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# Development and acceptability of the person-centred observation and reflection tool for supporting staff and practice development in dementia care services

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## Abstract

**Background:** Observational tools can support the understanding of the complex needs of older people with dementia and aid delivery of person-centred care. However, existing tools are complex and resource intensive to use.

**Objectives:** To develop and evaluate the acceptability and feasibility of a low-resource, observational tool to support staff reflection and practice development.

**Methods:** Intervention development of the Person-Centred Observation and Reflection Tool (PORT) and acceptability and feasibility study, using surveys and focus groups in the UK, Norway and Spain.

**Results:** PORT was reported as easy, accessible and acceptable to use. The observation was identified as powerful for individual staff development and provided an evidence-based source for underpinning individualised care planning. Potential time challenges associated with implementation were identified.

**Conclusion:** Initial evaluation indicates PORT is an acceptable and feasible tool for use in health and social care settings for older people. Further research is needed on implementation models and the impacts of PORT use.

**Implications for Practice:** PORT may be a useful tool to support individual staff development in care settings and person-centred care planning for people with dementia.

## KEYWORDS

dementia, intervention, observational tool, practice development, reflective practice, staff development

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## 1 | INTRODUCTION

Improving the quality of care for people with dementia in formal care settings is a global priority (WHO, 2017). Dementia brings a set of often complex care needs. Staff working in formal care services, many of whom are nurses, are most likely to be caring for someone with dementia who is older, and when their needs are so great that they are unable to be cared for at home (Toot et al., 2017), or when they are also acutely unwell (Røsvik & Rokstad, 2020). It is at this time that the delivery of good person-centred care (PCC), based on individual needs, is required. However, the communication problems that result from dementia can make it difficult for someone with the condition to express their needs and for staff to understand these (Banovic et al., 2018). This can lead to people with dementia expressing behavioural and emotional responses to unmet needs, which may be in the form of agitation, aggression, distress or apathy (Banovic et al., 2018). Staff working in formal care settings widely report lacking the knowledge or skills to deliver PCC (Güney et al., 2021). Therefore, tools are needed that can help staff to better understand the needs of individuals with dementia and to develop person-centred approaches to these.

Observational tools can help staff working in formal care settings to understand and interpret the needs of people with dementia and may provide a valuable method for supporting the delivery of PCC based on personal reflection on practice (Griffiths et al., 2021; Mills et al., 2018; Towers et al., 2015). A number of observational tools have been developed to deepen understanding of the experience of people with dementia in formal care settings and develop practice (see Table 1).

Staff using these tools report the benefits of observation to increase their empathy and understanding of individual needs. This, in turn, informs their own care practice. However, challenges occur in transferring this to other staff (Griffiths et al., 2021). Additionally, consistent implementation barriers to using these tools have been identified, including their complex and time-consuming nature, specialist training requirements and staff lacking the requisite skills to drive forward practice change (Griffiths et al., 2019, 2021; Towers et al., 2015). Therefore, observational tools that can facilitate a reflective practice improvement and staff development process, but which are simple and low-resource to use, and accessible to all staff are needed. This paper reports on the development of an observational tool, by an international group of experts, to address this gap.

## 2 | AIM

To develop an accessible, low-resource, empathy focussed observational tool to support individual staff reflection and practice development and to evaluate its acceptability in health and care services.

### What does this research add to existing knowledge in gerontology?

- Initial evaluation indicates that PORT is an acceptable and feasible tool for use in health and social care settings that support older people with conditions such as dementia.
- PORT enables staff users to empathise with the experience of older people with dementia or similar conditions.

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

- PORT may offer a practical and accessible staff and practice development tool for use in settings that provide care for older people.
- PORT can be used for individual staff development or care planning.

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

- This study indicates it is possible to use observational tools as the basis for staff and practice development in settings that care for older people.
- Further research is needed to understand optimal models of implementation and impacts.

## 3 | MATERIALS AND METHODS

### 3.1 | Design

Intervention development and initial acceptability testing following the Medical Research Council Framework for the development and evaluation of complex interventions were undertaken (Skivington et al., 2021), utilising associated guidance on complex intervention development (O'Cathain et al., 2019). We adopted an implementation-based approach, focussed on ensuring real-world uptake (O'Cathain et al., 2019). This was undertaken through an iterative approach, including cycles of development, feedback and revision (O'Cathain et al., 2019).

### 3.2 | Initial development and pilot testing

An expert working group comprised of nine members including the study authors and other international practitioners with expertise in dementia care practice development met in person initially and virtually (three workshops lasting 1–2 h) in 2019–2020 to develop an initial draft of the tool and accompanying guidance for use. The basis

TABLE 1 Existing observational tools for practice development in dementia care.

Tool	Purpose/setting	Use and evaluation
Dementia Care Mapping (DCM) (Bradford Dementia Group, 2005)	Individual care planning, wider practice development in all formal care services	Specialist staff trained in DCM (4 days) and skilled in leading practice change. External experts are needed to sustainably implement and deliver significant change (Surr et al., 2020).
Adult Social Care Outcomes Framework (ASCOT) mixed methods tools (Towers et al., 2015, 2016)	Impact of social care services on people with dementia measuring domains of quality of life	Specialist-trained, external staff conduct observations over 1–2 days. Expert input is readily accepted by homes, but the requirement for staff to complete interviews about residents quality of life puts a strain on resources. (Towers et al., 2015, 2016)
Person–Interaction–Environment tool (PIE) (Godfrey et al., 2018)	Improving the care of people with dementia in the general hospital	Trained users who are senior members of staff and can drive practice change. Implementation is poor without requisite resources and alignment with the hospital's other dementia initiatives (Godfrey et al., 2018).
PIECE-dem (Brooker et al., 2011)	Detection of abuse and neglect in people with advanced dementia living in care homes as part of the research	Observations were conducted by researchers over 2 days. No published evidence on use for practice development.
Person-centre Observation and Reflection Tool (PORT)	Staff reflection and individual practice development, individual care planning.	Observations conducted by any trained member of staff for up to 1-h.

for this was the following question ‘What are the most useful issues for staff to observe to deepen their empathy, in order for them to improve the day-to-day quality of life for people they care for?’

The expert group also drew on findings from published research on implementation of observational practice development tools (e.g. Godfrey et al., 2018; Griffiths et al., 2019, 2021; Kelley et al., 2020; Rokstad et al., 2015; Surr et al., 2018, 2020; Towers et al., 2015, 2016) and their own research and practice experience in this field.

Version 0.1 of the tool was developed following a 2-day in-person meeting, based on detailed written notes taken during the meeting. Expert group members provided written feedback on this draft, which was then discussed and refined at a virtual meeting and version 0.2 was agreed upon. Expert group members then piloted version 0.2 through observing, a 1-h video of care being delivered within a care home setting. This recording was from a research study evaluating a PCC intervention, conducted by one of the expert group members, with permission to use the video for educational purposes. Where expert group members used observational methods within their day-to-day work in dementia care settings, they used the tool informally as a structure for these. A second virtual meeting was then held to discuss experiences and identify further refinements. Changes were made to the observation and summary sheets to improve ease of use. Version 0.3 was then piloted by the expert group members again using the video of care practice. A final virtual meeting was held to agree on version 0.4, which was taken forward for formal evaluation with health and social care professionals.

### 3.3 | Person-centred observation and reflection tool (PORT)

Typically, PORT involves a member of the care team observing up to three people with dementia (or individuals who have limited capacity to communicate) for up to an hour. Observation periods would

usually be selected to look at a specific time of day or aspect of care around which there may be concerns. Individuals being observed may be selected because there are specific questions about the service meeting their needs or opportunistic based on who is present in the public areas.

There are two levels of PORT users:

1. PORT observer—any member of staff with direct contact with people with dementia; they work with the mentorship/supervision of a PORT Coach and may use it regularly as part of their ongoing professional development.
2. PORT coach—senior members of staff experienced in the use of PORT.

During the observation period, the PORT observer is required to note

1. how the person being observed appears to be feeling (from one of five broad categories, e.g. happy, neutral, agitated or upset),
2. whether or not they are engaged with the world, and if yes to observe who/what they are engaged with,
3. whether they experience good social support.

Recordings are made at regular time intervals. Usually, this would be every 5 min, although there is flexibility to have 2- and 1-min recording intervals depending on the purpose of the observation. Training to understand the PORT recording framework can be completed in 1–2 h.

Following completion of an observation period, a reflective summary sheet is completed by the observer with support from the coach, for each person who was observed. This includes an overall description of the person's experiences of care, their mood and engagement and what supports or undermines these. The observer is also asked to

reflect on how the observation made them feel. Through discussion with the PORT coach, the observer also reflects on what could be done to improve quality of life and identifies 1–3 actions to take forward for the care they deliver to the individual or more generally. PORT also provides space to consider opportunities for engagement more generally within the setting. These summaries can be used by PORT coaches to support individualised care planning and delivery of PCC.

### 3.4 | Acceptability testing PORT training and tool use

#### 3.4.1 | Design

Acceptability testing of the PORT training and tool was carried out during 2020–2022 in the UK, Norway and Spain, with staff working in health and social care settings. The evaluation sought to understand (1) their reactions to PORT training and how well it prepared them to use the tool, (2) their experiences of conducting PORT observations and (3) their perspective on the usefulness of the tool and ability to put it into practice.

#### 3.4.2 | Sample

The UK sample (see Table 2) were 40 health and social care staff who had either completed a post-graduate award in which PORT training was included or unaccredited continuing professional development training on PORT, provided by two UK Universities (the University of Worcester and Leeds Beckett University). All participants were provided with online synchronous PORT training using Microsoft Teams video-conferencing software, as part of their programme of study. Participants studying in the accredited programme used PORT by observing, the research video that was also used by the expert group members asynchronously, followed by an online synchronous discussion that mirrored the role of the PORT Coach. Participants, who completed unaccredited training, observed sections of the 'Finding Patience—The Later Years' film (Health Education England, 2016) during their synchronous training. Finding Patience depicts the experiences of a Caribbean woman with dementia moving into a care home. Following training participants were free to use PORT as an observer or to use the provided training materials to onward train others in their own workplace as PORT observers, and thus to take on the role of PORT Coach.

The participants in Norway were 36 staff working in four nursing homes in one municipality which was aiming to implement person-centred practice in all residential care units. To achieve this, PORT was selected as one of the methods together with the TIME method (Lichtwarck et al., 2016, 2019) and the VIPS framework (Brooker & Latham, 2016). Participants received 2-h PORT training via online synchronous methods using Microsoft Teams video-conferencing from one of the study authors (AMR). After the training session, they used PORT in their workplace, with a recommendation they carry

TABLE 2 Summary of PORT training in each country.

Location	Who trained	Training method
UK	40 health and social care professionals trained as PORT observers	Online synchronous Video of care practice during training delivery to practice PORT use
Spain	41 Nursing staff from 20 nursing homes in one region of Spain trained as PORT observers.	In person PORT practice conducted in the workplace
Norway	36 Nursing staff in four residential homes in one municipality trained as PORT observers	Online synchronous PORT practice conducted in the workplace

out their first observation with a colleague, to provide peer-to-peer support and discussion. They were invited to a further synchronous session via Microsoft Teams with the trainer, 4–5 weeks later to discuss their experiences and ask further questions on conducting PORT observations.

The Spanish participants were 41 nursing home staff working in 20 nursing homes within the same private care provider organisation, in one region of Spain. Each nursing home had at least 100 beds and offered public care. Three homes were in rural areas and the rest were in an urban environment. None of the nursing homes had implemented or developed a PCC approach previously and staff had never used an observational tool to assess dementia care. All nursing homes were taking part in a programme to implement PCC in all of their residential care units, which was led by two of the study authors (JVM and EF). This involved training staff from each nursing home on PCC and using the PORT tool.

The training was delivered in person, over 4 months, with one 4-h training session per month (16h total). PORT training was delivered in session 2, after initial training on PCC in session 1. In the 4 weeks after PORT training, participants were asked to use PORT in practice, observing three residents for 2h per week (8h in total). Based on their observations, they were asked to complete an in-depth care plan for one resident, based on Kitwood's (1993) enriched model of PCC.

Table 2 summarises the number of individuals trained to use PORT and the method of training delivery.

#### 3.4.3 | Methods

An online survey was used to gather feedback in the UK and Spain. Focus group interviews were used to understand PORT user reactions and experiences in Norway.

### 3.5 | Surveys

The UK and Spanish surveys contained the same questions. There were a series of demographic questions followed by 16 questions about PORT use comprised of fixed response, Likert scale and open-ended questions. UK Participants were invited to complete the PORT survey either after the end of the formal post-graduate module or 1–2 weeks following PORT training for the unaccredited CPD programme. They were sent the invite and a link to the survey by e-mail by a member of the education/training team who was not responsible for delivering PORT training. One further reminder was sent 4 weeks later to encourage additional returns. Return rates were hampered by PORT training being delivered during the spring and autumn of 2020 when health and care services were under significant pressure from the COVID-19 pandemic. Spanish participants were invited to complete the PORT survey 3 months after the end of their formal PCC and PORT training programme was completed.

### 3.6 | Focus group interviews

In Norway, an interview guide was developed focusing on how participants experienced the training and use of PORT, how the observation and summary sheets work in practice, experiences of the usefulness of the tool in practice, barriers and facilitators for implementation and how the tool could be improved. Three focus groups took place around 6 months after the PORT training. The interviews were facilitated by two experienced researchers, one of whom delivered the PORT training (author AMR). A total of 22 participants took part in the three focus groups (7+7+6). The focus groups were 55–62 min in length and were recorded and transcribed verbatim for analysis.

### 3.7 | Data analysis

#### 3.7.1 | Surveys

Fixed response answers were analysed using descriptive statistics in Microsoft Excel. Open-response questions were analysed thematically using the Framework Analysis variant of Thematic Analysis by one of the authors (CS) and then checked for meaning by a second author (JVM).

#### 3.7.2 | Focus groups

The transcribed focus group interviews were analysed by one of the authors (AMR) using a thematic content analysis inspired by Graneheim and Lundman (2004). Qualitative content analysis can be conducted on different levels of abstraction, and the content of a text can either be manifest describing the visible, obvious components, or latent involving an interpretation of the underlying meaning of the text. The materials collected in this study were analysed

on a manifest level and presents what is directly expressed in the text, providing a description of its visible and tangible components (Graneheim & Lundman, 2004). The analysis was conducted in the following steps: (1) All transcripts were read to provide a sense of the whole and themes that described experiences in using PORT were identified; (2) meaning units in the text were identified and condensed into descriptions close to the text; (3) the meaning units were extracted and labelled with codes that was grouped into categories and finally identified as findings to be written out in text.

#### 3.7.3 | Data integration

Data were integrated using a narrative weaving approach as described by Fetters et al. (2013), where qualitative and quantitative findings are presented together on a theme-by-theme or concept-by-concept basis. As recommended by Fetter et al., we integrated the data considering the outcomes of *confirmation*, where findings from different data sets concur; *expansion*, where the findings from each data set diverge and expand insight in a complimentary way and *discordance*, where the findings from different data sets are incongruent or conflict with each other. The data from the Norwegian and Spanish participants were translated into English ahead of data integration. Integration was completed initially by one author (CS) before being checked for meaning and accuracy by two further authors (AR and JVM).

#### 3.7.4 | Ethical issues

Ethical approval for each of the studies was granted by the University of the Chief Investigator for each study—(Leeds Beckett University, UK; Norwegian National Centre for Aging and Health, Norway; University of Barcelona, Spain).

## 4 | RESULTS

Six people commenced, five completed the UK survey and 41 participants completed the Spanish survey. In Norway, 22 participants took part in the focus groups (see Table 3). Participants across all three countries were predominantly female and white. In the UK and Spain, participants worked across a variety of roles within health and social care and represented a range experiences working in dementia care. The Norwegian sample was comprised solely of registered and assistant nurses.

### 4.1 | Conducting a PORT observation and using the PORT data recording sheets

The vast majority of participants trained in PORT across the three countries reported that generally, PORT was easy to use. We

TABLE 3 Participant demographics<sup>a</sup>.

Participants N (%)	UK (n = 5)	Norway (n = 22)	Spain (n = 41)
Female	4 (80)	22 (100)	33 (80)
Male	1 (20)	0	9 (20)
Age			
18–29	0		4 (10)
30–39	0		21 (51)
40–49	2 (40)		14 (34)
50–59	3 (60)		2 (5)
60+	0		0
Ethnicity			
White	5 (100)	22 (100)	40 (98)
Black	0	0	0
Asian	0	0	0
Latin-American	0	0	1 (2)
Mixed	0	0	0
Other	0	0	0
Sector			
Health care	1 (20)	22 (100)	0
Social care (care home/assisted living)	3 (60)	0	41 (100)
Voluntary/charitable	1 (20)	0	0
Role			
Manager/deputy	0	0	11 (27)
Nurse	1 (20)	22 (100)	2 (5)
Care/support worker	0	0	9 (22)
Activity co-ordinator	1 (20)	0	3 (7)
Social worker	0	0	5 (12)
Psychologist	0	0	7 (17)
Occupational Therapist	0	0	1 (3)
Physiotherapist	0	0	3 (7)
Education/training	1 (20)	0	0
Student	1 (20)	0	0
Administration	1 (20)		
Time working in dementia care			
0–5 years	1 (20)		
6–10 years	2 (40)		10 (24)
11–15 years	0		10 (24)
16–20 years	2 (40)		14 (35)
20+ years	0		7 (17)
	0		0

<sup>a</sup>Full demographic details were not collected from Norwegian participants.

examined their responses in relation to each component of the PORT process: instructions for use, observations and reflective summaries.

#### 4.1.1 | Instructions for use

All UK and Spanish participants reported that they found the information contained in the PORT instructions for use to be helpful.

From not knowing much, to everything lived and learned; I think it is very complete. (Spanish survey respondent)

One UK participant noted that it would be useful to include in the instructions for use, more guidance on how to implement PORT, particularly for those who have not used observational tools previously.

Bit more guidance on how to introduce into practice (UK Survey respondent)

Two Spanish participants noted that they would like further information and support on how to understand and support individual residents.

Much more emphasis on how to support people, setting aside our personal interest. (Spanish survey respondent)

#### 4.1.2 | PORT observation sheets

All UK participants found it easy to record data on the PORT observation sheet. This finding was mirrored in two-thirds of the Spanish respondents. Two Spanish respondents stated recording was fairly or very difficult and the remainder felt neutral. When practising the use of PORT via video, all UK participants, while 28% of Spanish participants felt observation of three participants was easy. Around 30% of Spanish participants felt neutral and 35% said it was difficult. At least two-thirds of respondents across both countries stated observing three participants with PORT at any one time was about right, with the remainder feeling this was too many.

The main difficulty that many participants noted in conducting PORT observations across the three countries was the layout and a lack of space available for writing notes about their observations of engagement, staff interactions and more general aspects of care. There were also suggestions for modifications to the data that are recorded during a PORT observation including the ability to record mood state in a more nuanced way.

Perhaps include more variety of emotions in PORT Observation Sheet (Spain survey respondent)

The possibility to consider the impact of aspects of the environment on observed participants was also requested.

In some situations, I see that the resident is affected by something happening in the environment that

is not to be described as an interaction with staff. I would like to be able to add these observations ... as well. (Norway FG participant)

... it made me aware of how important it is to keep the eye contact during communication. (Norway FG participant)

This was reflected in the responses of Spanish survey participants.

#### 4.1.3 | Individual reflective summaries

Participants across the three countries reported finding the individual reflective summary sheet as a useful approach to summarise their observations and considered it to be an adequate tool to reflect on the findings.

I think it's really good on the individual summary sheet to finish with 3 defined ("SMART") actions to take forward. (UK survey respondent)

I think it is a very useful tool to observe and understand the reality of the person and adjust their care to what they really need, not what makes our work easier.

After having done the PORT, now I stop more to observe people and even stop to give them a hug if they need it.

Thus, PORT observations were felt to be acceptable to conduct and the provided documentation was acceptable with some minor amendments suggested.

Thus, observers reported starting to reflect on care practice during the observation and afterwards felt readily able to share both the observation and the reflection with colleagues. Another participant shared her unexpected experience of how little happened in the surroundings to stimulate the residents and how passive they were not showing any signs of joy or engagement.

#### 4.2 | The acceptability of PORT as a tool for individual staff and delivery of person-centred care

PORT was noted by all participants to be an acceptable tool to use in health and social care settings for the purpose of developing individual staff skills and knowledge and for the wider delivery of PCC. There were four concepts identified under this area including: The power of observation and reflection, PORT Underpinning the improvement of PCC for individual residents, accessibility to all and team ownership and Potential challenges for the use of PORT.

It was so silent and nothing at all happened. (Norway FG participant).

The use of PORT thus opened her eyes to the need for more stimulation to enhance engagement from the residents.

#### 4.2.2 | PORT underpinning the improvement of PCC for individual residents

Where participants had used PORT within their own practice there were numerous examples provided of how observations had been used to evidence changes in care for individual residents and record impacts of this.

##### 4.2.1 | The power of observation and reflection

Particularly positive aspects of PORT identified by participants were its use of observation and reflection, which were felt to be particularly powerful for individual staff development.

Being able to observe is very powerful and can be more instructive than a training session. (UK survey respondent)

I used the PORT to remove a restraint from a lady. It served to make us realize that she did not need it and to argue with her family (they did not want to withdraw it) to withdraw it, (Spanish survey participant)

Resident who presented a lot of agitation due to being restrained day and night. ... it was decided to withdraw all restraint and increase more help for the resident. She is currently not restrained, ... and her agitation has subsided. (Spanish survey participant)

Several focus group participants mentioned that making the observations gave them moments of realisation which were important for their own practice as exemplified by one participant:

Suddenly I say how the resident couldn't follow the communication from the nurse when she turned around and the resident was unable to see her face.

##### 4.2.3 | Accessibility to all and team ownership

PORT was felt to be an accessible tool and one that could and should be used by all those working in dementia care settings.



I think that the PORT tool should be known by all workers who work with people with dementia. (Spanish survey respondent)

The potential for all staff to be able to undertake PORT observations without long and expensive training was valued by participants, meaning PORT was seen as an inclusive and accessible tool.

This tool with its focus on front line staff will I hope enable carers to understand better how their actions and the environment can support or detract from well being, without ... a long, expensive ... training course. (UK survey respondent)

Also seen to be positive was its ability to be used by all staff, with those leading the process adopting coaching rather than external expert role meaning it was individuals and the team as a whole that developed and owned the ideas for practice change.

What I really value about this tool is that my role would be as "coach"—it does not contribute to a dynamic of my [external] service as the "specialist" or "expert" giving advice. Instead, it supports working in way which is more collaborative and supportive. (UK Survey respondent)

#### 4.2.4 | Potential challenges for the use of PORT

Some challenges to the use of PORT in health and social care settings were mentioned. Some participants found it challenging to undertake observations in their own working place/unit. They were unsure about how it would affect their close colleagues to feel observed by them. In these residential care homes, the observers switched units and undertook PORT observations in another unit in the care home.

We decided to make the observations in another unit in our nursing home. I found it a little complicated to sit down and make observations of my close colleagues (Norway FG participant)

Challenges related to feeling the need to intervene or support the delivery of care in their own unit when other staff were busy or residents had needs, rather than sitting and observing, were noted by some Spanish survey participants.

Observation is difficult in those continuous care units where the activity and turnaround are altered and the intervention of the observing staff is necessary. (Spanish survey participant)

To schedule time for observations was another challenge that needed attention from the leadership. To do proper observations for

an hour or even for half an hour, they needed replacement from their duties in the unit. This means that the time for using PORT needs to be scheduled in the working plans on the days of observations.

We have struggled to find free time to do the observations. ... there is always something that needs to be taken care of in the unit. So, ... it needs to be clarified with the leadership and scheduled in the working plans. (Norway FG participant)

I believe that it is a very good work experience; however we do not have the time to use it. (Spanish survey participant)

## 5 | DISCUSSION

This paper has reported on the development and international acceptability testing of a new observational and reflection tool to support staff and practice development in dementia care services. The tool was developed to address the gaps in existing observational tools which have been reported to lack accessibility to all, be complex to use and can require input from or use by external experts for successful implementation. The study has shown that PORT is deemed by participants working across a variety of sectors and roles within health and social care and across three European countries, to be feasible to use. The accessibility of PORT for use by all staff members, and the ability of teams to own and self-manage the process was felt to be a strength. This means that PORT fills a gap, addressing limitations of existing tools such as DCM (Griffiths et al., 2021; Surr, Griffiths et al., 2019; Surr, Shoemsmith, et al., 2019), ASCOT (Towers et al., 2016) and PIE (Godfrey et al., 2018), which require lengthy training and use by staff members who have the skills to lead organisational practice change.

The majority of participants generally reported using the PORT documentation and conducting observations of three participants was straightforward. It is notable that participants in the UK were already working within organisations committed to the delivery of PCC hence their enrolment in one of the programmes via which PORT training was delivered. Observations using a training video were conducted during the training itself, under the instruction of a facilitator, including time for reviewing observations and immediate discussion of experiences and data recorded. In Spain, participants were being exposed to PCC first the first time as part of the training programme PORT was embedded within. They first used PORT after training delivery, within their workplace. It may be, therefore, that for the minority of Spanish participants who found the initial use of PORT to be difficult, the combination of lack of previous exposure to PCC, the individual application of PORT back in their workplace and a time lapse between PORT training and first use may have combined to create uncertainty. This suggests participants need to have undertaken training in, and to be confident in the principles of PCC prior to undertaking PORT training and that embedding of videos

to practise observations using PORT within the training itself may provide a more enhanced learner experience and preparedness to use the tool.

Respondents reported observation and reflection to be a powerful mechanism for raising awareness of and providing a more in-depth understanding of resident's needs. This could be used to develop their own practice as well as to identify evidence-based care improvements to inform care planning and practice for individual residents. Reflection is an established approach to learning (Campbell & Rogers, 2022; Moon, 2004; Schon, 1991) and the development of individual practice across a range of sectors (Kraft et al., 2021). Reflection with a mentor or supervisor is a well-established mechanism for personal development and support within health and care services but is relatively unexplored in the context of delivery and embedding of person-centred dementia care (Edgar et al. 2023). This study adds to this body of knowledge by demonstrating observation and reflection are seen as feasible mechanisms to facilitate the delivery of PCC.

A minority of participants, all from the Spanish survey respondents, did identify potential challenges for using PORT in their day-to-day practice. The most cited potential barrier was time. This was despite PORT being less resource intensive to use than existing observational tools, given the focus on this feature during the design process. Related to this was staff feeling they needed to intervene in care when the environment was busy, rather than being able to simply observe. One reason for this may have been the requirement as part of their training, to complete 8 h of observations over a 4-week period, in order to develop initial skills in use of the tool. Ongoing use for individual staff members as part of a staff development process would be much less than this (2 h every 6 months), with larger time demands on PORT coaches, or where staff wish to use PORT observations for care planning and problem-solving around individual resident care. Nevertheless, the lack of resources due to time and understaffing, a well-established barrier to the implementation of PCC and interventions to achieve this in dementia care services (Groot Kormelinck et al., 2021; Güney et al., 2021; Karrer et al., 2020; Surr et al., 2018) remains a challenge to consider for implementation of PORT. Given this study has examined only initial feasibility, further research is needed to explore the longer-term application of PORT in day-to-day practice. Individualised or tailored approaches to implementation that are flexible to the needs of each set may be required (Groot Kormelinck et al., 2021; Karrer et al., 2020; Rapaport et al., 2017), based on the reason(s) for which an organisation may wish to use PORT.

## 5.1 | Strengths and limitations

The strengths of this study were the mixed methods used to assess the acceptability of PORT and its testing across three European countries. The sample sizes in this study were small, but this is appropriate for initial feasibility testing. They were, however, limited to individuals working within a small number of care provider organisations. The sample was also not ethnically diverse, and the majority

were nurses. The small return rate for UK surveys is likely to be due to their release during the COVID-19 pandemic and the impacts this had on staff time to undertake additional activities (e.g. at the University of Worcester, the survey was released just prior to the first UK COVID-19 lockdown and when they were completing their module assignment; at Leeds Beckett University in September 2021 when there were high rates of staff sickness in care homes due to COVID-19). It may be that those who did respond to the survey did so because they held particularly strong views about the tool.

## 6 | CONCLUSION

Observation and reflection hold the potential for supporting individual staff and wider person-centred practice development in services that care for people with dementia. PORT presents a feasible tool to use for this purpose, with some minor refinements to existing documentation. However, further research is now needed to examine if and how it may be successfully implemented in provider organisations and whether this impacts individual residents, staff and wider practice outcomes.

The PORT tool can be accessed in the following languages.

English: <https://www.leedsbeckett.ac.uk/research/centre-for-dementia-research/the-person-centred-observation-and-reflection-tool/>

Spanish and Catalan: <https://www.linkedin.com/company/observandi/> and authors JVM [jvilamiravent@ub.edu](mailto:jvilamiravent@ub.edu) and EF [elefer@copc.cat](mailto:elefer@copc.cat)

Norwegian: <https://www.aldringoghelse.no/personsentret-observasjons-og-refleksjonsverktoy-port/>

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## CONFLICT OF INTEREST STATEMENT

The authors have no conflicts of interest to declare.

## DATA AVAILABILITY STATEMENT

Data from this study may be made available from the corresponding author for research purposes based on reasonable request and appropriate ethical approval.

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