

# **Dementia Care Mapping™ to reduce agitation in care home residents with dementia: the EPIC cluster RCT**

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**Declared competing interests of authors:** Claire A Surr was previously employed by the University of Bradford, which owns the intellectual property (IP) rights to the Dementia Care Mapping™ (DCM) intervention tested in this trial. In this role, she held responsibility for DCM training and method development. She was a technical author on the British Standards Institute's PAS 800 guide on implementing DCM in health and social care provider organisations. She declares personal fees from Hawker Publications Ltd (London, UK) outside the submitted work. Clive Ballard reports grants and personal fees from Acadia Pharmaceuticals (San Diego, CA, USA) and Lundbeck Ltd (Copenhagen, Denmark), personal fees from Hoffman-La Roche Ltd (Basel, Switzerland), Otsuka Pharmaceutical (Tokyo, Japan), Novartis International AG (Basel, Switzerland), Eli Lilly and Company (Indianapolis, IN, USA) and Pfizer Inc. (New York, NY, USA) outside the submitted work. Murna Downs works at the University of Bradford, which holds the IP rights for DCM and runs courses for practitioners and professionals who wish to learn how to use the method. David Meads was a member of the NIHR Health Technology Assessment Elective and Emergency Specialist Care methods panel from February 2013 to June 2017. Louise Robinson was a member of the NIHR Primary Care Themed Call Board until 18 February 2014.

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## Plain English summary

### EPIC cluster RCT

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## Plain English summary

Agitation is common in care home residents and may result from care that does not meet individual needs. Dementia Care Mapping™ (DCM) is a tool used within care homes to improve the delivery of person-centred care, which may help reduce agitation. This randomised controlled trial aimed to understand whether or not DCM is better than usual care at reducing resident agitation, behaviours that staff may find difficult to support and the use of antipsychotic medicines, as well as at improving residents' quality of life and staff communication. It also assessed its value for money.

We recruited 726 residents with dementia from 50 care homes. After initial data collection, care homes were randomly assigned to DCM (31/50) or told to continue with usual care (19/50) and data were collected again after 6 and 16 months. A further 261 residents were recruited after 16 months. We also interviewed staff, relatives and residents about the use of DCM after the final data collection had taken place.

Two staff members in each DCM home were trained to use DCM and were helped by an expert to use it for the first time. They were asked to use it again a further two times without support. Results showed that DCM was no better than usual care in relation to any of the outcomes. It was also not shown to be value for money. Only one-quarter of care homes used DCM more than once. The care staff who were interviewed said that the benefits of using DCM included reduced resident boredom and increased staff confidence. There were also many challenges, including the time needed to complete DCM, a lack of managerial support and problems with staffing levels.

Putting DCM into practice in care homes was difficult, even with expert support, and most care homes did not complete three DCM cycles. Future research should explore models of implementing DCM that do not rely on care home staff to lead them.



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## This report

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