Results: The effect of negative self-perceptions of aging on depressive symptoms was smaller among those who perceived higher levels of positive DC and lower levels of negative DC by their partners than among those perceiving lower positive DC and higher negative DC. The influence of supportive dyadic coping was higher when the levels of negative self-perception of aging were higher. Gender was a determinant factor in the moderation.

Conclusions: Positive DC mitigates the negative effects of negative self-perception of aging on wellbeing (by the mechanism of moderation), while negative DC amplifies this association and goes along with lower well-being in persons who report negative self-perceptions of aging. Training couples in supportive dyadic coping may be a resource to buffer the negative effect of negative self-perceptions of aging on well-being.

P94: Co-design of a theory-based implementation plan for a digital holistic assessment and decision support framework for people with dementia in care homes

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Background: Despite positive findings around the use of eHealth in dementia care, evidence for its efficacy is insufficient to ensure its adoption into routine care. Early involvement of end-users in the design of an implementation plan is a key strategy for promoting translation of findings into practice.

Objective: This study aimed to identify the requirements for use of an eHealth intervention to support assessment and decision making for use with people with dementia in care homes, and co-design strategies for its implementation.

Methods: A qualitative co-design method was applied through a series of workshops. Participants included family carers of people with dementia, and health and social care practitioners with direct experience of working with people with dementia. The workshops focused on identifying requirements for use and co-developing implementation strategies in response to factors identified to influence implementation. A deductive thematic analytic approach was taken, guided by the key concepts of the Normalisation Process Theory.

Results: Three workshops were conducted from July'21-November'21, attended by 39 participants. Three overarching phases of requirements were identified: 1) incentivising adoption of eHealth; 2) enabling operation of an eHealth intervention; 3) sustaining use of eHealth. Initial adoption requires promotion of the interventions benefits to engage stakeholders, and its alignment with national recommendations for good quality dementia care. Operationalising eHealth involves ensuring its compatibility with current care home processes and technology, provision of sufficient training and support from 'champions'. To sustain its use, ongoing monitoring of the implementation plan and provision of feedback to allow stakeholders to appraise its effects is required.

Conclusions: Implementing eHealth across a complex system of care homes is a multifaceted process. Using the key requirements identified in the workshops, we have developed a multi-strategy plan centered around three phases of implementation, to promote uptake of eHealth to support assessment and decision making for people with dementia in care homes. This is strengthened through collaborating with end-users to increases its value, credibility and real-world relevance. The theoretically informed strategies target mechanisms previously demonstrated to shape the implementation process and outcomes, ready for testing in care homes.