing the restraining forces that negatively affect the movement from the existing equilibrium and maintaining a balance between the two. The second step involves executing the planned changes and the third step involves stabilizing the new equilibrium which resulted from the change by balancing both the driving and restraining forces. In other words, at the third step, newly acquired equilibrium is entrenched in value systems and culture.

Critics of Lewin’s model assert that there is an assumption made that the stakeholders in the process will share a unified vision, but this is not necessarily so in reality (Bamford & Forrester, 2003). Burnes (2004b, 1996) criticizes the apparent lack of focus on acquiring buy in from stakeholders given the reality of conflict and organisational politics. Lewin’s model is also criticised on the basis that its third stage – ‘refreezing’ implies that there will be a reversion to a state of equilibrium. Cummings and Worley (2009) argue that in reality equilibrium is never achieved, as change never ends.
3.3.2 HSE change model (HSE, 2008)
The HSE change model has four broad stages which cover seven steps. In the first (Initiation) stage, preparations are made to lead the change by defining the change and mobilising support across the organisation. In the second (Planning) stage, focus is on building commitment for the change across the system and engaging in activities that increase readiness and capacity to embrace the requirements of the change. Details of the change are also outlined and an implementation plan developed in the second stage. In the third (Implementation) stage, agreed changes are implemented and in the fourth (Mainstreaming) stage, attention is given to integrating the new behaviours, skills and work practices in the organisations culture as well as establishing ways to evaluate and learn from the change process. Todnam (2005) criticises this and other models which propose pre-planned steps as being unreflective of the reality of the conditions under which organisations operate.

3.3.3 Kotter’s change model (Kotter, 1996)
Kotter’s change model (Appendix 6) follows eight steps. In the first step he stresses the need to ‘establish a sense of urgency’ so that people can identify with the need to change. In the second step he recommends assembling a group of people with power and influence in the organization to lead the change, a ‘guiding coalition’. In the third step he focuses on the importance of developing a vision and strategy. In the fourth step he emphasizes communication and in the fifth step, he recommends supporting people in the change effort in order to increase ownership of the change. In his sixth step Kotter proposes that ‘short-term wins’ should be shared to show people that the change is working and in the seventh step he recommends consolidating these gains in order to produce more change. In the final step, Kotter advises that the ways of embedding the successful change in culture should be explored to ensure long-term success and avoid reversion to the old and comfortable ways of doing things.
Several authors have criticized the sequential alignment of Kotter’s steps and the recommendation that these should be followed in strict order (Sidorko, 2008; Burnes, 1996). Moreover, other critics have expressed the view that organisations have a preference for change processes which evolve from its own culture and are not based on externally prescribed steps (Burnes & James, 1995; Schein, 1985). Appelbaum et al. (2012) also highlighted the absence of specific and detailed guidance on the issue of managing resistance, if this was to arise in spite of all eight steps having been executed. Resistance they argued was a significant aspect of change management.

3.3.4 Organisational impact

A second SWOT analysis was carried out with the focus on the change to be initiated. A team ethos and readiness to change attitude were identified as strengths within the POA team in order ‘to achieve optimum mental health and personal well being for patients and their families’. This meant that the change would be hinged on established values. In addition, frustration was often expressed by members of the POA team when dealing with referred patients who have lost capacity as a result of a progressive condition, without having organised their affairs despite having been in contact with HCPs for years. The fact that training was required to implement discussions was a possible weakness. The absence of structured advice on EPA was also a possible weakness. Opportunities lay in channelling the teams’ enthusiasm through implementing EPA discussions as this could result in a greater sense of fulfilment. In addition, the planned information sessions would likely result in an increase in the expertise and confidence within the team. Several threats were identified including the impact of the culture within the multidisciplinary team which meant that EPA discussions were seen as the role of the SW; ethical debates, given the vulnerability of the targeted population; financial constraints inherent in producing a health information booklet; geographical distribution of patients in the POA service which would make it difficult for the principle change agent to coordinate change; and time constraints in a busy service that may impede training sessions and the widespread implementation of discussions.
3.4 Change model
The change project entitled ‘Enduring Power of Attorney (EPA) – implementing and sustaining discussions’, was aimed at increasing the awareness and understanding of EPA among staff of the POA team, patients and carers through implementing guidelines on EPA discussion. The project was undertaken based on Kotter’s change model as derived from his publications in 1996 and 1995 (Kotter, 1996, 1995). Both of these publications have been criticised as having been based solely on Kotter’s personal experience in business and research; and lacking independent empirical rigour; nevertheless, Kotter’s work especially his eight step change model remain key references in change management literature (Appelbaum et al., 2012). A discussion of the change project undertaken follows below using each of Kotter’s eight steps as sub topics.

3.4.1 Establish a sense of urgency (step 1)
According to Kotter, change agents need to introduce change information ‘boldly and dramatically’ in order to establish a strong sense of urgency. He highlights the need for the change to be understood, and stressed the importance of this first step in order to garner the cooperation of stakeholders. Consistent with Kotter’s first step, Kobi (1996 as cited by Appelbaum et al., 2012), stated that important aspects of change initiation included presenting the change as attractive and achievable, giving stakeholders clear goals. Kotter declared that if this first step was not approached properly it would prove difficult for the change agent to initiate (or sustain) the change.

An understanding of the culture existent within the POA team was crucial in planning for this first step, and key insights were formed because of the position of the change agent as an ‘insider’ within the team. According to Drennan (1992), culture is reflected by the things that typify the organisation, ‘the habits, the prevailing attitudes and the grownup pattern of accepted and expected behaviour’. From a new comer’s perspective, several cultural trends are evident within the team, from a smart casual dress code to a ‘team spirit’ orientation. The predominant culture however is that of pride in one’s work and a drive to be an expert in one’s
field. Most of the staff employed in the team had identified mental health in older people as a special interest at the time of their employment; and permanent staff within the team, often use the term ‘cherry picked’ to refer to their membership in the team. This culture augmented the service ethos and increased the chance that any change which was hinged on best practice would be received well. In addition, the POA team had its headquarters located within a Day Hospital cited apart from the Psychiatric inpatient unit and the General Hospital. It therefore enjoyed a high degree of autonomy from other mental health teams (MHTs) and other medical disciplines in the region. Most team members were permanent staff except for three non consultant hospital doctors (NCHDs) whose appointment in the team was based on six month to year long contracts. This autonomy and stability likely fostered the organisational culture. It also created an environment where best practice guidelines could be implemented without the need for crossing several bureaucratic channels that would have been in play at the wider hospital level.

Another notable aspect of the culture is the importance of Mondays within the team. Due to the provision of care being focused in the community, team members are often unavailable in the team headquarters. All the team members however meet for the team meeting on Monday morning and can be accessed at the same time.

For the EPA project, a ninety minute information session was planned for Monday morning. A formal lecture on EPA was given which lasted about sixty minutes. Subsequently, the guidelines developed for implementing discussions based on best practice were introduced. This was followed by a compelling case summary presentation of a patient who had recently come to the attention of most members of the team and seemed to embody all the reasons why an EPA should be created. A summary of pre audit findings was presented and an outline of the aims and objectives of the change project and an estimated time schedule for implementation was put forward. Finally, a summary of the planning that had gone into the project including a completed audit, and applications in place to secure ethical approval and external funding for aspects of the project (grant) were reported. A five minute question and answer session was included. The presentation was in power point format with visual stimuli added to maintain interest and create memorable visual reminders. The included case summary put the proposed change in clinical context
by adding a human and relatable angle especially in a team with a culture of each member striving for excellence in their clinical practice. The overall aim of the presentation was to create urgency in relation to the need for change, foster engagement in the project and demonstrate sufficient knowledge base and commitment on the part of the change agent.

Kotter suggested that an external change agent may be useful in change management, and the benefit of external change agents was underscored by Gist et al., in 1989 and Armenakis et al., in 1993. The change agent in this case was not external to the team, but had been in the team for less than six months of a contracted year, and so was viewed as an internal agent who retained an external orientation. In order to build urgency, the frequency with which the change is communicated was cited as important (Kotter, 1995; Ginsberg & Venkatraman 1995) and Jansen (2004) was of the opinion that communication should happen often and updates about the change process given in order to prevent stakeholders’ interest from waning. ‘Booster’ information sessions were scheduled for ten minutes at the end of subsequent team meeting and this was projected as an opportunity for the team to consolidate knowledge base, discuss cases in relation to the guidelines, or else raise questions for clarification and/or indicate any other avenues for support. Introducing this continuation at the start accentuated the change agent’s commitment. The potential for resistance was considered at this stage given that change has been shown to cause stress and generate unplanned problems and resistance (Stewart & O’Donnell, 2007). Some resistance occurred at this stage, but was not managed until further on in the change process.

3.4.2 Create a guiding coalition (step 2)

To achieve success in an organisation’s change process, Kotter stated that there was a need to create an alliance with crucial people to lead this change as opposed to having a single change agent. He called this alliance a ‘guiding coalition’ and suggested that the inclusion of key stakeholders who had some positional power in the organisation, held leadership roles within the organisation, were knowledgeable in the change being proposed and were respected by other stakeholders. The
importance of a guiding coalition was demonstrated by Cunningham and Kempling (2009) during their case review of three change processes.

Positional power and expertise have been found to have a positive impact on the success of a change initiative (Lines, 2007) and people’s opinions toward change is known to be influenced significantly by opinion leaders (Burkhardt, 1994). Power was defined as ‘the potential to influence’ by French and Raven (1959) and as ‘the capacity of individuals to overcome resistance on the parts of others, to exert their will and to produce results consistent with their interests and objectives’ (Huczynski & Buchanan, 2007). According to Pfeffer (1992), power is important when major decisions have to be made, when performance is difficult to assess and in situations where there is indecision and/or differences exist. Kotter differentiated between managers and leaders of change highlighting the importance of leadership without which in his opinion, a change initiative would not succeed. Concurring, Self et al. (2007) surmised that change was more likely to succeed if championed by a leader within the organisation as there was a greater chance of buy in from the other stakeholders. In contrast, Penrod and Harbor (1998) argue that a guiding coalition will not have any major influence on the change initiative if major stakeholders do not alter their actions.

Power within an organisation can be considered using frameworks such as the stakeholder analysis and the degree of influence and interest of stakeholders can be plotted on a Power/Interest grid (Balogun, 2001) Stakeholder identification is usually the first step in stakeholder analysis (Blair et al., 1990; Hatten & Hatten, 1987). Huczynski and Buchanan (2007) define a stakeholder as anyone who is likely to be affected by change in organisation, whether directly or indirectly. Clarkson (1995) grouped shareholders into primary (essential to the survival of the organisation); and secondary (not essential for survival but interact with the organisation). On the other hand Blair and Fottler (1990) grouped stakeholders into internal (operate within the bounds of the organisation); interface (interact with the external environment); and external (contribute to, compete with or have a special interest in the function of the organisation). In preparation for the EPA project, a
A stakeholder analysis was carried out. Stakeholders were identified (Table 2) and a Power/Interest grid was applied (Figure 2).

<table>
<thead>
<tr>
<th>Stakeholders (EPA project)</th>
<th>Internal</th>
<th>External</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary</td>
<td>Grid code</td>
<td>Secondary</td>
</tr>
<tr>
<td>CMHT (clinical)</td>
<td>A</td>
<td>CMHT non-clinical</td>
</tr>
<tr>
<td>. Consultant (1)</td>
<td>B</td>
<td>. Administrative</td>
</tr>
<tr>
<td>. SR (1)</td>
<td>C</td>
<td>. Care support</td>
</tr>
<tr>
<td>. Registrar (1)</td>
<td>D</td>
<td>Medical students</td>
</tr>
<tr>
<td>. GP trainee (1)</td>
<td>E-I</td>
<td>Nursing students</td>
</tr>
<tr>
<td>. CMHN (5)</td>
<td>J</td>
<td>OT students</td>
</tr>
<tr>
<td>. Staff nurse (1)</td>
<td>K</td>
<td></td>
</tr>
<tr>
<td>. Snr OT (1)</td>
<td>L</td>
<td></td>
</tr>
<tr>
<td>. OT (1)</td>
<td>M</td>
<td></td>
</tr>
<tr>
<td>. SW (1)</td>
<td>N</td>
<td></td>
</tr>
<tr>
<td>. Pharmacist (1)</td>
<td>E</td>
<td></td>
</tr>
<tr>
<td>CMHT (non-clinical)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>. Team co-ordinator</td>
<td></td>
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</tr>
</tbody>
</table>

Table 2: Stakeholders – including codes for identifying each

The relative positions of power or interest were assigned by the change agent based on insight acquired through observation and interpersonal interactions.

Figure 2: Power/Interest grid for EPA project (adapted from Bryson, 1995) - including grid codes from Table 2
French and Raven (1959) delineated six power bases including reward, coercion, legitimacy, expertise, reference, and information, and claimed that a change agent could potentially use each power base to target behaviour and attitudes in stakeholders. Outcome behaviour was dependent on the power base employed.

**Figure 3**: Power bases and influence on behaviour (adapted from French & Raven, 1959)

Buchanan and Badham (1999) reviewed the subject of power and politics within organisations and reported on power tactics. They were of the opinion that understanding one’s power base would help inform the most suitable power tactic to utilize. They defined power tactics as ways in which individuals translate power bases into specific actions. Prager’s (1993 as cited by Cunningham, 2001) exhaustive list of twenty-two power tactics is available in Appendix 7. Buchanan and Badham (1999) stressed the importance of political skill in a change agent arguing that a change agent who was a ‘political entrepreneur’ and understood the political dimensions of change would likely succeed.
The EPA change agent made a conscious effort to understand the politics in operation within the POA team and mainly employed the tactics of ‘forming coalitions’ and ‘displaying charisma’. Inter personal relationships were developed with strategic team members including the TC and one of the Community Mental Health Nurses (CMHNs), both of whom were then in a position to influence other members. The two most influential members of the team were identified as the CP and the TC. The CP was seen as the overall lead in the team and was directly responsible for supervising all the doctors in the team. The TC was a Nursing manager and CMHN, directly supervised all the nurses in the team in addition to co-ordinating team management and overseeing the implementation of best practice and clinical governance. Both the CP and TC had positional and personal power, were well liked and in established leadership roles within the team. They were courted and the vision of the EPA project was discussed with them on a one to one basis. The CP had published an article on EPA a few years prior and was interested. The TC welcomed the introduction of best practice and was happy to support the change. The positional power of the change agent within the organisation contributed to the ease of access to these two influential team members and likely added a dimension of mutual benefit to these interactions. These two influential team members were incorporated into the guiding coalition.

3.4.3 Develop a vision and strategy (step 3)

A clear vision and strategy should be decided by the guiding coalition according to Kotter in order to ensure guidance in the change initiative. The visualisation of change is a key aspect of the change process (Whelan-Berry & Somerville, 2010; Kotter, 1996) and plays a significant role in displacing the existent state of affairs targeted by change (Flamholtz & Kurland, 2006). When the vision is exciting and portrays a goal that stakeholders want to partake in, they are more likely to commit to change (Herold et al., 2008).

The guiding coalition was involved in planning the change strategy. Several meetings were held between the change agent and the guiding coalition after the
POA service audit. Based on the insight of the guiding coalition, because of their supervisory role, a plan was set to present an introductory information session and thereafter follow through with booster sessions. The key aim of the first information session was to provide a formal lecture on EPA, thereby setting the stage for the change. Booster sessions were opportunities to keep the change in focus and clarify issues which may have arisen as well as consolidate on learning in relation to EPA. The vision for the EPA project was clearly presented at the first information session and strengthened with each subsequent information sessions. In addition, the information booklet when added to the community kits of the CMHNs would serve to bolster knowledge base and keep the vision and strategy to the fore. Kotter reasons that irrespective of how the first two steps of his change model had been received, when a vision for change was presented clearly, stakeholders were more likely to identify with it. Understanding a vision is as important for the guiding coalition and other leaders within the organisation as it is for all other stakeholders and Washington and Hacker (2005) affirm that when leaders understand a vision they are more likely to be excited about it, promote it and position it for success. Critics of Kotter’s third step however, dispute the emphasis on the vision stressing instead that it is the implementation of that vision that is important (Cole et al., 2006; Paper et al., 2001).

3.4.4 Communicate the change vision (step 4)
In relation to change, communication has been identified as key to limiting ambiguity (Nelissen & van Selm, 2008; Bordia et al., 2004), and promoting stakeholder satisfaction and confidence in the change (Nelissen & van Selm, 2008). The more complete the information one has, the more likely one is to commit to change (Wanberg & Banas, 2000). Frahm and Brown (2007) further highlighted the benefit of communication with stakeholders, and identified team meetings as key to this process. Kotter suggests that communication should be repeated many times to ensure that the message permeates through to intended stakeholders. This link between repetition and retention is supported by several authors (Klein, 1996; Dansereau & Markham, 1987; Daft & Lengel, 1984; Bachrach & Aiken, 1977). In addition, Kotter emphasizes the benefit of interactive communication, a notion that
is supported by authors like Gioia and Sims (1986), D’Aprix (1982) and Jablin (1982).

Communication was a key aspect of the EPA project. As part of the process of developing the guidelines for suitable patients, two reviewers apart from the change agent were involved. The guidelines were not generated from scratch and so there was no effort made in this regard to extensively review literature or to integrate expert opinion and clinical expertise with patients' values and preferences. An already developed guideline in the UK was used as a standard, reflecting evidence based medicine (EBM). Initially, several meetings were held with the CP and draft guidelines were agreed upon. Further meetings were then held with both the TC and CP and the final guidelines were decided. The guidelines were presented to the team at the first information session.

In a similar manner, when developing the information booklet, several meetings were held with the CP who was directly involved in reviewing the information sourced from literature search to ascertain what key aspects would be included, and how best to represent this. The team was subsequently presented with the draft booklet. This was done one week after the first information session. Suggestions for improvement were made and applicability to patient population was reviewed. At the same time the draft was forwarded to the ‘expert panel’ which consisted of a Consultant Geriatrician, a Solicitor and a Manager in the Health promotion department of a voluntary organisation which had an advocacy role. The Consultant Geriatrician responded to an email requesting review and forwarded her comments via email. The Solicitor was approached in person and given a draft booklet to review. She responded via email with her recommendations. Access to the Health promotions Manager was sought by liaising with a local manager of the voluntary organisation. Emails were also the route for sending across the draft booklet for review and for receiving response.
The importance of two-way communication between all stakeholders was emphasized, especially communication between the HCPs and the patients or carers. Bearing in mind that the onset of concrete thinking may occur even in the early stages of dementia, HCPs were advised to use short, simple and clear statements and questions when communicating with patients. Based on experience, most of the staff were familiar with this type of communication. Feedback from patients and carers on any aspect of the EPA discussions were also welcomed. Sometimes this feedback was given to a team member other than the one who discussed the EPA initially. The information booklet developed was also a means of communication and attention was paid to its development to ensure ease of readability and content clarity.

The EPA project employed more than one mean of expression, oral discussion and written information, to ‘relay’ change. Kotter recognised the gain from the use of more than one mode of expression to relay change. Roberto and Levesque (2005) in their study identified the use of metaphor as one such alternative mode of expression which was effective. Klein’s (1996) assertion that clear top down communication was important not only because information received by stakeholders in this manner was seen as official, but also because it contributed to stakeholders’ confidence in their leaders’ knowledge; was incorporated in the EPA project through the involvement of the guiding coalition both of whom were knowledgeable and had well established communication links within the team.

3.4.5 Empower broad-based action (step 5)

Although Kotter stressed the importance of communication, he also emphasized the fact that communication alone did not suffice in successfully carrying out a change process, in his fifth step. He articulated the need to empower stakeholders by improving the structures, skills, systems and supervisors of an organisation. Klidas et al. (2007) identified that organizational structure, supervisor attitudes, and training were contributory to empowering stakeholders. According to Kotter, training was crucial in equipping stakeholders for change, giving them a sense of control (Kappelman et al., 1993). This idea was echoed by Ellinger et al., (2010)
and Kappelman & Richards (1996), who identified communication, training, and coaching as means for empowering stakeholders. The effect of training was confidence in stakeholders, which enhanced their sense of ownership and accountability in the change process and translated to a bottom up approach to change (Denton, 1994). The study by Wanberg and Banas (2000) also demonstrated that stakeholders who participate in planning change efforts are more positive and knowledgeable about the change, feel a sense of ownership and are likely to stick with the change.

The knowledge base in an already vastly experienced team was reinforced and enhanced through the information sessions. The first and subsequent sessions were interactive and the aim was to shore up confidence and expand knowledge bases. A very simple structural change which entailed introducing an additional column on the Patient list for team meetings meant that review of EPA discussions became a weekly phenomenon and the change strategy was better placed to be absorbed as routine. Each team member therefore was involved with some level of ownership in relation to their patients and the implied need for accountability ensured a broad based involvement from the team.

Success in this step of Kotter’s change model may well depend on the willingness of the stakeholders to carry out the change. Eccles in 1994 listed thirteen sources of resistance to change including ignorance, comparison, disbelief, loss, inadequacy, anxiety, demolition, power cut, contamination, inhibition, mistrust, alienation and frustration. Bedeian (1980) suggested that there were four reasons why resistance to change occurred including the existence of parochial self interest, lack of trust and misunderstanding, contradictory assessment and low tolerance. In planning the EPA project, resistance in relation to work overload had been anticipated. This however did not prove to be the case possibly because most of the team embraced the vision and need for change. Resistance emerged from a different source however - a POA team member who had concerns regarding crossing of roles and blurring of role boundaries. The resistance appeared to have been based on a contradictory assessment and this type of resistance had not been anticipated.
Clarke (1994) argues that the key to dealing successfully with negative reactions to change and resistances to it, is to expect resistance and to look at the reasons for it. By anticipating resistance and locating its source, there is a better chance of supporting people through it by being sensitive to their interests and concerns.

Several attempts were made by the change agent to manage the resistance with the support of the guiding coalition and in line with the recommendations of Kotter and Schlesinger (2008) (Appendix 9). Attempts were made to facilitate and support the team member who was resisting the change through role validation, but none were successful. Negotiations and attempts to find common ground for agreement were also unsuccessful. Based on the classification of stakeholder typology by D’Herbemont and Cesar (1998) (Appendix 10), this team member was identified as a possible ‘Waverer’. A pre-existent political structure within the POA team lessened the impact of this resistance.

Another source of resistance came from an external stakeholder who was in middle management. When approached in relation to the use of a HSE solicitor and engagement with the HSE Health Promotions department, this was perceived as a financial threat and the suggestion was dismissed. Given the politics within the wider hospital system, these avenues were not pursued and instead a private solicitor was contacted through her involvement with the POA team at a different level, and alternative links were developed with a voluntary organisation’s Health promotion department.

Lewin (1951) proposed that the outcome of change is dependent on the balance of the effects of two opposing forces – the driving (competing) forces and the restraining (impeding) forces. His Force Field Analysis (FFA) enables managers or change agents to identify forces in action for a given change initiative and with this information introduce strategies to ensure that the balance of forces are in favour of the change. Achieving a favourable balance can be through:

a. Introducing a competing force specifically to counter and identified impeding force
b. Bolstering competing forces

c. Generally increasing competing forces

d. Generally reducing impeding forces

A Force Field Analysis (FFA) was applied to the EPA project midway through the change (Figure 4) and is represented below. The balance of the effects of the forces was forward propulsion of the change.

Figure 4: Force Field Analysis – EPA project
3.4.6 Generate short-term wins (step 6)
Kotter identified that there was benefit in feeding back progress on the change process to stakeholders. Early victories and short term wins propel people to the finish line and longer term goals (Pietersen, 2002) and instil confidence in the progression of the change process (Reichers et al. 1997). If during a change effort, an organisation publicises small wins, change acceptance will be more likely (Reay et al., 2006). Early wins in the EPA project including the award of ethical approval and monetary grant, were communicated to the team through the forum of the booster sessions. Successful EPA discussions and positive feedback from patients and carers, who had received the booklet and with whom EPA had been discussed, were also fed back to the team. These served to assure the team that the change was progressing well and had been embraced by team members. It also served to reinforce positively the input from the team members. This tied in with Kotter’s view that celebrating short term wins allowed for positive reinforcements and rewards to be accorded deserving stakeholders.

Short-term wins according to Kotter underscored the fact that the change effort was succeeding, allowed stakeholders celebrate the success and served in addition as a measure against which long term goals could be evaluated and alterations made if necessary. Similarly, Ford et al. (2008) argued that the evidence of success was key to change implementation while Drtina et al. (1996), linked short term wins positively with resolution of resistance. Unsurprisingly, Hamel (2000) concluded that in the same way early wins lent credibility to a change process, early failures acted as setbacks.

3.4.7 Consolidate gains and produce more change (step 7)
Kotter’s seventh step centred on the importance of consolidating on short term wins in order to produce more gain by enabling the resolution of issues which may have arisen in the course of change implementation. Pfeifer et al. (2005) agreed with this, stating that short term wins helped validate the reliability of the change processes and justified stakeholder input to that point. Kotter also felt that early wins could help to defuse self centred and cynical stakeholders. Jansen’s (2004) reference to
the positive link between acquiring sufficient evidence in support of change, arguably short term wins; and change momentum bolsters all the arguments above.

In relation to the EPA project, an incident occurred which involved a ‘catastrophic’ reaction from a depressed patient who felt the EPA discussion had been introduced because the team believed she did not stand a chance of improvement and was on her way to ‘losing her marbles’. Support was given to this patient and when this was discussed during a booster session, support was also given to the team member who had implemented the discussion. The exclusion and inclusion criteria for initiating discussions were revisited and team ownership was emphasized. Subsequently when this patient fed back that she had discussed the EPA with her daughter and had ended up feeling empowered by the process, this was immediately discussed at the next booster session and celebrated as a win.

3.4.8 Anchor new approaches in the corporate culture (step 8)
Kotter addressed the concept of expiration of achieved change outcomes if these were not entrenched in culture. He felt that clearly mapping out how the change had achieved success and making certain that present and subsequent stakeholders continue along the changed pathway were important in preventing this expiration from happening. Senge et al. (1999) alluded to the same thing when they proposed that maintaining significant change was dependent on transformation in thinking. In addition, Massey and Williams (2006) argued that a system of support which offered a structure for mentoring, training, and shadowing opportunities for change agents was required in order for change to be sustained.

At the initiation of the EPA project, a change was made to the structure of the Patient list used at every team meeting. This involved adding an extra column representing a provision for the entry of MMSE scores and an update on EPA discussions for every patient on the list. In the early stages of the change process, the emphasis was on implementing EPA discussions with all the appropriate patients on the team’s caseload. Subsequently, when this target appeared to have
been achieved judging by the evidence on the Patient list, the emphasis shifted to new patients. Consistently, patients who were acutely unwell were excluded as per the guidelines. With the high flux of referrals however, there was a threat that the process could fall through the cracks. The added column on the Patient list however meant that MMSE scores and EPA discussions had to be considered routinely at every team meeting. This set up the change to be embedded in culture. Moreover, the guiding coalition who bought into and were invested in supporting the change were permanent staff and so in the event that the change agent was no longer employed within the team, there was a likelihood that the change would be continued. The introduction of the EPA information booklet on the shelves in the team headquarters and in the community kits of the CMHNs would also serve as a reminder of the change and propel discussions through routine practice, into organisational culture.

3.5 Strengths and limitations of the project

3.5.1 Strengths
Strengths of the EPA project include the following:

a. The need for change was clearly established through comprehensive pre audit of existing practices.

b. The use of human, financial and physical resources was planned to get the best results possible within a specific time-period.

c. The SMART objectives provided clarity in terms of what the project was aimed at, eliminating ambiguity and were matched with appropriate evaluation methods.

d. The planned approach which was hinged on Kotter’s change model contributed to the precision of aspects of the structure processes and outcomes which would be addressed.

e. The different components of the project were completed within the estimated time frames.
f. A collaborative partnership was established with a voluntary organisation.

g. The project focused on a topical issue and this contributed to the acceptance of the change proposals.

h. The development of an information booklet and guidelines for implementing EPA discussions; hold potential benefit for the wider health service.

3.5.2 Limitations
a. The objectives of the EPA project were time-bound and their long term sustainability or influence on shifting culture was not assessed.

b. A cost benefit evaluation could not be completed as the relative costs of the EPA versus the WOC were variable given that legal fees were dependent on individual circumstances and could not be standardized.

c. Some external stakeholders were not accessed.

3.6 Summary
According to Pettigrew and Whipp (1991) there are no universal rules when it comes to leading and managing change, no one shoe fits all. Change models are selected by change agents based usually on individual judgement of suitability. Culture, resistance and power are all concepts which are part of the fabric of change. While the EPA project challenged the status quo, it was not in variance with the underlying attitudes and values of most POA team members who identified individually with best practice.
Chapter 4: Evaluation

4.1 Introduction

The Plan, Do, Check, Act (PDCA) cycle (Figure 5) is a four step model for carrying out change which was developed by Shewart and popularised by Deming in 1982. At the ‘Plan’ phase, data is collected and analysed. In the ‘Do’ phase, change is implemented and in the ‘Check’ phase, the outcomes of a change project are compared to expected outcomes – evaluation. Finally in the ‘Act’ phase, practices are standardised and lessons are learned (Deming, 1982). Lazenbatt (2002) defined evaluation as ‘a method of measuring the extent to which an intervention achieves its stated objectives’.

Figure 5: PDCA cycle (Deming, 1982)

According to Green and South (2006), evaluations help determine how effective interventions have been and how these interventions can be sustained or developed; add to empirical data on the intervention; contribute to improvements in health programmes; contribute to improvements in policy; and promote transparency. Lazenbatt (2002) suggested that evaluation should be explored using the four Es:
Efficiency – how well aims and objectives are met; Effectiveness – how well stated objectives lined up to expected outcomes; Economy – how many outcomes were achieved; and Equity – how fair the distribution of opportunities were between people. The main focus of evaluation of the EPA project was efficiency.

4.1.1 Types of Evaluation

Process Evaluation: Examines the procedures and tasks involved during the implementation of a programme or initiative.

Outcome Evaluation: Reviews the short term effects of the programme/initiative e.g. attainment of immediate goals of the organisation

Impact Evaluation: Appraises the long term effect of the programme/initiative e.g. attitude or knowledge

Cost-Benefit Evaluation (Economic evaluation): Drummond et al. (1987) defined economic evaluations as ‘the comparative analysis of alternative courses of action in terms of both their costs and their benefits’. There are five types of economic evaluations:

a. Cost-minimization analysis (CMA)
b. Cost-effectiveness analysis (CEA)
c. Cost-utility analysis (CUA)
d. Cost-benefit analysis (CBA)

4.2 Evaluation methods and tools

Evaluation methods for the EPA project were based on the project objectives. Objective one was to develop a patient focused health information booklet on EPA which is concise and easy to read and understand in the last quarter of 2012. Evaluation was in the form of expert review from a Consultant Geriatrician, a Solicitor and a Manager in the Health promotion department of a voluntary organisation. Feedback requested from these three experts was unstructured and open ended (Appendix 12 - 14) so as not to limit input. A fourth expert, the Consultant POA, also contributed but feedback was requested using a structured
and standardised tool (Appendix 15). This structured approach was selected to increase objectivity given the level of involvement of this fourth expert in developing the booklet. Feedback from patients and carers were based on standardised open ended questions (Appendix 19). Administering these questions through a focus group was recommended by the developers of the tool. A small focus group involving three patients was conducted and this meeting was recorded using audio tapes. Following this, one to one interviews were conducted which were similarly audio taped. Feedback was obtained from a total of ten patients and carers.

The second objective was to develop written guidelines for HCPs initiating EPA discussions with patients in the last quarter of 2012. An evaluation of these guidelines was factored into the process of creating them. The guidelines were created based on a standard, and reviewed by the POA’s CP and TC. The third objective was to enhance awareness and knowledge of EPA among staff in the last quarter of 2012 and the first quarter of 2013. An evaluation of the impact of the information/training sessions was performed using the Kirkpatrick model. Finally, the fourth objective was to implement EPA discussions with patients and carers based on developed guidelines, in the first quarter of 2013, to enhance awareness of EPA among patients and carers. The degree of awareness in patients and carers was directly correlated to the extent of implementation of EPA discussions. An audit of the practice of implementing discussions was therefore seen as reflective of the awareness which patients and carers had. Auditing this practice was carried out weekly as each patient seen in the week was reviewed at team meetings. This process was facilitated by the fact that the ‘Patient list’ system (Appendix 20) had been amended to include a column for EPA discussion.

4.3 Evaluation results and discussion of findings

4.3.1 Develop a patient focused health information booklet on EPA
Details of the expert reviews are included in Appendix 12 - 15. Three of these reviews were provided at the draft phase of the booklet. They reflect that the
content of the booklet covered key aspects of the information on EPA. Suggestions were made for improving some of the content and in particular the format. The final expert review was provided following the production of the booklet (Appendix 15). It rates the booklet as having achieved all aspects of three areas targeted: Clear communication, Quality content that meets consumers’ needs and Content that assists informed decision making. A detailed report on the transcription of responses from the patients and carers based on the standard questions is outside the remit of this dissertation but all the patients and carers who gave feedback were positive in relation to the appeal, readability, presentation and content of the booklet. In relation to the perceived usefulness of the booklet a prominent theme was that the information was useful. As part of this however some of those who responded were of the opinion that they would not create an EPA yet.

4.3.2 Develop written guidelines for health care professionals
The guidelines were approved by two identified reviewers.

4.3.3 Enhance awareness and knowledge of EPA among staff
Feedback following the first information session was very positive with 12 of 13 team members saying that they felt their knowledge base had been enhanced. One team member declined to complete the feedback. The change agent and CP did not participate to increase objectivity. Feedback on the weekly guidance was mostly positive with 3 of 7 team members saying that they ‘very confident’ in implementing discussions with patients while 4 of 7 felt ‘confident’. 4 of 7 felt ‘very supported’ in the process of change initiation; 1 of 7 felt ‘supported’ while 2 of 7 felt ‘neutral’. Also, 3 of 7 felt ongoing information sessions were ‘very useful’ while 4 of 7 felt the sessions were ‘useful’. The change agent and CP did not participate and some team members were unavailable including the team member who declined to participate in the first feedback.
4.3.4 Implement discussions on EPA with patients and carers based on developed guidelines

An audit of the practice of implementing discussions indicated 100% compliance (by the second contact with the patient) with new patients and ongoing reviews. The point of second contact was selected as patients’ suitability for implementing discussions was at times decided at the team meeting if individual team members had doubts especially in relation to their mental state at the time of the first contact.

4.4. Summary

Evaluation demonstrated that the change process was a success. Integration of the review of EPA discussions within existent structures meant that auditing the process was simplified. Not all team members felt ‘very confident’ and ‘very supported’ in the implementation process and this reflects an area for improvement.
Chapter 5: Discussion & Conclusions

5.1 Introduction
Quality in health services reflects ‘the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge’ (IOM, 2001). In the ‘Act’ phase of the PDCA cycle, the findings from evaluating a change project are implemented as part of Total Quality Management (TQM) defined as ‘a comprehensive strategy of organisational and attitude change, for enabling staff to learn and use quality methods, in order to reduce costs and meet the requirements of patients and other customers’ (Øvretveit, 2000); or simply, ‘doing the same things better’ (Parsley & Corrigan, 1999). The PDCA Act phase was not completed in the time frame for the EPA project.

5.2 Implications of the change for management

5.2.1 Overview
The summative impact of the EPA project was an improvement in quality. The EPA project impacted the POA team in all three levels of quality outlined by Øvretveit (1992) as follows:

Patient quality: improvement in the totality of service provided; improved efficiency in the area of EPA.

Professional quality: implementing best practice; better understanding of current legislation and implications for care; high performing staff with enhanced knowledge base.

Management quality: incorporating discussions into routine visits and assessments; organization can respond faster to client demands; change was applied without negatively affecting the day to day running of business as discussions fit into part of overall assessments already in place; booklet on EPA available in the POA service; networking with voluntary organisations and auditing process with systems already in place.
5.2.2 Impact on organisation

On reviewing the position of the organisation at this stage of the change several strengths were identified. Firstly, several team members who had completed higher level training were comfortable with the concept of evaluation, whether self directed or targeting patients and were able to use feedback forms and manage other sources of feedback (e.g. the focus group) with confidence. Secondly, most of the team members who were involved in the process as facilitators of the discussions (especially the CMHNs) already had a good rapport with patients on their case load and so the process of implementing discussions was eased. The availability of an active User (patient) group who would readily provide feedback and some of whom participated in the focus group was seen as an opportunity. In addition, the availability of MMSE scores on the Patient list would provide a baseline reference to which subsequent scores can be compared. This would likely contribute to clarity of clinical presentation and so constitutes an opportunity for the team.

A limitation which emerged as the project unfolded was that EPA discussions appeared to have shifted from the SW forte to the CMHN forte given that most patients’ first and second contacts were with the CMHNs. This was opposed to the initial assumption that all the team members would be involved fairly equally. The outcome of this may be that other team members could lose confidence if they were infrequently engaged in implementing discussions. Furthermore, the enactment of new legislation would mean that both the guidelines developed and the information booklet produced would become outdated. If this happened in the course of the next six months the time and staff resources inputted would arguably have been wasted.

5.3 Recommendations for future improvements

a. Explore avenues of accessing cost benefit information.

b. Improve staff support on a one to one basis and in a neutral environment given that evaluation findings highlighted that some team members only felt ‘neutral’ in relation to feeling supported.
c. Disseminate guidance and training on EPA as well as information booklets to other MHTs and medical disciplines

d. Carry out further audits to ensure best practice implementation is ongoing

e. Review of guidelines with the emergence of new standards or new legislation

5.4 Conclusion
Implementing a change project which results in improvement in quality of service provision implies success. There is however a need for ongoing evaluation and further implementation of the findings from that evaluation. The PDCA cycle does not end in Act but rather cycles into the next Plan phase. In this way a change project not only achieves its aims and objectives but in addition creates further opportunities for improvement and further change.
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Appendices

Appendix 1: Mini Mental State Examination (Folstein et al., 1975)

The Mini-Mental State Exam

<table>
<thead>
<tr>
<th>Max.</th>
<th>Score</th>
<th>Orientation</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>()</td>
<td>What is the (year) (season) (date) (day) (month)?</td>
</tr>
<tr>
<td>5</td>
<td>()</td>
<td>Where are we (state) (country) (town) (hospital) (floor)?</td>
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<tr>
<td></td>
<td></td>
<td>Registration</td>
</tr>
<tr>
<td>3</td>
<td>()</td>
<td>Name 3 objects: 1 second to say each. Then ask the patient all 3 after you have said them. Then repeat them until he/she learns all 3. Count trials and record. Trials ________</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Attention and calculation</td>
</tr>
<tr>
<td>5</td>
<td>()</td>
<td>Serial 7’s. Stop after 5 answers. Alternatively spell “world” backward.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Recall</td>
</tr>
<tr>
<td>3</td>
<td>()</td>
<td>Ask for the 3 objects repeated above.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Language</td>
</tr>
<tr>
<td>2</td>
<td>()</td>
<td>Name a pencil and watch.</td>
</tr>
<tr>
<td>1</td>
<td>()</td>
<td>Repeat the following “No ifs, ands, or buts”</td>
</tr>
<tr>
<td>3</td>
<td>()</td>
<td>Follow a 3-stage command: “Take a paper in your hand, fold it in half, and put it on the floor.”</td>
</tr>
<tr>
<td>1</td>
<td>()</td>
<td>Read and obey the following: CLOSE YOUR EYES</td>
</tr>
<tr>
<td>1</td>
<td>()</td>
<td>Write a sentence.</td>
</tr>
<tr>
<td>1</td>
<td>()</td>
<td>Copy the design shown.</td>
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</table>

Give 1 point for each correct answer.
Total score ________
Appendix 2: Change management tools, models and approaches (Iles & Sutherland, 2001)

**HOW CAN WE UNDERSTAND COMPLEXITY, INTERDEPENDENCE AND FRAGMENTATION?**

- Weisbord’s Six-Box Organisational Model
- 7S Model
- PESTELI
- Five Whys
- Content, Context and Process Model
- Soft Systems Methodology
- Process modelling (Process flow; Influence diagram; Theory of Constraints (TOC))

**WHY DO WE NEED TO CHANGE?**

- SWOT analysis

**WHO AND WHAT CAN CHANGE?**

- Force field analysis
- ‘Sources and potency of forces’
- ‘Readiness and capability’
- Commitment, enrolment and compliance
- Organisation-level change
- Total Quality Management (TQM)
- Business Process Reengineering (BPR)
- Group-level change
- Parallel learning structures
- Self-managed teams
- Individual-level change

**HOW CAN WE MAKE CHANGE HAPPEN?**

- Organisational development (OD)
- Organisational learning and the Learning Organisation
- Action research
- Project management

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<th>Creator</th>
<th>Model name</th>
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<td>1990</td>
<td>Beers et al.</td>
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<td>10-step for Organisational Change</td>
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<td>Eight Stage Processes for Successful Organisational Transformation</td>
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<td>Armenakis et al.</td>
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<td>2000</td>
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<td>2000</td>
<td>Gavin</td>
<td>Seven-step Change Acceleration Process</td>
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<td>Anderson &amp; Anderson</td>
<td>Nine-phase Change Process Model</td>
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<td>C. Marlene</td>
<td>Model of Identity Transformation in Organisation</td>
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### Appendix 5: ‘Six most cited change models’ (Cheung, 2010)

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<td>1. Analyse the change</td>
<td>1. Analyse the organisation and its need for change</td>
<td>3. Diagnose &amp; analyse the current situation</td>
<td>1. Mobilise energy and commitment through joint identification of business problems and their solutions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Plan the change</td>
<td>7. Craft an implementation plan</td>
<td>4. Generate recommendations</td>
<td>5. Detail the recommendations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Communicate the change</td>
<td>9. Communicate, involve people and be honest</td>
<td>4. Communicating the change vision</td>
<td>1. Persuasive communication</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Consolidate &amp; institutionalise the new state</td>
<td>10. Reinforce and institutionalise change</td>
<td>8. Anchoring new approaches in the culture</td>
<td>6. Institutionalise success through formal policies, systems, and structures</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Create a vision and a common direction</td>
<td>1. Establishing a sense of urgency</td>
<td>1. Establish the need to change</td>
<td>2. Develop a shared vision of how to organise and manage for competitiveness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Create a sense of urgency</td>
<td>5. Support a strong leader role</td>
<td>2. Creating a guiding coalition</td>
<td>5. Start change at the periphery, then let it spread to other units without pushing it from the top</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Line up political sponsorship</td>
<td>6. Separate from the past</td>
<td>2. Active participation</td>
<td>3. Identify the leadership</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Separate from the past</td>
<td>7. Consolidating gains and producing more change</td>
<td>5. Diffusion practices</td>
<td>6. Pilot testing the recommendations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Pilot testing the recommendations</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Preparing the recommendations for rollout</td>
<td></td>
<td></td>
<td>7. Monitor and adjust strategies in response to problems in the change process</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>6. Management of internal and external information</td>
<td></td>
</tr>
</tbody>
</table>
Appendix 6: Kotter’s change model (Kotter, 1996)

- **Step 1**: Establish a sense of urgency
- **Step 2**: Create a guiding coalition
- **Step 3**: Develop a vision and strategy
- **Step 4**: Communicate the change vision
- **Step 5**: Empower broad based action
- **Step 6**: Generate short term wins
- **Step 7**: Consolidate gains and produce more changes
- **Step 8**: Anchor new approaches in the corporate culture
### Appendix 7: 22 Power Tactics (Cunningham, 2001)

<table>
<thead>
<tr>
<th>Tactic</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Controlling the agenda</td>
<td>Determining beforehand items, courses of action, or decisions</td>
</tr>
<tr>
<td>Using ambiguity</td>
<td>Keeping communications unclear and subject to multiple meanings</td>
</tr>
<tr>
<td>Brinksmanship</td>
<td>Disturbing the equilibrium of the organisation to control choice options</td>
</tr>
<tr>
<td>Displaying charisma</td>
<td>Using the respect others have for our character traits, presence, or method of operation to affect their behaviour in desired ways</td>
</tr>
<tr>
<td>Forming coalitions</td>
<td>Securing allies – both employees and other stakeholders in the group or associated with it</td>
</tr>
<tr>
<td>Co-opting opposition members</td>
<td>Placing a representative of the opposition group on our decision making body to induce the representative to favour, rather than oppose our interests</td>
</tr>
<tr>
<td>Controlling decision criteria</td>
<td>Selecting criteria by which decisions are made so that desired decisions result regardless of who decides</td>
</tr>
<tr>
<td>Developing others</td>
<td>Increasing the capacities of others, thereby increasing overall power</td>
</tr>
<tr>
<td>Using outside experts</td>
<td>Involving congenial experts in collegial decisions, thus allowing us to affect results without personally deciding</td>
</tr>
<tr>
<td>Building a favourable image</td>
<td>Creating an attractive persona of skills, capacities, values, or attitudes to which others differ</td>
</tr>
<tr>
<td>Legitimizing control</td>
<td>Formalizing our right to decide through appeals to hierarchy or appeals to legal precedent</td>
</tr>
<tr>
<td>Incurring obligation</td>
<td>Placing others in debt to us so that they do what we desire</td>
</tr>
<tr>
<td>Organisational placement</td>
<td>Placing allies in strategic positions or isolating potential opponents</td>
</tr>
<tr>
<td>Proactivity</td>
<td>Unilateral action to secure desired results</td>
</tr>
<tr>
<td>Quid pro quo</td>
<td>Negotiating trade offs with others to secure desired results</td>
</tr>
<tr>
<td>Rationalisation</td>
<td>Conscious engineering of reality to secure desired results</td>
</tr>
<tr>
<td>Allocating resources</td>
<td>Distributing resources under our control in ways that will increase our power in relationships with others</td>
</tr>
<tr>
<td>Dispensing rewards</td>
<td>Rewarding or punishing others in order to win their support</td>
</tr>
<tr>
<td>Ritualism</td>
<td>Inducing institutionalised patterns of behaviour in others or in the organisation that foster maintenance of our power role</td>
</tr>
<tr>
<td>Using a surrogate</td>
<td>Using an intermediary to secure compliance in others</td>
</tr>
<tr>
<td>Using symbols</td>
<td>Reinforcing control through symbols, objects, ideas, actions.</td>
</tr>
<tr>
<td>Training and orienting others</td>
<td>Transmitting knowledge, skills, values, or specific behaviours to others to instil our goals, values, philosophy, or desired behaviours in them</td>
</tr>
</tbody>
</table>
Appendix 8: Guidelines on patient suitability

Inclusion criteria

- MMSE > 20

Exclusion criteria

- MMSE < 20
- Acute presentation with mental illness
- Delirium or other acute medical diagnoses
- Recent move to Long Term Care (< 2 weeks)
- Hospital admission
- Recent discharge from hospital
- Recent bereavement (< 3 months)

If any active patients are excluded because they were found to lack capacity due to a reversible cause, they will be re-included in the project if they regain capacity within the period of the change implementation.
Appendix 9: Managing Resistance – approaches (Kotter & Schlesinger, 2008)

<table>
<thead>
<tr>
<th>Approach</th>
<th>Commonly used in situations</th>
<th>Advantages</th>
<th>Drawbacks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Education &amp; communication</td>
<td>Where there is a lack of information or inaccurate information and analysis.</td>
<td>Once persuaded, people will often help with the implementation of the change.</td>
<td>Can be very time consuming if lots of people are involved.</td>
</tr>
<tr>
<td>Participation &amp; involvement</td>
<td>Where the initiators do not have all the information they need to design the change, and where others have considerable power to resist.</td>
<td>People who participate will be committed to implementing change, and any relevant information they have will be integrated into the change plan.</td>
<td>Can be very time consuming if participators design an inappropriate change.</td>
</tr>
<tr>
<td>Facilitation &amp; support</td>
<td>Where people are resisting because of adjustment problems.</td>
<td>No other approach works as well with adjustment problems.</td>
<td>Can be time consuming, expensive, and still fail.</td>
</tr>
<tr>
<td>Negotiation &amp; agreement</td>
<td>Where someone or some group will clearly lose out in a change, and where that group has considerable power to resist.</td>
<td>Sometimes it is a relatively easy way to avoid major resistance.</td>
<td>Can be too expensive in many cases if it alerts others to negotiate for compliance.</td>
</tr>
<tr>
<td>Manipulation &amp; co-optation</td>
<td>Where other tactics will not work or are too expensive.</td>
<td>It can be a relatively quick and inexpensive solution to resistance problems.</td>
<td>Can lead to future problems if people feel manipulated.</td>
</tr>
<tr>
<td>Explicit &amp; implicit coercion</td>
<td>Where speed is essential and the change initiators possess considerable power.</td>
<td>It is speedy and can overcome any kind of resistance.</td>
<td>Can be risky if it leaves people mad at the initiators.</td>
</tr>
</tbody>
</table>
Appendix 10: Stakeholder typology (including management strategies)  
(adapted from D’Herbemont & Cesar, 1998)

<table>
<thead>
<tr>
<th>Stakeholder typology</th>
<th>Dealing with stakeholders</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Zealots</strong></td>
<td>Keep their enthusiasm on board or project will die</td>
</tr>
<tr>
<td>Support project without question</td>
<td>Very committed and refuse to compromise</td>
</tr>
<tr>
<td><strong>Golden triangles</strong></td>
<td>Give them concrete responsibilities and let them drive things</td>
</tr>
<tr>
<td>Most important group.</td>
<td>Level of synergy ensure project progress</td>
</tr>
<tr>
<td>Sufficient antagonism to propose improvements</td>
<td></td>
</tr>
<tr>
<td><strong>Schismatics</strong></td>
<td>Difficult to use as they are up and down so much</td>
</tr>
<tr>
<td>Totally in favour of the project</td>
<td>Simultaneously believe it is not being progressed correctly</td>
</tr>
<tr>
<td>A thorn in sides of opponents</td>
<td></td>
</tr>
<tr>
<td><strong>Waverers</strong></td>
<td>Listen to them and negotiate with them</td>
</tr>
<tr>
<td>Depending on circumstance they will or will not support the project</td>
<td>Find areas on which they agree to manoeuvre</td>
</tr>
<tr>
<td>They know that they are listened to by both sides which increases their synergy</td>
<td></td>
</tr>
<tr>
<td><strong>Passives</strong></td>
<td>Lead them</td>
</tr>
<tr>
<td>The silent majority (40 – 80% of players)</td>
<td>Reach them through their neighbours</td>
</tr>
<tr>
<td>If they follow the project will succeed, if not it will fail voicing their opinion increases their antagonism</td>
<td>Reach them by selling the project</td>
</tr>
<tr>
<td><strong>Moaners</strong></td>
<td>Pay attention to know what others might say otherwise ignore them</td>
</tr>
<tr>
<td>Do what it says on the tin</td>
<td></td>
</tr>
<tr>
<td>They act as an early warning system, saying what others might think</td>
<td></td>
</tr>
<tr>
<td><strong>Opponents</strong></td>
<td>Can’t be convinced: they must be defeated</td>
</tr>
<tr>
<td>A sensitive force but not for the project</td>
<td>Avoid being kind or looking after their interests</td>
</tr>
<tr>
<td><strong>Mutineers</strong></td>
<td>Deal with them as with Opponents</td>
</tr>
<tr>
<td>Their antagonism drives them to prefer to lose everything rather than let someone else succeed</td>
<td></td>
</tr>
</tbody>
</table>
Appendix 11: The evaluation cycle (Lazenbatt, 2002)

- Do you need to evaluate?
- Clarify purpose, timescale, resources
- Is it for internal or external use?
- Select method
- Collate & analyse data
- Cost effectiveness
- Write report and findings
- Disseminate internally or externally
- Inform future work
Subject: Re EPA booklet

Hi,

Quite happy with the booklet - it's an excellent idea and I'd love to have it to hand out at my clinics!

The only thing I might suggest is on the first page under 'who should consider' it might be worth saying all adults but especially those worried about their memories etc.

Catch up soon
Appendix 13: Expert panel Feedback 2 (Solicitor)

Dear,

I think that the leaflet could be amended slightly to take account of the following points:

1. Everyone not just people beginning to suffer from dementia should execute an EPA. None of us know that we would never have a stroke or brain haemorrhage or other sudden debilitating illness or injury.

2. A person could also discuss with family members who know them well and whom they trust if they have capacity.

3. The Attorney can also manage the persons finances on their behalf.

If you need clarification on any of this please do not hesitate to contact me.

Best wishes with your leaflet.
Appendix 14: Expert panel Feedback 3 (Health promotions Manager - Voluntary organisation)

Dear

Many thanks for sending your proposed booklet onto us, it is an area that is so important for people facing a diagnosis of dementia.

You have adopted a very accessible approach to what is often a daunting topic for people! I have outlined my comments below, which I hope you may find helpful;

Style:

- A font like Avenir, Helvetica or Arial can be more accessible
- Your font size is 12 which is great, think about 1.5 line spacing, NALA recommend it but it is not essential.
- The Q&A format works really well, we have used that also with great feedback, at the moment the document is a list of Q & A's - you could maybe put in some headings to create sections eg - Creating an EPA - which house the Q&A.
- There are times when your para's indent on the second line, probably better to all start at the same point.
- I find a white background with a black text in the main and a strong colour text for headings can be useful and improve accessibility.

Content

There are a couple of points I always try to include when discussing EPA, these are based on legal input we have had.

- A diagnosis of dementia does not automatically mean a person cannot make financial and legal decisions. While a person has the capacity to outline their wishes and to understand the effect of a legal and financial decision then they can continue to make decisions - such as making a will or setting up an EPA.
- If you have a diagnosis of dementia and you are setting up an EPA, best practice suggests that your solicitor include a medical opinion that at the time of instruction you had capacity to understand. The solicitor should also be satisfied you are not under undue pressure from anyone else.
- It is advisable to consider having at least 2 Attorney's that you trust who can share the responsibility. Also a substitute is important, particularly if you
decide to only have one Attorney - in case the person you pick cannot take up the role when it is required due to unforeseen circumstances.

- You could include the Law Society contact details as they have a directory of solicitors

- You may want to mention the pending legislation which will impact this area - that there are changes coming etc.

You mention you are looking for expert opinion we also get legal opinion to sign of content on areas like this. I attach guidance notes for solicitors issued by the Law Reform Commission – this might be helpful.

Finally, I am delighted to say that we recently secured funding to develop information products for people with early stage dementia and we will be beginning this project in the coming weeks. Part of the suite of products will be about planning for the future - including legal planning.

If I can help in any other way or if you want to discuss any aspect of the project please do not hesitate to contact me,
Appendix 15: Expert panel Feedback 4 (Consultant POA)

Quality checklist for reviewing health information (CYWHS, 2006).

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>Unsure</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A. Clear communication</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is the information clear and easily understood?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is the information presented in sections?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do the sections have clear headings?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does the style and layout enhance the communication?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is the language and tone used non-judgemental?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is the language used likely to be understood by those who will read it?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are three or more syllable words used as little as possible?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are medical terminologies, abbreviations and jargon explained?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is it written in the second person (e.g. ‘you’ instead of ‘the patient’)?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is the terminology used consistent (i.e. are the same words used to describe the same ideas)?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does it avoid the use of global imperatives (eg you will, carers must)?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>B. Quality content that meets consumers’ needs</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is it clear that consumers were involved in the development of the information?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are the aims or objectives of the information clearly stated?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is the intended audience clearly stated?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does the information meet the specified aims?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is the most useful information presented first?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is the information included current?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is the evidence provided referenced?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is the information provided in a balanced and non-biased way?</td>
<td></td>
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</tr>
<tr>
<td>If there are areas of uncertainty of knowledge, are they addressed?</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Are there any omissions of which consumers need to be aware?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has information about further sources of support and help been included?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are the organisations and professional groups involved clearly identified?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is the date of the publication included?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>C. Content that assists informed decision making</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does the information encourage and support shared decision making or assist consumers to ask questions about their own treatment?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are all the options available included, and are the risks and benefits discussed?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is there mention of what might happen if the ‘no treatment’ option is selected?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are details of where consumers can obtain further information included?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Appendix 16: Kirkpatrick’s model for evaluation

<table>
<thead>
<tr>
<th>Level</th>
<th>Evaluation Type (What is Measured)</th>
<th>Evaluation Description and Characteristics</th>
<th>Examples of Evaluation Tools and Methods</th>
<th>Relevance and Practicability</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Reaction</td>
<td>Reaction evaluation is how the delegates felt about the training or learning experience.</td>
<td>'Happy sheets', feedback forms. Verbal reaction, post-training surveys or questionnaires.</td>
<td>Quick and very easy to obtain. Not expensive to gather or to analyse.</td>
</tr>
<tr>
<td>2</td>
<td>Learning</td>
<td>Learning evaluation is the measurement of the increase in knowledge - before and after.</td>
<td>Typically assessments or tests before and after the training. Interview or observation can also be used.</td>
<td>Relatively simple to set up; clear-cut for quantifiable skills. Less easy for complex learning.</td>
</tr>
<tr>
<td>3</td>
<td>Behaviour</td>
<td>Behaviour evaluation is the extent of applied learning back on the job - implementation.</td>
<td>Observation and interview over time are required to assess change, relevance of change, and sustainability of change.</td>
<td>Measurement of behaviour change typically requires cooperation and skill of line-managers.</td>
</tr>
<tr>
<td>4</td>
<td>Results</td>
<td>Results evaluation is the effect on the business or environment by the trainee.</td>
<td>Measures are already in place via normal management systems and reporting - the challenge is to relate to the trainee.</td>
<td>Individually not difficult; unlike whole organisation. Process must attribute clear accountabilities.</td>
</tr>
</tbody>
</table>

Kirkpatrick’s model (businessballs.com) Available at: [http://www.businessballs.com/kirkpatricklearningevaluationmodel.htm](http://www.businessballs.com/kirkpatricklearningevaluationmodel.htm)
## Appendix 17: Feedback form used for first information session based on Kirkpatrick’s model

Feedback form based on Kirkpatrick’s model. Available at:  
([http://www.businessballs.com/kirkpatricklearningevaluationmodel.htm](http://www.businessballs.com/kirkpatricklearningevaluationmodel.htm))

<table>
<thead>
<tr>
<th>Training Evaluation &amp; Feedback</th>
<th>course title &amp; date</th>
<th>a lot</th>
<th>some</th>
<th>a little</th>
<th>none</th>
<th>specific highlights and/or suggested improvements?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enjoyment: Did I enjoy the course?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>New knowledge and ideas: Did I learn what I needed to, and did I get some new ideas?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Applying the learning: Will I use the information and ideas?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Effect on results: Do I think that the ideas and information will improve my effectiveness and my results?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Any other comments?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Name …………………………….  
Appendix 18: Feedback on ‘Booster sessions’

**Information sessions on Enduring Power of Attorney (EPA) (CYWHS, 2006).**

1. Are you involved in the EPA project?

   Yes      No

2. How confident do you feel when discussing the EPA with patients or carers


3. How would you rate the information session on EPA

   a. Very useful  b. Useful  c. Neutral  d. Very little use  e. Not useful at all

4. Did you feel supported during the process of initiating the project?

   a. Very supported  b. Supported  c. Neutral  d. Very little support  e. Not supported
Appendix 19: Feedback from patients and carers

Sample focus group questions for consumers (CYWH, 2006).

Appeal

Q. What was your initial reaction to this (brochure/booklet)? Can you tell me what you liked about it and what you disliked?

Follow-up prompts: Did it hold your attention? Would you be likely to pick it up in a waiting room? What types of people do you think would read this?

Readability

Q. How readable do you think this booklet is? Could most people easily understand it?

Follow-up prompts: Are there any terms you would like explained? Is the style and level of language used appropriate?

Presentation

Q. What are your views about the ‘look and feel’ of this booklet including the layout, colours, illustrations and graphics?

Content

Q. Does the booklet provide you with the information you need about the Enduring Power of Attorney

Q. What do you think are the main messages of this booklet?

Perceived usefulness

Q. How useful do you think this information is?

Q. Would you be likely to use this information?

Overall

Q. In summing up, what do you think are the best or most useful aspects of this booklet? What are least useful?

Q. How would you suggest that this booklet could be improved?
Appendix 20: Sample of Patient list from team meetings (highlighting new column)

<table>
<thead>
<tr>
<th>Name</th>
<th>MMSE</th>
<th>EPA</th>
<th>PCN No</th>
<th>Chart No</th>
<th>DOB</th>
<th>Location</th>
<th>Date seen</th>
</tr>
</thead>
<tbody>
<tr>
<td>New patients</td>
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Appendix 21: EPA booklet (cover page)
Appendix 22: mini Gantt chart

- Pre-audit
- Apply for Ethical approval
- Apply for Grant
- Submit Project proposal
- Produce draft of booklet and Guidelines
- Review of Guidelines (2 reviewers)
- Expert panel review of booklet
- Grant awarded
- Project start - training (& evaluation)
- POA team feedback on draft of booklet
- Final revision and production of booklet
- Review of booklet by Consultant POA
- Selection of suitable patients based on Guidelines
- Ethical approval
- Implementing discussions on EPA
- Evaluations including Patient feedback
- Writing up project
- Project submission
## Appendix 23: Project Poster

### Enduring Power of Attorney (EPA) - implementing and sustaining discussions

#### Introduction & Background

In Ireland, the Enduring Power of Attorney (EPA) is a legal document which empowers an individual to leave advance directives in relation to his/her care in the event of incapacity. It is like handing the baton of care to someone else when you can no longer do it yourself.

In the absence of the EPA, the responsibility of making care related decisions falls on the state through the Ward of Court system.

1405 Wardship orders were signed in Ireland in 2011 as opposed to 440 appointed EPAs; these numbers may reflect a lack of awareness or understanding of the provision for advance care instructions.

The EPA project was carried out in a Psychiatry of Old Age (POA) Service. Patients may present with Mental illness, Dementia, Stroke or Parkinson’s disease. All of these may cause incapacity.

### Aims

1. Develop a patient focused health information booklet on EPA which is concise and easy to read and understand, in the last quarter of 2012.
2. Develop written guidelines for health care professionals initiating discussions on EPA with patients, in the last quarter of 2012.
3. Enhance awareness and knowledge of EPA among staff of the POA in the last quarter of 2012 and the first quarter of 2013.
4. Implement discussions on EPA with patients and carers based on developed guidelines, in the first quarter of 2013, to enhance awareness of EPA among patients and carers.

#### Change Process

The EPA project was planned, continuous and transitional. It was based on Kotter’s 8 step model.

1. **Establish a sense of urgency**
   - In the context of the POA culture, urgency was created by presenting a compelling patient summary, pre audit findings, project aims and objectives and an estimated time schedule for implementation.

2. **Create a guiding coalition**
   - Bearing the politics within the POA team in mind, the two most influential members who had both positional and personal power were courted and incorporated into the guiding coalition.

3. **Develop a vision and strategy**
   - The change strategy was focused on portraying the vision as an exciting goal that stakeholders would want to partake in and was presented over several information sessions.

4. **Communicate the vision**
   - Communication took the form of several meetings with team members, emails with the expert panel and one to one discussions between team members and between team members and patients/carers.

5. **Empower broad-based action**
   - Each team member had some level of ownership in relation to their patients.

6. **Generate short-term wins**
   - The award of ethical approval and monetary grant as well as positive feedback from patients and carers, were communicated to the team.

7. **Consolidate gains and produce more change**
   - The gains of the project and team ownership were emphasized often and guideline exclusion and inclusion criteria revisited whenever indicated.

8. **Anchor new approaches in the corporate culture**
   - A structural change made to the POA system.

#### Evaluation

In line with stated objectives

a. The booklet developed was rated as having achieved all aspects of three areas targeted (expert panel review)

b. The guidelines developed were approved (2 reviewers based on standard)

c. 92% of staff felt their knowledge had been enhanced (Kirkpatrick’s model)

d. All the patients who gave feedback were aware of the EPA. An audit of EPA discussions by staff indicated 100% compliance by the second contact with the patient.

### Organisational Impact

The summative impact of the EPA project was an improvement in Total Quality Management.

- Patient quality: Improvement in the totality of service provided. Improved efficiency in the area of EPA.

- Resistance emerged mainly from one team member who worried about crossing of roles and blurring of role boundaries.

### Conclusion

Implementing a change project which results in improvement in quality of service provision implies success. Embedding the change in culture is crucial to prevent expropriation, closing the loop on the PDCA cycle.

#### References

4. Kotter’s 8 step model.
5. North Carolina Indigent Defense