

## **The experience of caring for patients with dementia within a general hospital setting: A meta-synthesis of the qualitative literature**

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## **Abstract**

**Objectives:** The optimal care of people with dementia in general hospitals has become a policy and practice imperative over recent years. However, despite this emphasis, the everyday experiences of staff caring for this patient group is poorly understood. This review aimed to synthesise the findings from recent qualitative studies in this topic published prior to January 2014 to develop knowledge and provide a framework to help inform future training needs.

**Method:** A systematic search of the literature was conducted across five academic databases and inclusion/exclusion criteria applied to the retrieved papers. A meta-ethnographic approach was utilised to synthesise the resulting 14 qualitative papers.

**Results:** Five key themes were constructed from the findings: overcoming uncertainty in care; constraints of the environmental and wider organisational context; inequality of care; recognising the benefits of person-centred care; and identifying the need for training. These themes explore the opportunities and challenges associated with caring for this group of patients, as well as suggestions to improve staff experiences and patient care.

**Conclusion:** The synthesis highlighted a lack of knowledge and understanding of dementia within general hospital staff, particularly with regard to communication with patients and managing behaviours that are considered challenging. This limited understanding, coupled with organisational constraints on a busy hospital ward, contributed to low staff confidence, negative attitudes towards patients with dementia and an inability to provide person-centred care. The benefits of dementia training for both ward staff and hospital management and peer discussion/support for ward staff are discussed.

**Keywords:** dementia, staff, hospital, communication, challenging behaviour

## Introduction

Older adults are admitted into hospital more frequently and for longer periods than younger people (Trueland, 2014) with over half of those patients having some form of cognitive impairment (Herman, 2010). In the UK, it has been shown that more than 97% of hospital staff have cared for patients with dementia on hospital wards at one time or another (Alzheimer's Society, 2009). Among health care professionals, hospital is commonly believed to be the safest place for a person with dementia with a physical health complaint (Cunningham & Archibald, 2006). However, those with dementia can experience longer hospital admissions (Bynum et al., 2004; Gutterman, Markowitz, & Lewis, 1999), a loss of independence (Zekry et al., 2009) and an increase in disruptive behaviours (Kolanowski, Richards, & Sullivan, 2002). This means that the medical problem that initiated hospital admission not only becomes harder to treat, but the hospital stay may adversely affect everyday functioning and wellbeing (Chrzescijanski, Moyle, & Creedy, 2007).

Lack of knowledge in dementia care within general hospital staff and limited available training is acknowledged to contribute to the problems of caring for patients with dementia (Alzheimer's Australia, 2014; Department of Health, 2009). There is a lack of pre-qualification dementia training for both nurses (Pulsford, Hope, and Thompson, 2006) and doctors (Hasselbalch et al., 2007; Tullo & Allan, 2011). In addition, post-qualification training can be variable, depending on factors such as the employer (Doherty and Collier 2009; Royal College of Psychiatrists, 2013) or the ability of managers to release staff from an already busy and pressurised ward environment (Griffiths, Knight, Harwood, & Gladman, 2014). This results in varying levels of knowledge and skills amongst general hospital staff. In response to this identified need, Health Education England plans to examine training

provided to all staff (Department of Health, 2014) and hence it is timely to seek to understand the experience of ward staff in more depth, in order to inform the future training provided.

When considering the experiences of staff in general hospital settings, the quantitative literature primarily focuses upon the management of aggressive behaviour, the challenge of high workloads and low staff levels, as well as the perceived need for dementia training (Bradshaw, Goldberg, Schneider, & Harwood, 2013; Gandesha, Souza, Chaplin, & Hood, 2012; Nnatu & Shah, 2009; Weiner, Tabak, Bergman, 2003). While this provides useful insights, such research is also constrained by the limitations of structured questionnaires which do not necessarily permit the exploration of in-depth participant views. However, a body of qualitative research now exists which considers staff experiences more broadly and, arguably, can permit greater understanding of some of the complexities of working with patients with dementia. Therefore, a thorough meta-synthesis of these studies is timely to bring together their findings and develop a greater theoretical understanding of this area.

To date, one review has considered the experiences of caring for patients with dementia in an acute setting (Doherty & Collier, 2009). However, this provided more of an overview of the literature and was specifically concerned with educational issues for adult health nurses. In contrast, the current paper seeks to explore and synthesise the literature relating to the experiences of a broad range of staff with responsibility for people with dementia in the general hospital setting. Using a meta-ethnographic approach (Noblit & Hare, 1988), overarching themes will be developed and the implications of these findings for dementia care will be discussed.

## **Method**

Various methods exist for synthesising qualitative research, all of which use existing research as their primary data (Barnett-Page & Thomas, 2009). For the current review, a

meta-ethnographic approach was selected (Noblit & Hare, 1988) which focuses on synthesising interpretations across studies. Following a process of induction and interpretation, this approach resembles the qualitative methods of those studies it seeks to synthesise (Britten et al., 2002). It assumes that combining studies with different epistemologies is a valid endeavour and indeed can act as a type of triangulation (Finfgeld, 2003). Thus it might be seen as adopting a critical realist or objective idealism epistemological perspective (Barnett-Page & Thomas, 2009).

### *Searching for relevant studies*

The search strategy augmented electronic database searches along with manual searching of references from relevant articles. Five databases (CINAHL, Embase, Medline, PsycINFO and Web of Science) were used. A Boolean search was conducted to allow the following terms to be combined:

- [dement\* OR Alzheimer's disease\* OR cognitive impair\* OR vascular\* OR confus\* OR memory\*]
- AND [general hospital\* OR acute\* OR ward\* OR medical\*]
- AND [staff\* OR nurs\* OR physician\* OR practi\* OR care\* OR profession\* OR health care\*].

The following inclusion and exclusion criteria were applied in order for studies to be considered. Papers were included if they (1) were written in English; (2) used qualitative methods of data collection and analysis; (3) included participants identified as a member of staff in a general hospital setting with experience of caring for patients with dementia (suspected or diagnosed) or cognitive impairment. Studies were excluded if they (1) were quantitative studies with no qualitative data; (2) were not supported by raw data such as

quotes, a fundamental selection criterion when conducting a meta-synthesis (Finfgeld, 2003); (3) were specific to offering palliative care and artificial feeding or hydrating; (4) were not published in a peer-reviewed journal. After the inclusion and exclusion criteria were applied, 14 papers were found suitable for meta-synthesis. To ensure transparency, the search strategy adopted has been detailed in Figure 1 (Bondas & Hall, 2007).

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Figure 1 here

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Findings from two papers were drawn from the same group of participants (Baille, Cox, & Merritt, 2012a; Baille, Merritt, & Cox, 2012b). However, given that the focus of each paper varied, looking at challenges of caring (Baille et al., 2012a) and strategies for providing care (Baille et al., 2012b), both were included for review.

### ***Quality appraisal***

Although some authors suggest using quality appraisal as part of their inclusion/exclusion criteria, this risks excluding relevant data (Barbour, 2001). There is also potential for confusing the “adequacy of a description of something in a report with the appropriateness of something that occurred in the study itself” (Sandelowski & Barroso, 2007, p. 136). Nonetheless quality appraisal is useful to allow description of the range of quality within the studies and reflect upon their contribution to the final synthesis (Atkins et al., 2008). The Critical Appraisal Skills Programme [CASP] (2013) was utilised, comprising of 10 questions to assess the credibility, rigour and relevance of the research. However, as well as referring to qualitative comments from the CASP (2013), comments were quantified to obtain an overall quality score (Duggleby et al., 2010). A strong score of ‘3’ denoted extensive justification and meeting of criteria, a moderate score of ‘2’ denoted addressing, but not elaborating on the issue, and a weak score of ‘1’ denoted a substantial lack in meeting

criteria or presenting justification. For each study, comments and total scores were collated (see Table 1). The papers varied in their quality with scores ranging from 15 to 27. Items such as reflexivity and ethical concerns were commonly not fully met. Additionally, although studies employed an appropriate research design, they did not always explicitly discuss their rationale for its use. While all papers were reflected in the synthesis, the weaker ones contributed least to the final themes.

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Table 1 here

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### *Characteristics of selected studies*

Detailed descriptive, demographic and methodological data were extracted from the 14 papers, as shown in Table 1. Papers included data from nurses, healthcare assistants, student nurses, medical officers, managers, occupational therapists, social workers, physiotherapists, domestic staff, receptionists and doctors (job titles may differ in different countries). However, the majority came solely from the perspective of nursing staff. The number of participants ranged between 7 and 87. The larger number originates from a study gathering data from quantitative questionnaires as well as qualitative comments. The papers were published across a 12 year period, between 2002 and 2014. Studies selected for inclusion originated mainly from the UK (Atkin, Holmes, & Martin, 2005; Baille, Cox, & Merritt, 2012a ; Baille, Merritt, & Cox, 2012b ; Calnan et al., 2012; Charter & Hughes, 2012; Cowdell, 2010; Fessey, 2007; Smythe et al., 2014), but also from Ireland (Nolan, 2006; Nolan, 2007), Sweden (Eriksson & Saveman, 2002; Nilsson, Rasmussen, & Edvardsson, 2013) and Australia (Borbasi, Jones, Lockwood, & Emden, 2006; Moyle, Borbasi, Wallis, Olorenshaw, & Gracia, 2010). Most data were gathered using focus groups or semi-structured

interviews. While the studies utilised a number of analytic approaches, thematic analysis accounted for the majority.

### *Analysis of the papers*

The seven steps of a meta-synthesis described by Noblit and Hare (1988) are an iterative, rather than discrete, linear process (Pope, Mays, & Popay, 2007). They include ‘getting started’; ‘deciding what is relevant’; ‘reading the studies’; ‘determining how studies are related’; ‘translating studies into one another’; ‘synthesising translations’; and ‘expressing the synthesis’. Steps one and two were achieved through completing a thorough literature search and implementing set inclusion and exclusion criteria (as described above). With repeated reading, the original findings were noted, including key phrases, metaphors, ideas or concepts. By separating the data in this way it became easier to identify relationships, similarities and differences between the studies and provided the raw data to be synthesised.

Studies were then translated into one another by comparing and synthesising the themes emerging in one account with those in other accounts, in a step-by-step way, keeping an open mind for new themes as they emerged. Translations were compared to one another and overarching themes were formulated that were able to encompass those of the initial studies while offering a new interpretation of the findings (Sandelowski & Barroso, 2007). Table 2 indicates which themes from the original papers contributed to the final themes.

The synthesis process was conducted primarily by the first author [*initials*], who then repeatedly revised these themes with input from [*initials author 2*] and [*initials author 3*]. The final themes were then discussed with [*initials author 4*] and [*initials author 5*] who helped set them in context, validate them and together all authors agreed on the final set of themes.



## Results

The findings of this meta-synthesis are presented in terms of five key themes: overcoming uncertainty in care; constraints of the environmental and wider organisational context; inequality of care; recognising the benefits of person-centred care; and identifying the need for training. Further details on each of these themes are now described.

### *Overcoming uncertainty in care*

A number of studies suggested the ability of staff to identify possible dementia was inadequate in the general hospital (Atkin et al., 2005; Baille et al., 2012b; Borbasi et al., 2006; Moyle et al., 2010; Nilsson et al., 2013). Reasons for this varied from limited knowledge and understanding of the condition (Borbasi et al., 2006) to patients' ability to conceal their difficulties: "We're overlooking patients with cognitive impairment because many of them are fantastic at hiding their handicap" (Nilsson et al., 2013, p. 1685).

When cognitive impairment had not been previously diagnosed but was suspected, patients were rarely formally assessed to confirm diagnosis or establish needs (Atkin et al., 2005; Borbasi et al., 2006; Moyle et al., 2010; Nilsson et al., 2013). Instead, staff relied on subjective judgement: "Nurses would say 'this patient is a bit off or a bit confused', but no one actually sat down and completed a thorough assessment to find out why" (Borbasi et al., 2006, p. 303). Again, this often related to limited knowledge of appropriate screening methods as well as lack of resources, time and training.

When patients were admitted with a known diagnosis, many staff felt uncertain about how to manage what were considered more challenging behaviours (Atkin et al., 2005; Baille et al., 2012a; Borbasi et al., 2006; Cowdell, 2010; Eriksson & Saveman, 2002; Smythe et al., 2014), such as communication difficulties, aggression and disorientation:

Sometimes I think, there's a confused patient, do I re-orientate them? Do I explain they're in hospital? Or do I just let them think they're in the middle of the Sahara

desert? I don't know what's best...I hate that feeling of not knowing what to do (Atkin et al., 2005, p. 1082).

Staff appeared to respond to these situations in different ways. Some questioned their own competency, anxious about whether they were communicating and providing care in the most appropriate way (Baille et al., 2012a; Borbasi et al., 2006; Eriksson & Saveman, 2002). Others directed their frustrations towards the individual with dementia (Fessey, 2007; Moyle et al., 2010; Smythe et al., 2014): "I was saying the same thing over and over and I wasn't getting anywhere no matter what I did...as far as I was concerned, it was like talking to a brick wall" (Smythe et al., 2014, p. 21). Both attributions left participants frustrated that the care they were providing was based upon "guess work" (Cowdell, 2010, p. 88).

Consequently, patients with dementia could often be perceived negatively (Baille et al., 2012a; Borbasi et al., 2006; Cowdell, 2010; Eriksson & Saveman, 2002; Smythe et al., 2014) and assigned powerful and pervasive labels such as "difficult" (Cowdell, 2010, p. 87). It was suggested that these ideas became entrenched within ward culture and impacted upon how staff interacted with patients: "Attitude is an issue...people with dementia are treated as second class citizens" (Baille, et al., 2012a, p. 35). Additionally, providing their care was viewed as less prestigious compared to other disciplines (Cowdell, 2010; Moyle et al., 2008). Studies therefore highlighted the need to improve the perceived status of people with dementia as well as the role of their caregivers.

### ***Constraints of the environment and wider organisational context***

Participants suggested that patients with dementia were commonly admitted to hospital due to underlying social problems, without clear medical need, often because the family were unable to cope (Borbasi et al., 2006; Eriksson & Saveman, 2002; Baille et al., 2012a). Similarly, patients whose medical condition had improved often remained on the

ward until appropriate community support could be put in place (Baille et al., 2012a; Borbasi et al., 2006, Eriksson & Saveman, 2002, Calnan et al., 2013). Referrals to residential care could reportedly take up to 12 weeks to arrange, making participants question whether patients with dementia were unjustifiably taking up beds (Borbasi et al., 2006).

Furthermore, the ward environment was considered inappropriate for confused individuals (Baille et al., 2012a; Borbasi et al., 2006; Eriksson & Saveman, 2002; Moyle et al., 2010; Nilsson et al., 2013; Nolan, 2007) as the high level of noise and stimulation often increased confusion and agitation. Additionally, a nurse in Borbasi et al.'s (2006) study identified that "the methods by which we need to ensure patient safety often compounds the problem" (p, 302). Doors would have to be locked at all times, or alternatively 'wandersome' patients required "excessive and unnatural monitoring" (Moyle et al., 2010. p. 423) and would be continuously redirected to bed. Again, this was described as frustrating and time consuming for staff.

Lack of time along with inappropriate staffing levels left staff struggling to provide even basic care, let alone care for more challenging patients (Baille et al., 2012a; Borbasi et al., 2006; Eriksson & Saveman, 2002; Fessey, 2007; Moyle et al., 2010; Nolan, 2006; Nolan, 2007). Participants described how the need to spend time with patient was "inconsistent with an organisational culture that values speed" (Baille et al., 2012a, p. 34):

I was talking to the patient while I was helping with this, trying to calm them down a bit'...there are certain managers who perceive that you don't have time for that (Baille et al., 2012a, p. 34).

Given these added pressures, patients with dementia were often ignored as staff felt they did not have time to meet their needs adequately (Baille et al., 2012b). As a nurse

commented: “I don’t feel like they were treated with dignity because of time constraints” (Baille et al., 2012a p. 34).

### *Inequality of care*

A number of studies identified that patients with physical health needs were commonly given greater priority than those exhibiting cognitive difficulties alongside their physical health needs (Atkins et al., 2005; Baille et al., 2012a, 2012b; Borbasi et al., 2006; Calnan et al., 2012; Cowdell, 2010; Eriksson & Saveman, 2002; Moyle et al., 2001; Nolan, 2007). On the one hand, this suggests a lack of knowledge and confidence in front-line staff about how to communicate with, and care for, patients with dementia (Baille et al., 2012a, 2012b; Cowdell, 2010). On the other hand, it has been argued that physical needs were simply considered more important (Borbasi et al., 2006; Atkin et al., 2005; Moyle et al., 2001; Nolan, 2007). This is best captured in the following statement: “Patients with dementia require constant attention when we have other priorities” (Borbasi et al., 2006, p. 303).

Given this hierarchy of need, one student nurse identified a common belief that patients with dementia should not be cared for in a general hospital setting, commenting: “They [other staff] see them as a nuisance ‘why are they here’...the attitude of staff is often that these people are just in the way, so they usually get ignored and left to the end” (Baille et al., 2012a, p 35). Methods were used to try to reduce the amount of time nurses were required to spend with these patients. Students or health care assistants were used as “babysitters” (Moyle et al., 2010, p. 424), allowing nurses to focus on patients with a “greater priority of care” (Moyle et al., 2010, p. 424). Alternatively, disruptive patients with dementia were “put in corridors so that others could sleep” (Eriksson & Saveman, 2002, p. 82) or, as the same study reveals, given high doses of sedatives to minimise their behaviours. Participants expressed that patients with dementia did not receive the same quality of care for their mental

or physical condition as those in need of equivalent medical care without dementia (Atkin et al., 2005).

### ***Recognising the benefits of person-centred care***

Despite the sometimes negative attitudes towards patients with dementia, in all but one study (Smythe et al., 2014) participants acknowledged the importance of providing person-centred care and recognising the individual rather than simply their dementia: “It’s alright having the medical info, but...people deserve more than that. They’re real people...you know, they’ve got a personality” (Charter & Hughes, 2012, p. 584).

Important in providing individualised care was building a good relationship with patients (Baille et al., 2012b; Borbasi et al., 2006; Nilsson et al., 2013; Nolan, 2006; Nolan, 2007): “You have to build up a kind of friendship...trust...the confused patient needs trust as much as anyone else” (Nolan, 2006, p. 211). Promoting this relationship was suggested to make a “real difference to patient well-being” (Borbasi et al., 2006, p. 304). However, only one student in all 14 papers gave a specific example of relationship building, explaining “When I give personal care I tend to ask the patient about their life, what they did when they were younger etc.” (Baille et al., 2012b, p. 23). More common were discussions regarding the barriers to building relationships. It was recognised that establishing a bond took time and “authenticity” on the part of the staff member (Nolan, 2006). However, a pervasive narrative running through all studies was that time was limited and communication was considered difficult.

It was also considered important to maintain a person’s independence (Baille et al., 2012a; Baille et al., 2012b; Fessey, 2007; Nolan, 2006). Examples included encouraging patients to complete their own activities of daily living and giving patients a role on the ward e.g. helping to fold laundry. However, time pressures again made it difficult to regularly

engage with patients and, therefore, staff preferred to avoid these additional aspects of care rather than be unable to maintain them.

Team reflection was considered a useful way of sharing ideas about how best to care for patients, as well as documenting relevant information (Baille et al., 2012b; Borbasi et al., 2006; Charter & Hughes, 2012; Eriksson & Saveman, 2002). This was because “everyone’s had experiences with the same patient and some people have built up a relationship with them...is that something other people can learn from?” (Charter & Hughes, 2012, p. 586).

### ***Identifying the need for training***

Given over-arching feelings of uncertainty and sometimes reluctance to care for patients with dementia, all studies highlighted a need for better education and training. While only two papers (Baille et al., 2012a; Baille et al., 2012b) discussed this need prior to qualification, most wanted training once in post. It was identified that this should be delivered to all members of staff “because everyone interacts with them” (Charter & Hughes, 2012, p. 587). Interestingly, nursing assistants who arguably provide the greatest amount of direct care felt they had the least preparation “I mean as much as I love my job...I could never say I know what I’m doing” (Smythe et al., 2014 p. 20).

Despite this resounding need, in-service training appeared to be infrequent and often considered inappropriate. The most common criticism of limited training was that it relied too much on theoretical principles that did not always transfer to a ward environment (Charter & Hughes, 2012; Borbasi et al., 2006; Cowdell, 2010): “It’s just slide after slide...somebody talking away and you switch off...when there’s stuff to act out, that’s the way I learn best” (Charter & Hughes, 2012, p. 583). A difficulty applying theoretical principals to an acute

environment was again linked to a shortage of time and resources: “It’s all good and well when you’re sitting in a class room, but when you’re actually putting it into practice, you don’t have a lot of time, you know, or the staff” (Smythe et al., 2014, p. 21).

Participants suggested various methods that might assist their understanding of dementia. It was considered that learning and reflecting with colleagues would provide support and enable the sharing of techniques that had proved successful with certain patients (Charter & Hughes, 2012). Additionally, observation of those with more experience was commonly requested: “How do you teach for dementia? The range is so huge...you need to observe someone doing it” (Smythe et al., 2014, p. 21). Alternatively, it was suggested that: “speak[ing] to someone with early onset dementia [sic; it appears the participant meant someone at the early stages of dementia], that would be really good training, for them to explain how they sometimes feel” (Charter & Hughes, 2012, p. 584, comments in square brackets added).

Staff members who had received training with both a theoretical and psychosocial element reported considerable benefits: “I think it gave me more patience, more confidence in how to talk to them and more understanding that they don’t always mean to do things that they do” (Smythe et al., 2014, p. 23).

## **Discussion**

Supporting people with dementia in general hospitals is a current area of focus in health, social and political arenas (Department of Health, 2015). In order to develop outstanding general hospital services that meet the needs of people with dementia and their families it is paramount to understand staff experiences of providing care to this population.

### *Person-centred care*

Within this review, person-centred care was recognised as important in the care of people with dementia in general hospitals in all but one study (Smythe et al., 2014).

Examples of particular aspects of person-centred care relevant to general hospital settings were building relationships and maintaining patient independence (e.g., Baille et al., 2012b, Cheston & Bender, 2003; Edvardsson et al., 2010). Staff recognised that building trust with a person with dementia, understanding their behaviour and encouraging them to maintain activities of daily living would likely contribute to the person's well-being.

Despite this recognition of the importance of person-centred care, there were a number of barriers that made implementing it a challenge. Firstly, it was suggested that staff were hampered by time or resource limitations (Borbasi et al., 2006). Secondly, staff highlighted a lack of confidence and competence in identifying the needs of people with dementia and in dealing with behaviour that challenges. For example, knowing what to do or say when people were disorientated or repetitive (e.g., Atkin et al., 2005). Staff also felt unable to identify levels of cognitive impairment accurately. Thirdly, there were examples of negative attributions being made towards people with dementia; Smythe et al. (2014) described staff members who attributed the challenges associated with caring as being the fault of the person with dementia. As attributional theory predicts, 'helping behaviour' is less likely to occur if cause is attributed to the person being helped (Weiner, 1985). Finally, the noisy and stimulating environment of a general hospital ward was highlighted as a factor in increasing levels of confusion and agitation. It may therefore be important to consider the features of a dementia friendly hospital as recently outlined by Waller and Masterson (2015), particularly in the use of large-scale signage to better denote spaces and places on the hospital ward, the removal of shiny floors to remove any doubt that the surface is wet and increase opportunities to walk around the ward safely.



### ***Staff perception of their role and the need for training***

Many staff stressed the priority of their job as being to care for the physical health needs of patients (e.g., Borbasi et al., 2006). Managing behaviours associated with dementia was not seen as part of their role and this often led to patients with purely physical health needs being given greater priority than those also exhibiting cognitive difficulties (e.g., Calnan et al., 2012). Staff frustration was further exacerbated by their feeling that people with dementia were sometimes admitted because a family were unable to cope rather than because of a clear medical need (e.g., Baille et al., 2012a). The role of providing extra support to people with dementia during a stay in hospital often fell to students and healthcare assistants, for example if patients were ‘wandersome’ and required increased monitoring.

Despite there being a general reluctance to care for people with dementia, all studies within the review highlighted a need for more education and training, which was viewed as necessary both for qualified staff and for healthcare assistants and students. Staff highlighted that training should be directly applicable to ward environments and should increase their confidence in dealing with challenging situations. Encouragingly, the use of views of people with dementia to inform education was also acknowledged as important, as well as ongoing team reflection (Charter & Hughes, 2012).

### ***Organisational change***

A key barrier for staff providing person-centred care was working in an “efficiency-driven organisation” (Nilsson et al., 2013, p. 1686). Spending time with patients getting to know them was not seen to be a priority for senior staff or hospital management and therefore with low staffing levels, it was very difficult for staff on the ward to prioritise this.

Addressing this issue requires intervention at a higher level than the ward, to ensure that senior clinical staff and managers understand that knowing patients as individuals, and giving

them time to complete tasks, is an intrinsic part of person-centred care, and this takes time. Hence dementia training needs to be targeted not just at a ward level, but also at a managerial one, if issues such as low staffing levels and the pressure to complete medical tasks quickly are to be addressed.

### ***Clinical and research implications***

The majority of studies within our review acknowledged the importance of person-centred care. Whilst this is encouraging, many barriers to the delivery of such care were identified. A primary way to address most barriers was suggested to be further training in dementia care for general hospital staff; this is consistent with a wealth of evidence that dementia education for healthcare professionals from all disciplines should be improved (Department of Health, 2009; Doherty & Colier, 2009; Tullo & Allan, 2011). The UK is currently addressing this; recent national training programmes have been mandated to ensure that all NHS staff looking after patients with dementia receive foundation level training to help staff spot early signs of dementia and support the development of their communication skills (Department of Health, 2014; RCN, 2013). Our review suggests training that would be of particular benefit: i) would be tailored specifically for general hospital ward environments; ii) would improve confidence; iii) would shift perceptions about the causes of challenging behaviour; iv) would help staff to view their job role as addressing the needs of people with dementia. Although limited, evidence from recent studies suggests that dementia training programmes undertaken within general hospitals can improve staff knowledge and confidence (Elvish et al., 2014; Galvin et al., 2010) and shift staff towards more person-centred perspectives regarding behaviours that challenge (Elvish et al., 2014). Further studies to investigate this would be of benefit and focus must also now turn to investigate the impact of training on direct patient care. In addition, training should also be directed at senior staff and those in managerial roles. Implementing person-centred care has implications for how

wards are staffed, and indeed for how overall medical care should be designed. A recent UK programme which aimed to improve the care of people with dementia in hospital implemented across nine NHS trusts found that the results were most positive when the trust/senior management were fully in support of the programme (Royal College of Nursing/University of Worcester, 2014).

### ***Limitations***

The majority of studies were undertaken with staff from a nursing background. Only Calnan et al.'s study (2013) included non-clinical staff such as domestic staff and administrators. Given that "everyone interacts with them" (Charter & Hughes, 2012, p.587), the review is limited in that it predominantly portrays the experiences of nursing staff. Secondly, the findings in this review are based on studies conducted in three western countries and therefore may not represent countries with very different cultures or models of healthcare provision. Finally, it was not always clear what specialty staff worked in. It was therefore difficult to explore whether certain branches of medicine and nursing held differing experiences of working with people with dementia.

### **Conclusion**

The care of people with dementia in general hospital settings is of paramount importance yet this review highlights it is challenging for a variety of reasons. Staff can lack confidence and competence in identifying cognitive difficulties, in assessing the needs of people with dementia and in responding to behaviour that challenges. In addition, ward design and environments are often not dementia friendly which can exacerbate confusion and agitation in people with dementia. Furthermore, low staffing levels and pressure to perform medical care efficiently means staff are not able to spend the necessary time with people with dementia, and thus their physical as well as psychosocial needs can go unmet.

Staff training, specifically tailored to a hospital setting, is clearly required and indeed is requested by both qualified (e.g., nurses) and non-qualified (e.g., healthcare assistants) staff. However, it must not be overlooked that the majority of staff within this review identified the importance of person-centred care. This suggests that issues must also be addressed at an organisational level if staff are to be in a position to provide care which meets the needs of people with dementia. Person-centred care needs to be valued by senior staff, in order that hospital culture and design enables this care to be provided.

The care of people with dementia within general hospitals raises a number of complex issues; the increasing emphasis on supporting people with dementia to live well within our neighbourhoods and communities means that it is an area which is set to receive increasing clinical and research focus in the years to come.

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*Table 1: Salient information from included papers including CASP score*

<b>Study</b>	<b>Sample</b>	<b>Gender</b>	<b>Location</b>	<b>Country</b>	<b>Focus</b>	<b>Sampling strategy</b>	<b>Data collection</b>	<b>Data analysis</b>	<b>CASP score</b>
Atkin, K., Holmes, J., & Martin, C. (2005).	19 registered staff nurses	Female $n = 17$ Male $n = 2$	Sites within an acute hospital trust	United Kingdom	Training needs of general nurses to care for patients with dementia	Not stated	Focus groups	Framework Analysis	19
Baille, L., Cox, J., & Merritt, J. (2012a).	20 2 <sup>nd</sup> and 3 <sup>rd</sup> year students, 6 in each focus group	Not stated	Recruited from one university in England	United Kingdom	Explore adult nursing students' experiences of the challenges of caring for	Self-selection following receipt of information packs	Focus groups	Thematic Analysis	25

					older people with dementia in hospital				
Baille, L., Merritt, J., & Cox, J. (2012b).	20 2 <sup>nd</sup> and 3 <sup>rd</sup> year students, 6 in each focus group	Not stated	Recruited from one university in England	United Kingdom	Explore adult nursing students' experiences of appropriate strategies for caring for older people with dementia in hospital	Self-selection following receipt of information packs	Focus groups	Thematic Analysis	25
Borbasi, S., Jones, J., Lockwood, C., & Emden, C.	4 senior medical officers, 5 clinical nurse consultants, 3 clinical nurses, 3	Not stated	3 large teaching hospitals	Australia	Health care professionals' experiences of managing patients who	Purposive sampling – healthcare professionals identified by	Semi-structured interviews	Thematic Analysis	26

(2006).	nurse unit managers, 1 registered staff nurse, occupational therapists, 3 social workers, 1 assistant director of nurses, 1 physiotherapist				have dementia but are in hospital for treatment of non-dementia related illness	key personnel. Self-selection if they wished to participate			
Calnan, M., Tadd, W. Calnan, S., Hillman, A., Read, S., & Bayer, A. (2012).	Ward managers, registered staff nurses, healthcare assistants, domestic staff, receptionists, doctors, physiotherapists,	Not stated	Four wards in four clinical areas in four trusts	United Kingdom	To identify aspects of the ward environment and activity, processes and organisation that maintain and challenge	Self-selection	Semi-structured interviews	Thematic Analysis	25

	occupational therapists				dignity of older people from the perspective of staff (as well as patients and relatives)				
Charter, K. & Hughes, N. (2012).	4 registered staff nurses, 3 healthcare assistants	Not stated	Mixed gender acute elderly medical ward	United Kingdom	To consider dementia education for healthcare workers in hospital from the perspective of staff nurses and healthcare assistants	Self-selection following receipt of information sheet	Focus groups	Grounded Theory	24

Cowdell, F. (2010).	18 interviews with registered staff nurses and healthcare assistants	Not stated	3 wards in one acute hospital	United Kingdom	To explore the experiences of nursing staff (and patients) of the care received by older people with dementia in acute hospitals	Not stated	Semi-structured interviews	Grounded Theory	27
Eriksson, C. & Saveman, B. (2002).	12 registered staff nurses	Female <i>n</i> = 12	5 acute wards, 1 A&E department	Sweden	To describe nurses' experiences of difficulties related to caring for	Possible participants selected by managers and consent given	Semi-structured interviews	Thematic Analysis	24

					patients with dementia in acute care settings				
Fessey, V. (2007).	87 registered staff nurses	Not stated	“Acute hospital wards”	United Kingdom	To explore the knowledge, understanding and implications for care of adult nurses working with patients with dementia in general hospital wards	Not stated	Qualitative comments taken from questionnaire	Thematic Analysis	15

Moyle, W., Borbasi, S., Wallis, M., Olorenshaw, R., & Gracia, N. (2010).	1 medical doctor, 2 acute care nursing directors, 1 clinical nurse consultant, 3 nursing unit managers, 2 clinical nurses, 1 registered staff nurse, 3 healthcare assistants	Not stated	Acute medical or surgical wards in large hospital	Australia	To explore the management of older people with dementia in an acute hospital setting from perspective of staff	Senior management asked staff to voluntarily participate in the study if fit criteria	Semi- structured interviews	Phenomenologically informed thematic analysis	24
Nilsson, A., Rasmussen, B. H., & Edvardsson, D. (2013).	3 licensed practical nurses, 4 registered staff nurses, 2 doctors	Not stated	20 bed cardiology ward	Sweden	To develop an understanding of the processes hindering person- centred care	Theoretical sampling but recruitment method not specified	Semi- structured interviews (as well as observations)	Grounded Theory	26

					for older people with cognitive impairment in acute care settings				
Nolan, L. (2006).	7 registered staff nurses	Female <i>n</i> = 7	Unit caring for acutely ill older persons in large acute hospital	Ireland	To explore nurses' experiences of caring for older persons with dementia in an acute hospital setting	Purposive sampling to identify set of participants who fit criteria but recruitment method not specified	Non-directive conversational interviews	Thematic Content Analysis	21
Nolan, L. (2007).	7 registered staff nurses	Female <i>n</i> = 7	Specialist unit caring for older	Ireland	To consider the experiences	Purposive sampling	Non-directive conversational	Thematic Content Analysis	21



			persons in a large acute hospital		of nurses caring for people with dementia within an acute hospital setting		interviews		
Smythe, A., Jenkins, C., Harries, M., Wright, J., Dee, P., Bentham, P., & Oyeboode, J. (2014).	15 participants from nursing and service settings	Not stated	3 wards within acute hospital	United Kingdom	To evaluate psychosocial training from the perspective of staff working with people with dementia in an acute hospital setting	Self-selecting by signing up to study following advertisement	Focus groups	Thematic analysis	19

**Table 2: Original study themes which contributed to final metasynthesis themes**

**Overcoming uncertainty in care**

Older people with mental illness are identified through their behaviour; General nurses perceive themselves as lacking the skills needed to recognise and manage mental illness; General nurses perceptions of their training needs (Atkin et al., 2005)

Organisational culture ; Deficits in knowledge, skills and attitudes of staff and students; The struggle to provide care (Baille et al., 2012a)

The acute care built environment; The acute care operational system; Key players within the acute care system; Role of staff; Current dementia care practice in the acute setting (Borbasi et al., 2006)

Skills and training; The ward culture (Calnan et al., 2012)

Learning about dementia; Learning from specialists (Charter & Hughes, 2012)

Philosophies of caring for people with dementia; The value that staff attach to their work; The ability of staff to provide care (Cowdell, 2010)

Ethically difficult situations which can lead to abuse; Difficulties related to disorderly conduct among patients with dementia; Difficulties related to the organisation of acute care as an obstacle to good nursing care of dementia patients (Eriksson & Saveman, 2002)

Knowledge and understanding; Attitudes towards dementia and implemented care (Fessey, 2007)

Defining confusion; Everyday challenges; The physical environment ; Specialising as care management (Moyle et al., 2010)

Falling behind in meeting the needs of older patients with cognitive impairment; Working without consensus about the care of older patients with cognitive impairment (Nilsson et al., 2013)

Caring as an ethical way of being (Nolan, 2006)

### **Constraints of the environmental and wider organisational context**

Physical environment; Organisational culture; Mobility (Baille et al., 2012a)

Flexible and creative care approaches (Baille et al., 2012b)

The acute care built environment; Current dementia care practice in the acute setting; Recommendations for dementia care practice in the acute setting (Borbasi et al., 2006)

The environment of care; Skills and training; The organisational context ; The ward culture (Calnan et al., 2012)

The value that staff attach to their work (Cowdell, 2010)

Ethically difficult situations which can lead to abuse; Difficulties related to disorderly conduct among patients with dementia; Difficulties related to the organisation of acute care as an obstacle to good nursing care of dementia patients (Eriksson & Saveman, 2002)

Focus on acute problems; The physical environment ; Specialising as care management (Moyle et al., 2010)

Working in a disease orientated and efficiency driven organisation; Working within a busy and inflexible environment (Nilsson et al., 2013)

Caring as an ethical way of being (Nolan, 2006)

The reality of caring; The meaning of caring (Nolan, 2007)

### **Inequality of care**

Older people with mental illness are identified through their behaviour; General nurses perceive themselves as lacking the skills needed to recognise and manage mental illness; General nurses do not believe older people with mental illness get a good service in general hospitals (Atkin et al., 2005)

Organisational culture; Deficits in knowledge, skills and attitudes of staff and students; Emotional needs and communication (Baille et al.,

2012a)

Key players within the acute care system (Borbasi et al., 2006)

The organisational context (Calnan et al., 2012)

Philosophies of caring for people with dementia; The ability of staff to provide care (Cowdell, 2010)

Ethically difficult situations which can lead to abuse; Difficulties related to disorderly conduct among patients with dementia (Eriksson & Saveman, 2002)

Focus on acute problems ; Focus on safety; Specialising as care management; Optimal care practices (Moyle et al., 2010)

Falling behind in meeting the needs of older patients with cognitive impairment; Working in a disease orientated and efficiency driven organisation (Nilsson et al., 2013)

The meaning of caring (Nolan, 2007)

### **Recognising the benefits of person-centred care**

Deficits in knowledge, skills and attitudes of staff and students; Getting to know the patient and building a relationship; Flexible and creative care approaches; Comfort and communication (Baille et al., 2012b)

The acute care operational system; The role of staff; Current dementia care practice in the acute setting; Recommendations for dementia care practice in the acute setting (Borbasi et al., 2006)

The organisational context ; The ward culture (Calnan et al., 2012)

Learning about the person (Charter & Hughes, 2012)

The ability of staff to provide care (Cowdell, 2010)

Difficulties related to the organisation of acute care as an obstacle to good nursing care of dementia patients (Eriksson & Saveman, 2002)

Attitudes towards dementia and implemented care; Challenging behaviours (Fessey, 2007)

Defining confusion; Focus on safety; Specialising as care management; Optimal care practices (Moyle et al., 2010)

Caring as an ethical way of being; Embracing each other – bonding; Working with relatives/carers in this process (Nolan, 2006)

The reality of caring; Caring for people with dementia who are agitated or aggressive differs from caring for people with dementia who are not agitated or aggressive; The meaning of caring (Nolan, 2007)

### **Identifying the need for training**

General nurses perceive themselves as lacking the skills needed to recognise and manage mental illness; General nurses perceptions of their training needs (Atkin et al., 2005)

Deficits in knowledge, skills and attitudes of staff and students (Baille et al., 2012a)

Flexible and creative care approaches (Baille et al., 2012b)

Recommendations for dementia care practice in the acute setting (Borbasi et al., 2006)

Skills and training (Calnan et al., 2012)

Learning about dementia; Learning about the person; Learning from each other; Learning from specialists (Charter & Hughes, 2012)

The ability of staff to provide care (Cowdell, 2010)

Difficulties related to the organisation of acute care as an obstacle to good nursing care of dementia patients (Eriksson & Saveman, 2002)

Attitudes towards dementia and implemented care; Knowledge and understanding (Fessey, 2007)

Defining confusion ; Optimal care practices (Moyle et al., 2010)

Working without consensus about the care of older patients with cognitive impairment (Nilsson et al., 2013)

Caring as an ethical way of being (Nolan 2006)

The meaning of caring (Nolan 2007)