View metadata, citation and similar papers at core.ac.uk
brought to you by CORE
provided by University of East Anglia digital repository

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56

Abstract

Dementia friendly wards are recent developments to improve care for patients with dementia in acute hospitals. This qualitative study used focus groups to understand the impact of dementia friendly ward environments on nurses experiences of caring for acutely unwell patients with dementia. Qualified nurses and healthcare assistants working in an acute NHS Trust in England discussed their perceptions and experiences of working in a dementia friendly ward environment. Four themes developed from the Thematic Analysis: 1) “It doesn’t look like a hospital”: A changed environment, 2) “More options to provide person-centred care”: No one size fits all, 3) “Before you could not see the patients”: A constant nurse presence and 4) “The ward remains the same”: Resistance to change. Recommendations and implementations for practice are discussed.

Keywords

Dementia, hospital environment, nursing, qualitative, focus groups

Introduction

An acute hospital stay can be confusing and frightening for a person with dementia, as well as impacting negatively on their physical, mental and cognitive abilities (Sampson et al. 2014; Boaden 2016; Dewing and Dijk 2014). People with dementia have reported their experience of hospital care as distressing because they were ignored by staff who failed to adequately explain what was happening (Codwell 2011). This is a very significant issue as a quarter of all hospital beds in the UK are occupied by a person with dementia (Thompson et al. 2011).

In the UK, the Department of Health published the National Dementia Strategy (Department of Health 2009a) alongside recommendations to improve dementia care in acute hospitals (Department of Health 2009b), both of which have now been superseded by the Prime Ministers Challenge on Dementia 2020 (Department of Health (2015). The Scottish Government (2010), Welsh

1
2
3 Assembly Government (2011) and the Department of Health (2011) developed regional strategies to
4
5 support people with dementia, including recommendations for improvement of care in acute
6
7 hospitals. The policy focus on improving dementia services across health and social care has
8
9 continued through the Prime Minister's Challenge on Dementia 2012 and 2020 (Department of
10
11
12 Health, 2012, 2015), which emphasises an integrated approach but also the need to continue to
13
14 improve acute care.
15
16
17 Initiatives to improve care for patients with dementia in hospital have targeted the workforce and
18
19 the patient. Strategies to develop the workforce include dementia awareness
20
21 training and education, provision of support through the development of both dementia champions
22
23 and clinical roles with a specific focus on dementia (Banks et al. 2014; Mayrhofer et al. 2015). Patient
24
25 initiatives identified patients with cognitive impairment through screening on admission, employed
26
27 application of symbols on patient notes and above bed spaces involving butterflies or forget-me
28
29
30 nots, provision of meaningful activities and person-centred care (Pendlebury et al. 2015; Brooke and
31
32 Herring 2016). These and other initiatives to improve care for patients with dementia have occurred
33
34 alongside changes to the environment in the NHS hospital where this study was based (refer to Box
35
36 1).
37
38
39 Traditional hospital ward environments were not designed to promote independence or
40
41 support patients with perceptual and visuospatial difficulties and yet these are prominent symptoms
42
43 in the most common types of dementia (Karantzoulis and Galvin 2011). Therefore, negotiating
44
45 environments with poor lighting, signage, clutter and white walls, ceilings and floors may
46
47
48 be difficult for patients with dementia. For example, in a synthesis of the evidence Houghton
49
50 et al. (2016) reported that patients with dementia found it difficult to find their way around a
51
52 hospital ward due to the repetitive décor. The busy and noisy environment with a large number
53
54 of-healthcare professionals caring for each patient is also problematic for, patients
55
56 with dementia, as they report difficulties in keeping-up with this fast-paced

environment (Moyle et al. 2008). The impact of this negative environment for patients with dementia is the likelihood of increased agitation, confusion and distress, a reduction in mobility and social interactions and leading to a risk of further health complications (Waller and Masterson 2015).

Recently, the design of ward environments has begun to receive attention and a number of guidelines have been produced (Fleming and Bowles 2004; Topo et al. 2012). The King's Fund project 'Enhancing the Healing Environments' (EHE) was a programme developed to support environment changes to hospitals across 26 NHS Trusts. From this project five overarching design principles were identified (The King's Fund 2013). Each of the design principles addressed outcomes that were important for patients with dementia, with overall aims to support decision-making, reduce agitation and distress, improve independence of activities of daily living, and increase socialisation and safety (Waller and Masterson 2015). The design principles include space for meaning activities, such as books, games and reminiscence activities but also provide outdoor spaces, handrails and areas to walk with resting points. They ensure improved legibility of signage, and supportive lighting, flooring, uncluttered areas and discreet security measures; improved orientation and way-finding through clocks and calendars, inclusion of natural light, removal of nurse stations to increase visibility of staff and also the use of colours and artwork to identify bays and individual bed areas. Lastly, they ensure familiarity can be enabled through dining areas utilizing traditional cutlery and crockery and containing personal items and photographs (Waller and Masterson 2015).

An evaluation of the King's Fund EHE Programme found a significant reduction in patient's agitation and distress and a reduction of patient falls in corridors and lounges (The King's Fund 2013). Sprinks reported similar results from the Taunton Somerset Foundation Trust, including a reduction in falls and incidences of violence involving people with dementia following dementia friendly environment changes in their hospitals.

The focus of improving hospital environments for patients with dementia has been sustained through a joint initiative between the NHS Institute for Innovation and Improvement and the Dementia Action Alliance with the launch of the Dementia Friendly Hospital Charter (2014). The goal of the Charter is for every hospital in England to be committed to becoming a dementia-friendly hospital environment, with a pledge and plan of action such as: signage that includes pictures and text, toilet doors being painted a single distinctive colour and toilet seats and hand rails in a colour that contrasts with the walls and floor, pictures/objects or colours to help people find their way around, and seating areas provided in wards and corridors. Further elements of environmental changes recommended by the Royal College of Nursing (2013) include: appropriate lighting and floor coverings, personalizing bed areas, adequate space and resources to support activity and stimulation.

Policies from government bodies and third sectors all recognise the importance of a dementia friendly environment to care for people with dementia (Innes et al. 2016). The dementia friendly environment changes observed in some acute NHS Trusts have been driven forward by nurses but how these changes impact on the care nurses provide for patients with dementia has not been reported (Sprinks 2012). The development of specialist roles for healthcare assistants to support patients with dementia have been implemented and evaluated, but not with specific reference to the impact of environment changes in the acute setting (Brooke and Herring 2016). The aim of this study was to explore how dementia friendly ward environments in an acute hospital impacted on the care nurses and health care assistants provided for their patients with dementia.

Methods

Design

A qualitative methodological approach was used to gain an understanding of qualified nurses' and healthcare assistants' perceptions of the impact of the dementia friendly ward environments on the care they provide for patients.

Qualitative data were collected via focus groups with nursing and healthcare staff. There were a series of carefully planned group-based discussions, designed to elicit perceptions of the staff providing direct care for patients (Krueger and Casey, 2009). Participants were recruited from a purposive sample, where existing relationships and social context of participants would support a deeper understanding of the topic (Githaiga 2014; Brown 2015). Focus groups provide a natural environment for participants with a shared culture (Kitzinger 1994), therefore staff were influencing and being influenced by each other (Hollander, 2004) much like they would in the clinical setting. The focus groups were structured to allow a small number of staff to share their perceptions and experiences of working in a dementia friendly environment, but were also large enough to obtain a range of experiences (Krueger and Casey, 2009).

Ethical approval was gained from the NHS Trust where data were collected. All participants were provided with a participant information sheet and given time to ask questions. Written, informed consent was provided by all participants prior to the commencement of a focus group. Anonymity within the focus groups was not possible due to the nature of the focus group design but confidentiality about the discussions outside of the group was assured, unless an aspect relating to patient or staff safety was raised. During transcription, focus group members' names were not recorded.

Setting

The study was completed across three wards within a District General Hospital (DGH) in England. The core catchment population for this DGH is 500,000. An estimated 12 people with dementia out of 100,000 of the DGH's catchment population are admitted to hospital at any one time. Extensive dementia friendly environment changes had been undertaken on each ward. The environment

changes were based on the recommendations of Dementia Friendly Hospital Charter (2014) and the Royal College of Nursing (2013), refer to Box 2 for an overview.

Participants

Qualified nurses and healthcare assistants were recruited from one of three dementia friendly wards through study flyers posted in staff rooms and the introduction of the study and provision of participant information sheets during monthly staff meetings.

Participants were junior qualified nurses (n=17) and healthcare assistants (n=21).

Procedure

Focus groups were held in seminar rooms within the chosen hospital site during routinely allocated weekly teaching sessions. The first author (JB) facilitated all focus groups, which were held from September through October 2015. Ten focus groups were carried out in total, three with just healthcare assistants, two with just qualified nurses and five comprised healthcare assistants along with qualified nurses (refer to Table 1). These variations occurred naturally and no attempt was made to control for group membership.

Analysis

Focus group discussions were audio recorded, transcribed verbatim and analysed using an inductive Thematic Analysis (Boyatzis 1998); Braun and Clarke 2006). Transcripts were read several times in order to become familiar with the text, relevant extracts to the study aim were highlighted, and

coded (Rice and Ezzy 1999). These codes were developed into a number of themes. This initial analysis was then reviewed with the second author, before being refined and organized into overarching themes. Throughout, the analysis followed a reflexive and iterative process.

Results

Four themes developed from the narratives exploring the impact of the dementia friendly ward environments on qualified nurses and healthcare assistants. These were: 1) “It doesn’t look like a hospital”: A changed environment, 2) “More options to provide person-centred care”: No one size fits all, 3) “Before you could not see the patients”: A constant nurse presence and 4) “The ward remains the same”: Resistance to change.

“It doesn’t look like a hospital”: A changed environment

The impact of the dementia friendly environment changes was the development of wards that no longer looked or felt like traditional hospital wards. A number of nurses viewed their dementia friendly ward as no longer being cold and clinical. Instead the bright colours depicted warmth and happiness, providing the impression of a non-clinical environment and a ‘homely atmosphere’, where patients could familiarise themselves with their bed space, which reminded them of home:

> I’ve never worked on another ward but I’ve obviously been on other wards and for me personally and for patients its easier because there are lots of colours, a lot of pictures and stuff they can familiarise themselves with because with other wards it’s just quite white and clinical and boring. (Focus group one, healthcare assistant)

One participant felt that the outcome of the change resulted in an environment that was no longer indicative of a clinical setting:

> Here it is quite warm and a nice atmosphere, even when I came in for the first time, I thought ‘wow this is nice, it doesn’t look like a hospital’. (Focus group six, healthcare assistant)

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57

Staff discussed the pictures displayed within the bays and along the ward corridors, which facilitated and supported interactions with patients and relatives. Staff felt the pictures acted as a focal point and the relaxed atmosphere created from the environment changes were seen as enabling new ways of communicating. These conversations supported staff, patients and their families to get to know and understand each other outside the provision of clinical information and a hospital orientated environment:

> The pictures are very good. We had a patient before, when there was a picture with two young girls in a field with a wooden gate, I think they were just sat there… and one of the patients was looking and he looked and it jogged his brain and he remembered all of his grandchildren. I thought that was fantastic and then he talked about them, it was really nice. (Focus group ten, healthcare assistant)

Importantly these interactions supported the commencement of collaborative working between nurses and patients and their families:

> The pictures in the corridor they all (patients and relatives) stop to look, because we have one old photograph and no one knows which street it is, so that one we all stop and try and figure out where it is… (Focus group three, qualified nurse)

The dementia friendly wards were viewed positively by staff, as a non-clinical environment supported them to provide care and support to patients and their families in a relaxed and homely ward that enhanced collaborative working.

“More options to provide person-centred care”: No one size fits all

Staff described the impact of the environment changes as enabling them to provide care dependent on a patient’s individual needs and being supportive of the delivery of person-centred care. They reported a positive impact on patients’ behavioural and psychological symptoms of dementia:

1
2
3 It does help actually (the changes to the ward environment), I would say the patients are less
4
5 agitated than they were before… (Focus group three, qualified nurse)
6
7
8 This member of staff also felt that the environment as it was now provided more choices to care for
9
10 people with dementia, which in turn allowed them to move away from traditional based care and
11
12 assess patients individually and support their psychosocial needs, as well as their health needs
13
14 during an acute admission:
15
16
17 At least you have more options to use to calm them (patients) if they are agitated, because we
18
19 have the sensory machine, now at least we have options of things to use. (Focus group three,
20
21
22 qualified nurse)
23
24 Although the principles of person-centred care were the focus of care, some patients with dementia
25
26
27 experienced distress at the environment changes implemented on the wards and
28
29
30
31
32
33 staff felt this needed to be recognised and acknowledged by managers:
34
35
36 The environment changes impact on patients differently.. we had a patient with dementia and
37
38 an acute delirium, who was really scared of the picture opposite her…she kept asking 'who is
39
40 standing there, is that my dog?' She must have a pet at home.
41
42
43 But generally, those patients with mild dementia who are waiting to go home, it distracts them
44
45 from doing other things, which can make them at risk of a fall. (Focus group two, healthcare
46
47 assistant)
48
49
50 Therefore, the changes did not impact positively on all patients. One nurse reported a patient who
51
52 found the inclusion of pictures disturbing and increased their agitation:
53
54
55 I had one patient a long time ago who was in the seaside bay and she was next to a boat in the
56
57 window and she started getting more confused and she said she thought she was on the boat

and when is the next stop as she wanted to get off the boat. So, with that patient.. I don't think the pictures were helpful. (Focus group seven, qualified nurse)

An element that appeared to impact negatively on patients were the transfers applied to the windows and staff discussed the need for patients to see the outside world and not to feel enclosed:

> I have to say, they have some kind of pictures on the windows, like stained glass but not (opaque transfers). I really hate them because the patients sometimes they want to look out of the window but they can't and I actually despise those pictures. I think they should go. (Focus group six, healthcare assistant)

> I don't know why they put those transfers on the windows, personally I don't like them, because patients don't know if it is day time or night time. (Focus group eight, qualified nurse)

> The windows have transfers, massive mistake, patients look out of the windows and can't make head nor tail of what is going on because the transfer covers the window. I don't think that was a good idea at all and relatives say the same thing and they (transfers) make the bays more enclosed and the patients get really confused. (Focus group nine, healthcare assistant)

Staff discussed the dementia friendly environment changes from a person-centred approach, and the need to understand the personhood of each individual in their care. Therefore, pictures and warm colours may support some patients, whilst causing distress to others. Although the transfers on windows that obstructed the view of the outside world impacted negatively on all staff and patients.

"Before you could not see the patients": A constant nurse presence

One element of the environment changes that emerged in all ten focus groups was the impact and experience of the removal of the nursing station from each ward. All staff were surprised by this

change and how it challenged their routine of completing their documentation away from their patients, positioned behind the nursing station. The environment changes along with ward managers' support meant staff used small tables within each bay to complete their documentation. The majority of staff expressed positive comments but only after they had become accustomed to this new way of working. Early on they found the imposed changes difficult:

> In the beginning we were not very happy, we have to be honest, we weren't. We were not very happy, before the changes our nurse station was small and now it is even smaller! (Focus group eight, qualified nurse)

Staff did adapt though and reported the benefits of completing documentation in the bays as it brought them into closer contact with the patients and helped them to be more specific about the care and intervention they have provided:

> I think it is quite nice to sit in a bay and do notes as it also prompts you who you are writing about and what you need to write. Yes, it was difficult in the beginning but we have now got used to it. (Focus group eight, qualified nurse)

> The tables in the bays, I like them as well. So, when you are doing your assessments you are right there and you can see the patient you are writing about. (Focus group five, qualified nurse)

Staff openly admitted that at certain times of the day, the nursing team would be found out of the way, behind the nurses' station completing their documentation and acknowledged this wasn't good for patient care. One member of staff acknowledged that the advantages of writing by the patients meant they could observe them and even potentially prevent falls:

> If you came before the environment changes, all of us were writing our notes in the day room, which I think is worse because you cannot see the patients and with these patients some of them are really confused and it is easier if you are writing and you can watch them

to prevent falls and to prevent injuries and so I think it is easier and much better if you are writing near the patients and not altogether in a big room. (Focus group seven, qualified nurse)

However, not all the nurses were positive and found the removal of the nursing station detrimental to their documentation.

It is not safe for us (completion of nursing documentation in the bay next to the patient). If something happened and you do not document it, it is us who will get into trouble not them (managers) but it is us who always get told off for not writing in the bay. They (managers) must know, they are also nurses, they must know that the documentation is vital for us but… (Focus group four, qualified nurse)

The majority of staff were supportive of the removal of the nursing station and the active encouragement to complete their documentation in the bay with their patients. This approach supported detailed documentation as well as remaining with their patients to ensure continuation of care. Only a minority of staff felt this approach was unsafe as felt the patients distracted them from completing their documentation accurately and fully.

“The ward remains the same”: Resistance to change.

There were, however, a number of ways that staff struggled with the changes. A minority of staff had misconceptions that ward changes would actually ‘improve’ patient’s dementia, rather than be a supportive approach for them to care for these patients. Other staff didn’t understand why some of the environment changes had been implemented (such as the new ward colour) and therefore could not understand how the changes would address some of the issues they thought were challenging when caring for patients with dementia.

> I have worked here for eight years, before when the ward was one colour; honestly for myself I don't think this is the process to improve dementia that is my opinion. (Focus group one, healthcare assistant)

> Even though they have spent all this money and changed the environments the problems of caring for patients with dementia remain the same, the changes to the environment have not changed that. (Focus group four, qualified nurse)

These views led some staff to be resistant to embracing and interacting with the environment changes, and they did not use the new techniques and resources available to them when caring for patients with dementia, and therefore did not observe any benefit from these changes. A minority of staff openly expressed that they lacked the understanding of what was the purpose of the dementia friendly environment:

> Unless they explain to us what the purpose of these changes (environment) are, why they are putting this green colour, blue… maybe we would try to understand but at the moment speaking for myself I do not see the point. (Focus group four, healthcare assistant)

More importantly, staff expressed that staff shortages meant that the environmental changes and the provision of new techniques and resources were difficult to adopt:

> You just need to give time to them (patients with dementia) and unless we have enough staff… let's be practical how can we? Sometimes you just end up frustrated. (Focus group four, healthcare assistant)

The dementia friendly ward environment changes were completed two years prior to this study, and yet a small number of staff remained resistant in accepting this approach to dementia care. Therefore, these staff could not or would not envisage the benefits the changed environments provided in supporting patients care or the positive impact for patients and their relatives generally.

Discussion

The ward environment changes were received with mixed reactions by both qualified nurses and healthcare assistants. Staff expressed the view that the environment was experienced as less clinical, appeared warm and friendly, and supported interactions with both patients and their families. The environment changes impacted on the care staff provided in two ways, first through providing them with more options to care for people with dementia and secondly providing an environment where they were closer to their patients throughout their working shift. However, a few staff were resistant to change and thought the environment changes did not make a difference on the care they provided. These staff felt the removal of the nursing station and the encouragement to complete their documentation in the bay with their patients was unsafe practice. This resistance was shown by a minority of staff as most felt completing their documentation with their patients was a positive approach to both caring for their patients and for more accurate documentation.

Staff discussed being close to their patients throughout the shift and generally felt this was a positive change and a benefit for patients. However, the presence of staff by may not be a factor for improving dementia care, as the presence of nurses who engage with their patients has been highlighted by patients with dementia as creating a feeling of safety and a safe environment (Eduardsson et al. 2011). This element was not specifically discussed by nurses in the present study, although staff reported being continuously present and responding quickly should a patient need support or assistance, which they believed reduced the number of falls.

The dementia friendly changes to the environment supported the introduction of bay nursing, this is where nurses remain in a bay to care only for those patients. This approach to nursing ensures each bay of patients has a dedicated nurse and health care assistant, who remain in the bay throughout their shift to support patients and to complete their documentation. Bay nursing has been implemented at Addenbrooke's Hospital, England on a specialist ward for dementia and delirium care, which included an element of staff engaging in activities outside of normal care with patients

and their families (Bray et al. 2015). The impact of both bay nursing and encouragement in activities were: reduction in falls from nine in one month to one in six months, no hospital-acquired pressure ulcers and patients reported feeling safer and more involved in their care (Bray et al. 2015). Although bay nursing had been incorporated in the present study, staff had not been encouraged to engage in activities outside of normal care with patients and their families, therefore the reduction in falls demonstrated by Bray et al. (2015) might not be generalizable. The importance of environment changes and new ways of working for nurses, such as engaging in activities with patients and their families appears to be essential to change dementia care in acute hospitals (Haesler, Bauer and Nay 2006).

Documentation of care was discussed by staff, in particular the change in completing nursing notes whilst remaining with their patients. Detailed and comprehensive healthcare records have been acknowledged as essential and assumed nurses require dedicated time to be able to complete their documentation in real time (Wood 2003). Nursing documentation is a legal requirement and outlined by the Nursing Midwifery Council as an essential element of communication for nurses (NMC 2015). Poor record keeping by nurses has been reported as the fourth most common allegation against nurses (NMC 2012), so it is understandably an important and emotive topic. The majority of nurses in the current study felt that completing their nursing notes in the bay with their patients supported the accuracy and detail of their documentation.

Clissett et al. (2013) explored the application of person-centred care through a personhood approach (Kitwood 1997) in acute hospitals and found only two of the five principles were identified: attachment and inclusion. Nurses had not incorporated the personhood principles of: identity, occupation and comfort. Good examples have been reported but healthcare professionals were not grasping all opportunities to support people with dementia to sustain their personhood (Clissett et al. 2013). The nurses in the current study discussed person-centred care and elements of attachment and comfort. Attachment within person-centred care has been described as developing

a connection in a trusting relationship with the person with dementia, and comfort has been described as closeness through touch and being physically present (Brooker 2007).

The current study explored the impact of environment changes on the care nurses and healthcare assistants provided, whereas Clissett et al. (2013) explored patients with cognitive impairment and their relatives' experience of an acute hospital stay. Despite these different approaches both studies identified the development of attachment between staff and patients, demonstrating an understanding and the commencement of person-centred care. In contrast with the findings of Clissett et al. (2013) nurses and healthcare assistants in the current study did use opportunities provided by the environment changes to engage with patients with dementia and their relatives. The wall pictures within each ward provided a focus and topic for discussion for patients, relatives and staff to get to know each other informally, supporting the development of a connection and a trusting relationship.

Staff in the current study identified the negative impact of the opaque window transfers on patients, as they were able to see out of the windows. Natural daylight has been identified as important for the health and well-being of patients in a number of hospital settings, including oncology and intensive care units (Browall et al. 2013; Trochelman et al. 2012). The design of dementia friendly wards needs to encompass evidence from other care environments, and involve people with dementia and their families to develop recommendations, especially with regard to opaque window transfers.

A large amount of research has concentrated on the impact of care environments, which have been defined to include a number of variables including: nurse recruitment/retention, job satisfaction, nurse safety and patient satisfaction (Aiken et al. 2008; Aiken et al. 2013; van Bogaert et al. 2014; Djukic et al. 2013). The most widely applied scale used to measure impact is the Nursing Work Index (Kramer and Hafner 1989) and the revised version (Aiken and Patrician 2000), which has been validated across different countries and cultures (Warshawsky and Havens 2012). The Nursing Work

Index does recognise the importance of the quality of nurse practice environment, but is not specifically related to physical environment or changes to the physical environment that support the care and independence of patients with dementia, which may in turn support nurses to provide person-centred care and impact on care environments. Currently, there are no scales which specifically evaluate the impact of the physical environment and support and care of patients in acute hospital settings.

Lastly, the minority of staff who were reluctant to engage with the environment changes and adapt to new ways of supporting people with dementia demonstrates that any environment that is well designed to be dementia friendly can be undermined by bad organization and poor staff knowledge (Andrews 2013). The hospital in the current study was addressing staff training needs through tier 1 (two hour session on dementia awareness) and tier 2 dementia training through simulation (four hour session observing and interacting with actors in different scenarios), with the commitment of matrons, managers and board members. The staff who were resistant to engage with the environment changes felt that these changes had been imposed on them, rather than working collaboratively to discuss changes planned (Davis et al 2009). The hierarchical structures and management of the acute hospital includes a focus on measurement of outcomes and a reduction in spend, which were seen negatively by these staff and felt to be the reasons for changes to the environments. This is supported in previous research, as Gifford et al. (2002) found that the culture and commitment of an organisation could influence both positively and negatively job satisfaction, empowerment and involvement of nurses. An important element in management of change within this setting is the incorporation of a nurse leader who would have been able to communicate and form relationships with staff and impact on their expectations of change. The active involvement of nurses might have impacted on their commitment to change and a reduction in resistance (Portoghese et al. 2012).

Implications and recommendations for practice

1
2
3 Acute hospital environments need to be adapted to support people with dementia, their families
4
5 and nurses. Some aspects of the environment can be adapted relatively easily and are inexpensive,
6
7 such as signage, de-cluttering of medical equipment and pictures to support personalised bed
8
9 spaces. An important aspect is the provision of facilities to support appropriate care, such as
10
11
12 creating a space for social dining and activities. Bay nursing to support nurses to remain as a
13
14 continued presence with patients is recommended, with or without the removal of the main nursing
15
16 station, but with the encouragement, training and education to support and engage with their
17
18 patients beyond the implementation of care.
19
20
21 *Limitations*
22
23
24 One limitation of this study is that it was not possible to have a cohort of staff who had worked on
25
26 the Older Person Wards before and after the environment changes, due to a high turnover of staff
27
28 and the movement of specialities around different wards. However, the participants of this research
29
30 were aware of the environment changes and the majority had worked on other traditionally
31
32 designed wards. This study focused on gaining an understanding of the impact of environment
33
34
35 changes on the care and support nurses provide to patients, and as such did not include the voices
36
37 of patients.
38
39
40 **Conclusion**
41
42 Dementia friendly wards are an important and impactful way to improve care and the lived
43
44
45 experience of people with dementia in the acute hospital setting, reducing confusion and creating a
46
47 supportive space. Implementation of dementia friendly ward environments leads to increased
48
49 contact with patients, and increased person centred care and possibly a reduction in harm. Provision
50
51 of change management strategies in future implementations' may improve staff uptake.
52
53
54
55
56 **References**

Aiken, L.H., Clarke, S.P., Sloane, D.M., Lake, E.T., & Cheney, T. (2008). Effects of hospital care environments on patient mortality and nurse outcomes. *Journal of Nursing Administration,* 38(5), 223-229.

Aiken, L.H., & Patrician, P.A. (2000). Measuring organisational traits of hospitals: the Revised Nursing Work Index. *Nursing Research,* 49(3), 146-53.

Aiken, L.H., Sloane, D.M., Bruyneel, L., van den Heede, K., Sermeus, W. for the RN4CAST consortium (2013). Nurses' reports of working conditions and hospital quality of care in 12 countries in Europe. *International Journal of Nursing Studies,* 50(2), 143-153.

Alzheimer's Society (2014) Dementia 2014: Opportunities for Change. www.alzheimers.org.uk/dementia2014 (last accessed July 2016).

Andrew, J. (2013). A guide to creating a dementia friendly ward. *Nursing Times,* 109(8), 20-12.

Banks, P., Waugh, A., Henderson, J., Sharp, B., Brown, M., Oliver, J., & Marland, G. (2014). Enriching the care of patients with dementia in acute settings? The Dementia Champions Programme in Scotland. *Dementia,* 13(6), 717-736.

Boaden, A. (2016). Fix Dementia Care – Hospitals. Alzheimer's Society: London. https://www.alzheimers.org.uk/site/scripts/download_info.php?fileID=2907 (last accessed July 2016).

van Bogaert, P., Timmermans, O., Weeks, S.M., van Heusden, D., Woutes, K., Franck, E. (2014). Nursing unit teams matter: Impact of unit-level nurse practice environment, nurse work characteristics, and burnout on nurse reported job outcomes, and quality of care, and patient adverse events – A cross-sectional survey. *International Journal of Nursing Studies*, 51(8), 1123-1134.

Boyatzis, R. (1998).Transforming qualitative information: Thematic analysis and code development Thousand Oaks, CA: Sage.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology,* 3, 77–101.

Bray, J., Evans, S., Carter, C., Brooker, D., & Milosevic, S. (2015). Improving activity and engagement for patients with dementia. *Nursing Older People*, 27(8), 22-26.

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55

Brooke, J. (2016). The challenge of nutritional support in hospital wards. *Journal of Dementia Care*, 24(2), 28-29.

Brooke, J.M., & Herring, S. (2016). The implementation of an Activities Care Crew: supporting patients with dementia in an acute hospital setting. *Nursing Older People,* 20(8), 20-25.

Browall, M., Koinberg, I., Falk, H., Wijk, H. (2013). Patients' experience of important factors in the healthcare environment in oncology care. *International Journal of Qualitative Studies on Health and Well-Being*, 8:20870.

Brown, S. (2015). Using focus groups in naturally occurring settings. *Qualitative Research,* 15(1), 86-97.

Clissett, P., Porock, D., Harwood, R.H., & Gladman, J.R.F. (2013). The challenges of achieving person-centred care in acute hosptials: A qualitative study of people with dementia and their families. *International Journal of Nursing Studies,* 50, 1495-1503.

Cowdell, F. (2010). The care of older people with dementia in acute hospitals. *International Journal of Older People,* 5(2), 83-92.

Davis, S., Byers, S., Nay, R., & Koch, S. (2009). Guiding design of dementia friendly environments in residential care settings: Considering the living experiences. *Dementia*, *8*(2), 185-203.

Dementia Action Alliance (2012). The Right Care: Creating Dementia Friendly Hospitals. http://www.dementiaaction.org.uk/therightcare (last accessed July 2016).

Dementia Action Alliance (2014). Dementia Friendly Hospital Charter http://www.dementiaaction.org.uk/rightcarecharter (last accessed July 2016).

Department of Health (2009a). Improving quality of the care for people with dementia in hospitals. London: Department of Health.

Department of Health (2009b). Living well with dementia: A National Dementia Strategy. London: Department of Health.

Department of Health (2012). Prime Minister's Challenge on Dementia: Delivering major improvements in dementia care and research by 2015. London: Cabinet Office, Prime Minister's Office.

Department of Health (2015). Prime Minister's Challenge on dementia 2020. London: Cabinet Office, Prime Minister's Office.

Department of Health Social Services and Public Safety Northern Ireland (2011). *Improving dementia services in Norther Ireland. A regional strategy.* https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/improving-dementia-services-2011.pdf (last accessed August 2016).

Dewing, J., & Dijk, S. (2014). What is the current state of care for older people with dementia in hospital? A literature review. *Dementia* doi: 10.1177/1471301213520172.

Djukic, M., Kovner, C., Brewer, C., Fatehi, F.K., Cline, D.D. (2013). Work environment factors other than staffing associated with nurses' ratings of patient care quality. *Health Care Management Review*, 38(2), 105-114.

Edvardsson, D., Sandman, P., & Rasmussen, B. (2011). Forecasting the ward climate: A study from a dementia care unit. *Journal of Clinical Nursing*, 21, 1136-1144.

Fleming, R., & Bowles, J. (2004). Units for confused and disturbed elderly: development, design, programming and evaluation. *Australian Journal of Ageing,* 6, 25-28.

Gifford, B.D., Zammuto, R.F., Goodman, E.A., & Hill, K.S. (2002). The relationship between hospital unit culture and nurses' quality of life/practitioner application. *Journal of Healthcare Management,* 47(1), 13-26.

Githaiga, J.N. (2014). Methodological considerations in utilization of focus groups in an IPA study of bereaved parental cancer caregivers in Nairobi. *Qualitative Research in Psychology,* 11(4), 400-419.

Haesler, E., Bauer, M., & Nay, R. (2006). Factors associated with constructive staff–family relationships in the care of older adults in the institutional setting. *International Journal of Evidence-Based Healthcare*, 4(4), 288-336.

Hollander, J. A. (2004). The social contexts of focus groups. Journal of Contemporary Ethnography, 33(5), 602-637.

Houghton, C., Murphy, K., Brooke, D., Casey, D. (2016). Healthcare staffs' experiences and perceptions of caring for people with dementia in the acute setting: Qualitative evidence synthesis. *International Journal of Nursing Studies,* 61, 104-116.

Innes, A., Kelly, F., Scerri, C., & Abela, S. (2016). Living with dementia in hospital wards: a comparative study of staff perceptions of practice and observed patient experience. *International Journal of Older People Nursing ,* 11, 94-106.

Karantzoulis, S., & Galvin, J.E. (2011). Distinguishing Alzheimer's disease from other major forms of dementia. *Expert Review of Neurotherapeutics* ,11(11), 1579-1591.

Kitwood, T. (1997). *Dementia Reconsidered: The Person Comes First*. Open University Press: Buckingham.

Kitzinger, J. (1994). The methodology of focus groups: the importance of interaction between research participants. *Sociology of Health and Illness,* 16(1), 103-121.

Kramer, M., & Hafner, L.P. (1989). Shared values: impact on staff nurse job satisfaction and perceived productivity. *Nursing Research,* 38(3), 172-177.

Krueger, R.A., & Casey, M.A. (2009). (4th Edition) *Focus Groups: A practical guide for applied research.* London, Sage.

Mayrhofer, A., Goodman, C., & Holman, C. (2015). Establishing a community of practice for dementia champions (innovative practice). *Dementia ,* 14(2), 259-266.

Moyle, W., Olorenshaw, R., Wallis, M., & Borbasi, S. (2008). Best practice for the management of older people with dementia in the acute care setting: A review of the literature. *International Journal of Older People,* 3, 121-130.

Nursing and Midwifery Council (2015). The Code: Professional Standards of practice and behaviour for nurses and midwifes. London: NMC.

Nursing and Midwifery Council (2012). Nursing and Midwifery Council: Annual Fitness to Practice Report 2011-2012. London: NMC.

1
2
3 Palmer, M., Larkin, M., De Visser, R., & Fadden, G. (2010). Developing an Interpretative
4 Phenomenological Approach to Focus Group Data. *Qualitative Research in Psychology*, 7(2), 99-121.
5
6
7
8 Pendlebury, S.T., Klaus, S.P., Mather, M., de Brita, M., & Wharton, R.M. (2015). Routine cognitive
9 screening in older patients admitted to acute medicine: abbreviated mental test score (AMTS) and
10 subjective memory compliant versus Montreal Cognitive Assessment and IQCODE. *Age and Ageing,*
11 44(6), 1000-5.
12
13
14
15 Portoghese, I., Galletta,M., Battistelli, A., Saiani, L., Penna, M.P., & Allegrini, E. (2012). Change-
16 related expectations and commitment to change of nurses: the role of leadership and
17 communication. *Journal of Nursing Management,* 20(5), 582-591.
18
19 Rice, P., & Ezzy, D. (1999). Qualitative research methods: A health focus. Melbourne: Oxford
20 University Press
21
22 Robinson, P., & Tyndale-Biscoe, J. (2014). Report 7: What makes a top hospital? Dementia Care May
23 2014. CHKS Insight for better healthcare.
24
25
26
27 Sampson, E.L., White, N., Leurent, B., Scott, S., Lord, K., Round, J., & Jones, L. (2014). Behavioural and
28 psychiatric symptoms in people with dementia admitted to the acute hospital: prospective cohort
29 study. *British Journal of Psychiatry,* 205(3), 189-196.
30
31
32
33 The Scottish Government (2010). *Scotland's national dementia strategy.*
34 http://www.gov.scot/Resource/Doc/324377/0104420.pdf (last accessed August 2016).
35
36
37
38 Smith, J.A., & Osborn, M. (2003). *Interpretative phenomenological analysis. Qualitative Psychology.*
39 London, Sage.
40
41
42
43 Sprinks, J. (2012). Nurses at the forefront of drive to make wards dementia-friendly. *Nursing*
44 *Standard,* 27(7), 12-13.
45
46
47
48 The King's Fund (2013). Improving the patient experience. Developing Supportive Design for People
49 with Dementia. The King's Fund Enhancing the Healing Environment Programme 2009-2012.
50 http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/developing-supportive-
51 design-for-people-with-dementia-kingsfund-jan13_0.pdf
52
53
54
55 Thompson, R., Heath, H., & Mills, N. (2011). *Dementia. Commitment to the care of people with*
56 *dementia in hospital settings.* Royal College of Nursing London: UK.

Topo, R., Kotilainen, H., & Eloniemi-Sulkava, U. (2012). Affordances of the care environment for people with dementia – an assessment study. *Health Environment Research and Design Journal,* 5, 118-138.

Trochelman, K., Albert, N., Spence, J., Slifcak, E. (2012). Patients and their families weigh in on evidence-based hospital design. *Critical Care Nurse*, 32(1), e1-e10.

Waller, S., & Masterson, A. (2015). Designing dementia-friendly hospital environments. *Future Hospital Journal,* 2(1), 63-8.

Warshawsky, N.E., & Havens, D.S. (2012). Global use of the practice environment scale of the Nursing Work Index. *Nursing Research*, 60(1), 17-31.

Welsh Assembly Government (2011). *National dementia vision for Wales. Dementia supportive communities.* http://gov.wales/docs/dhss/publications/110302dementiaen.pdf (last accessed August 2016).

Wood, C. (2003). The importance of good record-keeping for nurses. *Nursing Times,* 99(2), 26.

Box 1: Dementia initiatives implemented alongside dementia friendly ward environments

- Alzheimer's Society representatives based in in the hospital once a month to provide support and advice to patients and their families regarding dementia
- 'Information about me' booklet, which is similar to the Alzheimer's Society 'This is me' booklet but contains questions regarding information relevant to being an inpatient
- Forget-me not signage to identify patients with dementia
- Use of twiddlemuffs
- Reminiscence sessions, including museum object handling and singing
- Development and implementation of the Activities Care Crew
- Tier 2 dementia simulation training

Box 2: Dementia friendly ward environments

- themed bays with names and colours, for example Seaside bay is yellow, with the name over the entrance to the bay and pictures relevant to the seaside above each patients bed area
- flooring throughout each ward has been replaced with a matt wooden effect
- an activity room per ward, each with a different design, from a cinema to a newspaper room with local and national newspapers covering one wall and examples to browse
- designated area for social dining
- clocks and dates clearly visible in all areas
- clear signage
- distinct coloured doors for toilets and toilet seats, clinical room doors the same colour as the corridor
- large pictures along the corridors from the local area in the 1950s
- removal of each nursing station and the space converted to a social area with comfortable chairs and tables
- a sensory machine was purchased for each ward.

Table 1: Structure of focus groups

Focus Group	Participants	Roles
1	4	Healthcare assistant (x3) Apprentice healthcare assistant (x1)
2	4	Staff nurse (x2) Healthcare assistant (x2)
3	3	Staff nurse (x2) Healthcare assistant (x1)
4	3	Staff nurse (x2) Healthcare assistant (x1)
5	4	Staff nurse (x3) Healthcare assistant (x1)
6	5	Healthcare assistants (x5)
7	2	Staff nurse (x2)
8	3	Staff nurse (x3)
9	5	Healthcare assistant (x5)
10	5	Staff nurse (x3) Health assistant (x2)