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The experience of people with dementia and nurses in hospital: an integrative review

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Contributions

Study design: RD, AW, SL; Literature search: RD; analysis: RD, AW, SL and manuscript preparation RD, AW, SL

Abstract

Aims and objectives:

To identify and examine existing research exploring how people with dementia and nurses view acute hospital care.

Background

Admission to hospital can be traumatic for a person with dementia due to an inability to cope with unfamiliar environments, faces and routines. Adverse behavioural and health outcomes can result. Dementia adds complexity to patient care. Inability to deliver appropriate care is a source of stress and frustration for nurses.

Methods

Integrative review of the literature 2005-2015 reporting the experience of people with dementia and nurses caring for them in an acute hospital setting (n= 24).

Results

Hospitals focus on acute medical care; consequently people with dementia are considered low priority and a disruption to normal routine. Risk management often takes priority over patient dignity.

People with dementia are stigmatised. Families have significant roles to play in the care of a person with dementia in hospital but are often excluded.

Nurses struggle to complete even basic patient care, and focus on tasks often at the expense of specific patient needs. Support for nurses is lacking. The job satisfaction of nurses caring for people with dementia is poor.

Conclusions

Nurses require improved education and support to care for patients with dementia. Hospitals must focus on genuine caring concurrently with rapid discharge requirements, risk mitigation and fiscal restraint. More research is needed to inform the development of appropriate care for people with dementia in hospitals.

Relevance to clinical practice:

Nurses must understand the complex needs of people with dementia in hospital. Nurse education about dementia, practical support, strong clinical leadership and role-modelling is needed. Empathy for patients regardless of diagnosis must remain a core attribute of nurses. Current hospital culture requires wider system review to mitigate against stigmatisation of patients with dementia.

Summary Box

What does this paper contribute to the wider community?

- People with dementia often have a poor experience in hospital due the inability of the hospital system to accommodate the specific needs of this patient group. Enhancing awareness of this problem is a positive step towards rectifying it.
- This paper highlights the deficits in education and support for nurses caring for people with dementia in hospital.
- Stigmatisation of people with dementia has been identified and must be remedied.

Key words: Dementia, care experience, nurses, hospitals, integrative literature review.

The experience of people with dementia and nurses who care for them in hospital: an integrative review

Introduction

The number of people with dementia is increasing world-wide presenting a major challenge to health systems which must adapt to the needs of the many patients who will be admitted with this condition as a co-morbidity (Prince *et al.* 2015). A person with dementia can find admission to hospital a traumatic experience due to a limited ability to cope with a strange environment, faces and routines (Eriksson & Saveman 2002). This can result in a range of adverse behavioural and health outcomes which can be distressing for the individual, their families and the staff caring for them, and may unnecessarily extend the person's length of stay in hospital (Moyle *et al.* 2008).

Dementia and the related behavioural issues add another layer of complexity for nurses caring for patients on a busy ward. In the majority of cases people with dementia admitted to the hospital system have dementia listed as an additional diagnosis rather than the principal reason for admission, and in some cases the person may have dementia but be undiagnosed (AIHW 2012). Nurses consequently report a number of challenges which include feeling ill-informed or unprepared to deal with patients with dementia and the associated behaviour in an environment which is already under pressure because of inadequate resources and pressure to increase patient throughput. Being unable to deliver the most appropriate care is a source of stress and frustration for nurses (Byers & France 2008).

The World Health Organization (WHO 2012) advise that people with dementia and their caregivers have a significant and unique perspective on this situation and therefore should be involved in formulating policy, plans and services which relate to them. People with dementia have traditionally been omitted from direct participation in research, although family carers have been included to a limited extent (Moore & Hollett 2003).

The reason for this exclusion is because the deterioration in cognitive and verbal skills associated with the condition have led to the view that the input of this group is not valid (Nygård 2006). However this attitude is neither person-centred nor legitimate as it has been demonstrated that people with dementia can contribute to research and can add significantly to the body of knowledge about care and treatment (Beuscher & Grando 2009, Dewing 2002). Accessing the opinions of people with dementia is fundamental in order to reframe dementia through personal narratives and take the spotlight away from the biomedical focus on loss and burden. If people with dementia are not viewed as having a valid contribution to make they can be ignored (Beard *et al.* 2009) and the barriers which prevent the inclusion of their opinions in care planning will remain (Webster 2011). Older people with dementia have rarely been asked to discuss their experiences of hospitalization, to the detriment of our understanding (Atwal *et al.* 2007).

Similar reviews in relation to this topic have been undertaken previously. Dewing and Dijk (2016) published a literature review which was wide-ranging in scope, discussing and comparing the results of peer-reviewed journal articles, reports, policy documents and theses on the subject of the acute care of older people with dementia in general hospitals. Dewing and Dijk (2016) used the review of Moyle *et al.* (2008) who examined the theoretical and research-based literature related to the management of people with dementia in hospital as a baseline and focussed on literature that had been published more recently. Turner *et al.* (2015) conducted a meta-synthesis of the literature focussed on the experience of staff caring for patients with dementia in general hospital settings. This review contributes a new perspective which is primarily based on the direct feedback of the key players, namely the patients with dementia and the nurses who care for them in hospitals.

Aim

The aim of this literature review was to identify and examine the existing research that has explored how people with dementia and the nurses caring for them view the experience of care in hospital.

Methods

An integrative review is a method of reviewing the literature on a topic by reviewing, critiquing and summarising that which has been written in the literature previously about a particular issue in order to form a more comprehensive understanding and generate new perspectives (Torraco 2005, Whittemore & Knafl 2005). In addition the integrative review method is useful for identifying the gaps in current research (Russell 2005). An integrative review was determined to be an appropriate method to explore the literature on this topic as nurses and patients have issues which are separate but closely intertwined because of their interdependent relationship. In this paper the views of the two groups will be investigated and the results integrated in a discussion.

The questions that are the focus of this review are as follows:

- What impact does dementia have on the experience of patients in hospital?
- How do people with dementia perceive the attitude of staff to their illness?
- What is the experience of nurses caring for people with dementia in hospital?

Search strategy

An extensive literature search was conducted using the databases Cumulative Index to Nursing and Allied Health Literature (CINAHL), Ovid Medline and Scopus. The literature dated 2005- 2015 was searched for relevant material using Boolean technique in which two or more terms were searched and combined with AND, OR and NOT. The literature of the past ten years was considered to be appropriate for this review in order to reflect recent issues arising from pressures of an aging population on health systems. In addition, the bibliographies of significant articles were hand-searched for further relevant articles using an ancestry approach. A search of author names from major studies was conducted to determine if the author had written other work on a similar topic.

The criteria for inclusion was that the main focus was on the care of people with dementia in hospital, and the research was based on the direct viewpoint of either people with dementia or nurses caring for them. Only primary qualitative studies published in English in peer-reviewed journals during 2005 – 2015 were considered. Quantitative research was excluded in order to ensure that the direct opinions of the nurses and patients were the focus.

Articles were excluded if the main focus was residential or community care or the information was the opinions of others such as family carers or students. Theoretical articles, literature reviews, surveys and articles written from a biomedical viewpoint were also excluded.

The key search terms and MeSH terms used were as follows:

Dement*, Alzheimer's disease, cognitive impair*, hospital, ward.

Staff, nurs*, patient, person.

A flow chart of the search strategy can be viewed in Figure 1.

Figure 1

Critical appraisal

Each identified article was critically appraised using the Critical Appraisal Skills Programme (CASP) checklist for qualitative research (CASP International Network 2013). The CASP appraisal tool uses 10 questions which are designed to assist the researcher to think about the articles systematically, particularly in regard to the following three broad areas: 'Are the results of the review valid?', 'What are the results?', and 'Will the results help locally?' (CASP International Network 2013). The 10 questions commence with two screening questions which determine if it is worth proceeding further, and these are followed by more specific questions which assist in establishing the quality and strength of the research.

After screening with the CASP tool, the main identified weaknesses of the articles were that they were conducted in one specific setting with a small number of participants (Arnold & Mitchell 2008, Byers & France 2008, Cowdell 2010a, b, Digby & Bloomer 2014, Digby *et al.* 2012, Edvardsson & Nordvall 2008, Edvardsson *et al.* 2012, Harrison & Zohhadi 2005, Moyle *et al.* 2011, Nolan 2006, Norman 2006) which limits the transferability of the results. Ethical issues were not discussed in three of the articles (Atkin *et al.* 2005, Griffiths *et al.* 2014, Nolan 2007) and discussion of the relationship between the researcher and the participant was omitted from 11 of the 24 articles (Arnold & Mitchell 2008, Atkin *et al.* 2005, Borbasi *et al.* 2006, Byers & France 2008, Edvardsson & Nordvall 2008, Fukuda *et al.* 2015, Moyle *et al.* 2011, Nilsson *et al.* 2013, Nilsson *et al.* 2015, Nolan 2007, Scerri *et al.* 2015) Additionally the participant demographic details provided were either limited or not specified (Arnold & Mitchell 2008, Atkin *et al.* 2005, Borbasi *et al.* 2006, Byers & France 2008, Harrison & Zohhadi 2005, Hynninen *et al.* 2015, Moyle *et al.* 2011, Nilsson *et al.* 2013, Scerri *et al.* 2015) although in the case of Borbasi *et al.* (2006) inclusion of demographic details was mentioned, but the authors deemed it to be unnecessary. There was a predominance of studies which used participants from the same ward or site, making the transferability of results limited (n=15). One study included the demographic information of patient and family carer participants, but not of the formal carers whose opportunistic conversations were quoted in the results (Clissett *et al.* 2013). In some cases the discussion of the results was very brief (Atkin *et al.* 2005, Byers & France 2008, Digby *et al.* 2012, Scerri *et al.* 2015).

The main strengths identified in the included articles was that the impact of participation for patients with dementia was considered (Cowdell 2010a, b, Digby & Bloomer 2014, Digby *et al.* 2012, Porock *et al.* 2015), the data was obtained from multiple sites (Clissett *et al.* 2013, Fukuda *et al.* 2015, Porock *et al.* 2015), or the discussion incorporated good use of the evidence identified in the study (Edvardsson & Nordvall 2008, Goldberg *et al.* 2014, Harrison & Zohhadi 2005, Moyle *et al.* 2011, Nilsson *et al.* 2013, Nilsson *et al.* 2015, Nolan 2006, Norman 2006, Porock *et al.* 2015). The strengths and weaknesses of the articles are outlined further in Table 1.

The results discussed in the identified articles were analysed using the thematic analysis method described by Braun and Clarke (2006). To begin with, each one was examined, and the themes and ideas which had been identified by the authors during their research were extracted and tables created. Broad codes were developed based on the recurring concepts, and the prevalence of certain themes was determined. Discussions were conducted between the authors in order to come to a consensus on the most appropriate structure and names for the themes. Six recurrent themes were identified: priorities of care, nurse education, stigmatisation of people with dementia, risk management in the ward environment, the input of family carers, and nurse job satisfaction. The themes related to both patients and nurses are discussed below in narrative form.

Characteristics of the included studies

Despite the 1270 articles initially located, after screening the titles and abstracts for relevance and removing duplicates, 24 articles remained for inclusion for full CASP appraisal (CASP International Network 2013).

The country of origin of the articles was weighted strongly to the U.K. (n=10), followed by Sweden (n=4) and Australia (n=4). Single examples were identified from the U.S., Japan, Finland and Malta, and two from Ireland.

Sixteen articles were identified which primarily examined the perspective of nurses and eight studies reported the perspective of patients, although because of the closely entwined issues there was some overlap. Of the 24 articles, four used focus groups to explore the viewpoint of nurses (Arnold & Mitchell 2008, Atkin *et al.* 2005, Fukuda *et al.* 2015, Harrison & Zohhadi 2005) and eight articles used observational methodology which included opportunistic conversations with participants (Clissett *et al.* 2013, Cowdell 2010a, b, Edvardsson *et al.* 2012, Goldberg *et al.* 2014, Nilsson *et al.* 2013, Norman 2006, Porock *et al.* 2015). Two studies used data drawn from the same study and had a major component of observation followed by interviews with patients and/or family care-givers conducted in their homes following discharge (Clissett *et al.* 2013, Porock *et al.* 2015), one study included interviews with both patients and nurses (Cowdell 2010a) and one augmented a long period of observation with formal interviews with nurses (Nilsson *et al.* 2013). Twelve articles were primarily based on the results of interviews with either patients or nurses (Borbasi *et al.* 2006, Byers & France 2008, Digby & Bloomer 2014, Digby *et al.* 2012, Edvardsson &

Nordvall 2008, Griffiths *et al.* 2014, Hynninen *et al.* 2015, Moyle *et al.* 2011, Nilsson *et al.* 2015, Nolan 2006, 2007, Scerri *et al.* 2015).

In three cases, more than one article was written using the data from the same studies although there were some slight differences in interpretation in each article (Cowdell 2010a, b), (Nolan 2006, 2007) and (Clissett *et al.* 2013, Porock *et al.* 2015). In the case of data being referred to in more than one article, the data was counted only once for each study in the review.

Table 1: Overview of included studies investigating the experiences of people with dementia and nurses in hospital.

Priorities of care

Three articles reported that the patient with dementia was considered to present a disruption to the normal routine and an obstacle in the delivery of medical care to other patients (Atkin *et al.* 2005, Clissett *et al.* 2013, Harrison & Zohhadi 2005). Despite the increasing prevalence of patients with mental health conditions nurses continue to believe that physical treatment is their primary concern (Atkin *et al.* 2005, Clissett *et al.* 2013, Moyle *et al.* 2011) and patients with dementia are a low priority in comparison to those with acute health issues (Griffiths *et al.* 2014, Harrison & Zohhadi 2005, Moyle *et al.* 2011, Nilsson *et al.* 2013, Nilsson *et al.* 2015), although Fukuda *et al.* (2015) reported that in Japan, a higher priority is given to patients with dementia in order to prevent liability issues. Acute hospitals are fast-paced, inflexible, disease-orientated and driven by budgetary constraints in an environment often unsuitable for patients with dementia (Borbasi *et al.* 2006, Moyle *et al.* 2011, Nilsson *et al.* 2015). The unrealistic workload and inadequate staffing contribute to poor quality care for patients with dementia (Byers & France 2008, Hynninen *et al.* 2015, Nilsson *et al.* 2013, Nilsson *et al.* 2015, Scerri *et al.* 2015).

Eight articles reported that nurses tend to focus on tasks rather than care which is centred on the specific needs of a patient (Arnold & Mitchell 2008, Atkin *et al.* 2005, Borbasi *et al.* 2006, Byers & France 2008, Cowdell 2010b, Goldberg *et al.* 2014, Harrison & Zohhadi 2005, Moyle *et al.* 2011). The delivery of routine physical care such as hygiene, medication administration and toileting often takes up the majority of nurses' time and is frequently delivered in a functional manner with very little personal engagement (Goldberg *et al.* 2014, Griffiths *et al.* 2014, Moyle *et al.* 2011). Nurses may respond to their own feelings of anxiety and uncertainty by avoidance and depersonalisation of patients (Harrison & Zohhadi 2005). Goldberg *et al.* (2014) noted that patients were often ignored and staff did not introduce themselves as they delivered routine care such as delivering food trays, checking charts and tidying up. Borbasi *et al.* (2006) described situations such as this as a suspension of the patient's personhood and was also demonstrated in situations where the nurse ignored patient requests, was unsympathetic to their distress or unfairly prioritised the care of others. Remaining distant and disconnected from the patient was interpreted as the nurse gaining control and prioritising their own needs ahead of those of the patient (Borbasi *et al.* 2006). In some instances nurses appeared to have suspended compassion for the patients with dementia in the quest to get the work done rather than finding ways to overcome the difficulties they face (Moyle *et al.* 2011), however nurses who were able to summon patience and calm were more likely to make the experience for patients with dementia a favourable one (Scerri *et al.* 2015).

In a study set in the UK, (Cowdell 2010a, b) patients with dementia when directly asked about their interactions with the nurses, reported that the care was ~~perfunctory~~ done in a routinised way that satisfied the requirements, but was not centred on the person's needs. A patient described an example of an uncaring nurse-patient interaction: '...I felt terrible, nobody come to see you and said to you what's the matter or nothing... they didn't care, so long as they come in and you see 'em and they see you, that's all that matters' (Cowdell 2010a). Cowdell (2010b) and Clissett *et al.* (2013) described instances where patients suffered and showed obvious distress during care delivery but staff ignored their protests and specific needs in order to get the work done. Similarly in the study conducted by Edvardsson and Nordvall (2008) in Sweden, the nurses conveyed their lack of concern for the patients by their haste and manner. An Australian study (Moyle *et al.* 2011) also found that the interactions between patients and nurses were almost entirely focused on tasks, delivered with very little compassion. However for the patients, the quality of the care is the most important component of being in hospital, above the quality of their surroundings and other factors (Digby & Bloomer 2014).

The hospital admission of a person with dementia has a disruptive effect on the patient, their family and the staff; the reactions of each influencing the others (Fukuda *et al.* 2015, Porock *et al.* 2015). The psychological environment of the hospital ward is a complex interplay of interactions between the different groups, with the staff acting as catalysts for the emotional climate (Edvardsson *et al.* 2012, Porock *et al.* 2015). Staff who delivered care in a task-focused way without engaging with the patients risked marginalising the patients and prompting agitated or aggressive behaviour. In contrast staff who were available and engaged with the patients, involving them in conversation and meaningful activity had the opposite effect on the psychological climate of the ward and the patients' experiences (Edvardsson *et al.* 2012).

Education of nurses

Lack of education about mental health conditions was discussed in ten of the articles, in relation to nurses reporting that they felt under-prepared and lacking in the skills necessary to care for people with dementia (Arnold & Mitchell 2008, Atkin *et al.* 2005, Borbasi *et al.* 2006, Cowdell 2010a, b, Fukuda *et al.* 2015, Griffiths *et al.* 2014, Harrison & Zohhadi 2005, Hynninen *et al.* 2015, Norman 2006). The education that nurses in acute health have received both in general terms, and specifically related to cognition, has a direct bearing on their ability to care effectively for people with dementia (Borbasi *et al.* 2006, Eriksson & Saveman 2002, Griffiths *et al.* 2014, Moyle *et al.* 2011). Acute care nurses tend to lack specific knowledge about dementia and may not understand the difference between acute and chronic confusional states, resulting in care that is superficial and generalised for an older person rather than specific to the condition (Moyle *et al.* 2011). Atkin *et al.* (2005) reported that the nurses in their study considered that caring for such patients was outside their competencies and that they needed ongoing training and role-modelling. In the United Kingdom the general nurse training curriculum contains only a small mental health component which is apparently inadequate to prepare nurses for the care of such patients (Arnold & Mitchell 2008, Griffiths *et al.* 2014). Participants in the study by Arnold and Mitchell (2008) reported that few had received any mental health education since obtaining their nursing qualification, and that the doctors were in a similar position. Education during training and subsequently was focussed almost entirely on physical care, contributing to the hospital emphasis on treatment of physical illness as the priority (Arnold & Mitchell 2008).

Nurses who have had previous experience in caring for people with dementia can be a significant asset to the ward team and support more appropriate care (Borbasi *et al.* 2006, Griffiths *et al.* 2014). In contrast, lack of education, in-services and experience in managing mental health issues lead to the provision of sub-optimal care for people with dementia in acute wards (Fukuda *et al.* 2015, Griffiths *et al.* 2014).

Harrison and Zohhadi (2005) discussed the problem of a lack of preparedness as being divided into resources which were internal to the nurse such as skills, knowledge and time, and external including inadequate access to training, support, and clinical supervision. They also reported that there was a perceived lack of understanding and unrealistic expectations on the part of the hospital management. Education was seriously lacking and in some cases this led to professional distress for nurses who felt inadequate and ill-equipped to deal with patients with mental health problems (Borbasi *et al.* 2006, Griffiths *et al.* 2014, Harrison &

Zohhadi 2005). Support for the well-being of nurses was described as vital but not always apparent in health systems (Hynninen *et al.* 2015).

To understand patients' actions and deal with challenging behaviours including aggression, nurses need to understand confusion and the underlying conditions (Griffiths *et al.* 2014). In some instances, a lack of education and knowledge led to nurses using physical force or chemical restraint in order to complete tasks for uncooperative patients (Nilsson *et al.* 2015). Nurses described the frustration and guilt they felt when this was the case, attributing the poor care to their lack of skill (Nilsson *et al.* 2015).

Nurses often relied on their own philosophies of care, personal experience and ward culture rather than education or standardised guidelines to influence their care practices (Cowdell 2010b, Fukuda *et al.* 2015, Nilsson *et al.* 2013). Nurses reported being more confident delivering physical care and had difficulty dealing with emotional issues or behavioural symptoms (Cowdell 2010b).

Stigmatisation of people with dementia

Fifteen of the 21 articles representing 13 studies, discussed the stigmatisation of people with dementia, mainly in reference to the different treatment received by this patient group in relation to other patients (Arnold & Mitchell 2008, Borbasi *et al.* 2006, Clissett *et al.* 2013, Cowdell 2010a, b, Digby *et al.* 2012, Edvardsson & Nordvall 2008, Goldberg *et al.* 2014, Harrison & Zohhadi 2005, Moyle *et al.* 2011, Nilsson *et al.* 2013, Nilsson *et al.* 2015, Nolan 2006, Norman 2006, Porock *et al.* 2015). Categorising a person as having a mental health condition can lead to labelling and singling people out for different treatment, as a result of nurses not looking for the person behind the condition (Arnold & Mitchell 2008, Atkin *et al.* 2005, Borbasi *et al.* 2006, Clissett *et al.* 2013). Some of the nurses in these studies considered that people with dementia should be cared for in other facilities because acute hospitals are ill-equipped to deal with behavioural symptoms (Borbasi *et al.* 2006, Harrison & Zohhadi

2005, Moyle *et al.* 2011). This may also be because staff consider patients with dementia to be a nuisance or an inconvenience in the acute setting where staff are struggling to keep pace with even routine care (Moyle *et al.* 2011). As a consequence, the negative attitude of nurses to the patient with dementia turns the attention away from addressing their needs to looking for ways to move the patient out of the ward (Moyle *et al.* 2011). Additionally the nurses working in acute wards who do not see the care of patients with dementia as part of their job may feel that the presence of such patients devalues their role (Borbasi *et al.* 2006, Cowdell 2010a, Moyle *et al.* 2011, Nilsson *et al.* 2013). Importantly nurses have a significant impact on the ward culture and the general attitude to patients with mental health diagnoses (Borbasi *et al.* 2006, Edvardsson *et al.* 2012).

Patients with dementia who are quiet, cooperative and happy to remain seated are deemed acceptable in the acute ward but often receive less time than other patients who are more challenging (Cowdell 2010a, Nilsson *et al.* 2013, Nilsson *et al.* 2015, Norman 2006) however those who are confused, demanding or resistant to care can trigger feelings of anger and inadequacy in nurses (Nilsson *et al.* 2015). Nurses often view these patients as reduced to their parts which require specific action in a reductionist manner of a biomedical model (Norman 2006). As a consequence of minimal engagement and a focus on routine tasks, patients frequently report feeling devalued and bored (Edvardsson & Nordvall 2008).

Stigmatisation of people with dementia was also found to occur when nurses labelled patients according to their diagnosis or behaviour especially the behaviour that disrupted routine care delivery (Arnold & Mitchell 2008, Atkin *et al.* 2005, Norman 2006). Stereotyping is entrenched in some areas and staff frequently fail to see the person behind the illness (Borbasi *et al.* 2006). Dementia was downplayed as a diagnosis by a nurse quoted by Atkin *et al.* (2005) who said disparagingly "You don't die of confusion", suggesting that the nurses' priority belonged with the care of others who were more physically unwell.

Shift handovers can perpetuate the labelling of patients (Arnold & Mitchell 2008). A patient who has been described as confused by one nurse can carry the label of confusion throughout their hospital stay, with little regard being paid to mitigating factors such as the change in environment or the part that staff behaviour plays in the way patients react (Arnold & Mitchell 2008). It has been observed on occasion that nurses labelled patients according to their behaviour, discriminated against people with dementia and treated them differently, even cruelly (Atkin *et al.* 2005, Digby *et al.* 2012, Griffiths *et al.* 2014). Instances of nurses panicking, shouting or avoiding patients were noted (Griffiths *et al.* 2014). Similarly Clissett *et al.* (2013) observed that nurses sometimes put their own needs before those of the patients, chose not to engage with them despite the opportunity arising, or assumed an officious curt manner. Such behaviour was attributed to the nurse seeking to gain a sense of control in the face of a disruption to the work environment. Mockery and unsympathetic response to a distressed patient were cited as examples of unprofessional behaviour (Clissett *et al.* 2013).

In five articles it was reported that nurses made derogatory remarks about the patients either directly to them or within earshot, or the nurses discussed the patient in front of them as if they weren't there (Cowdell 2010a, Digby *et al.* 2012, Edvardsson *et al.* 2012, Goldberg *et al.* 2014, Norman 2006). The patronising attitude of the staff was not altogether lost on the patients, some of whom remarked on this (Cowdell 2010a, Digby *et al.* 2012). In the study by Edvardsson and Nordvall (2008) one of the patients felt the stigmatisation acutely: "... they toss me my sandwiches the way you would do a dog". In another study a patient with some insight admitted that he avoided saying that he was confused about something as it would be interpreted by the staff that he had dementia and they would treat him differently (Digby *et al.* 2012). Patronising language is common and contributes to the denial of the recipient's individuality and shows a lack of respect (Digby *et al.* 2012, Norman 2006).

Focus on safety (ward environment)

Hospitals are required to cater to the needs of a wide range of patients and staff but in many instances the buildings are outdated, over-crowded, noisy and unsuitable, even dangerous, for people with dementia (Borbasi *et al.* 2006, Fukuda *et al.* 2015, Porock *et al.* 2015). Ten of the 24 articles cited the constantly changing, busy hospital environment as a problem to this patient group because it is noisy and unfamiliar and can consequently escalate anxiety and trigger behavioural responses (Borbasi *et al.* 2006, Cowdell 2010a, b, Digby *et al.* 2012, Edvardsson & Nordvall 2008, Fukuda *et al.* 2015, Hynninen *et al.* 2015, Nilsson *et al.* 2013, Nolan 2007, Scerri *et al.* 2015). Porock *et al.* (2015) emphasized the effect that the disruption caused by admission to hospital on the person with dementia, and also the family caregivers, staff and other patients. Porock *et al.* (2015) described the way that the family and the health professionals reacted, as strategies to gain a sense of control for themselves, demonstrated in different ways. For the person with dementia, manifestation of this control could mean purposeful behaviour such as wandering, interfering with other people's possessions or calling out (Porock *et al.* 2015).

Managing patient safety with insufficient resources is a serious challenge for nurses; however the priority given to risk management can lead to some inappropriate and unnecessary interventions which gives primacy to the prevention of falls and infections, and swift discharge at the expense of person-centredness (Clissett *et al.* 2013, Moyle *et al.* 2011, Nilsson *et al.* 2015). Patient dignity can be overlooked in the quest for the safety of the person with dementia or other patients and staff (Moyle *et al.* 2011). Inappropriate interventions can include physical or pharmacological restraint which might prevent the patient from absconding or falling but can lead to other problems such as pressure areas, excessive drowsiness and de-conditioning (Borbasi *et al.* 2006, Moyle *et al.* 2011). In one study, restraint of patients with dementia was routine (Hynninen *et al.* 2015). The focus on surveillance of at-risk patients who need to be constantly checked could also result in less attention being paid to other patients on the ward (Fukuda *et al.* 2015, Goldberg *et al.* 2014, Nilsson *et al.* 2015, Nolan 2007).

Adapting care to cope with patients' behavioural symptoms without additional resources adds to the challenge of delivering safe, dignified care (Nilsson *et al.* 2015). Moyle *et al.* (2011)

described the use of chemical or physical restraint, often with the assistance of security guards, as a method used at times to manage aggressive or violent patients. Despite this being a poor alternative to more person-centred approaches such as looking for the reason for the confusion or agitation, restraint was justified by the staff as a way of ensuring patient and staff safety. Nilsson *et al.* (2015) observed that nurses resorted to physical force at times when they felt that they were unable to communicate with patients yet still had a responsibility to complete care tasks. Acting in a way which is clearly against the patient's will is a form of assault however the nurses stated that they felt justified when they considered that the actions were in the best interest of the patient (Nilsson *et al.* 2015). Hynninen *et al.* (2015) reported that chemical and physical restraint was used at staff discretion, especially when there was no personal nurse supervision available.

Having an additional amount of supervision for patients with dementia often does not result in an increase in meaningful interaction (Moyle *et al.* 2011). When cost considerations permit, hospitals use 'specials' who are staff assigned to continuously observe a patient for the shift to prevent the patient from falling, harming themselves or others, absconding, and to allow staff to deliver care to other patients. However ‘special’ staff are not specifically expected to deliver care or diversional therapy to the patient with dementia (Moyle *et al.* 2011). The use of 'specials' may result in fewer falls but does not necessarily improve the care for the patient and in fact may lead to an escalation in anxiety if the patient feels that their physical space is invaded (Moyle *et al.* 2011).

Family

The involvement of the family in the care of the person with dementia in hospital was discussed in 12 of the 24 articles (Borbasi *et al.* 2006, Clissett *et al.* 2013, Digby & Bloomer 2014, Digby *et al.* 2012, Fukuda *et al.* 2015, Goldberg *et al.* 2014, Hynninen *et al.* 2015, Moyle *et al.* 2011, Nilsson *et al.* 2013, Nolan 2006, Porock *et al.* 2015, Scerri *et al.* 2015).

In many instances family support is a significant source of comfort to a person with dementia who is in a strange environment. Help with decision-making, and reassurance that someone is acting in their best interest is comforting and may lessen anxiety (Digby *et al.* 2012, Edvardsson & Nordvall 2008). Inclusion of the family can also be important from the perspective of the family who have a close relationship with the patient (Digby *et al.* 2012).

Building a relationship between the staff and the relatives of a patient with dementia is important, as family can be a valuable source of information and assistance (Fukuda *et al.* 2015, Hynninen *et al.* 2015, Nolan 2007, Scerri *et al.* 2015). Family members, which may include a loving life partner, may often have been caring for a person with dementia for many years at home before the person's admission to hospital, and the admission can cause serious disruption to the lives and experiences of the carer (Porock *et al.* 2015). In many cases the person with dementia will be unable to provide personal information; however the family may have experiential knowledge and valuable insight to contribute as an alternative or adjunct (Hynninen *et al.* 2015, Nolan 2007). The family carer then becomes an integral member of the care 'triad' which comprises the hospital team, the family and the patient (Adams & Gardiner 2005). However staff do not always welcome the input of family or welcome their presence despite the additional help and information that the family can provide (Clissett *et al.* 2013, Goldberg *et al.* 2014). The family were generally considered assets to the care of a patient with dementia however there was the potential for conflict between family and staff and within the family, especially in regard to unscrupulous behaviour on the part of family members or a dispute about the discharge destination (Borbasi *et al.* 2006, Nolan 2007). In Japanese culture it is expected that the family will attend to their relative with dementia while they are in hospital, however this situation has the potential to spark conflict when the family and the nursing staff do not agree on goals of care, or if the family are not willing or able to cooperate (Fukuda *et al.* 2015).

Even though family involvement in care was acknowledged as being beneficial, Moyle *et al.* (2011) found that there was no clear strategy to ensure that hospital staff included the family in discussions. In many instances family involvement was left to the family to initiate, and the focus of the nurses remained with acute medical issues. The family may also have issues such as grief or embarrassment that could be addressed by the staff, however many nurses do not consider supporting the family as part of their role which remains primarily centred on the direct needs of the patient (Nolan 2007).

Job satisfaction

Ten studies revealed that caring for people with dementia could impact negatively on the job satisfaction of nurses (Arnold & Mitchell 2008, Byers & France 2008, Clissett *et al.* 2013, Cowdell 2010a, Fukuda *et al.* 2015, Griffiths *et al.* 2014, Harrison & Zohhadi 2005, Hynninen *et al.* 2015, Moyle *et al.* 2011, Nilsson *et al.* 2015). The reasons for dissatisfaction stemmed mainly from feelings of inadequacy and lack of education in mental health disorders (Arnold & Mitchell 2008, Byers & France 2008, Clissett *et al.* 2013, Cowdell 2010a, Fukuda *et al.* 2015, Griffiths *et al.* 2014, Harrison & Zohhadi 2005, Hynninen *et al.* 2015, Nilsson *et al.* 2015) and the insufficient resources with which nurses are expected to manage people with dementia in the acute ward environment (Arnold & Mitchell 2008, Byers & France 2008, Clissett *et al.* 2013, Fukuda *et al.* 2015, Harrison & Zohhadi 2005, Hynninen *et al.* 2015, Moyle *et al.* 2011, Nilsson *et al.* 2015).

The disruption caused by patients with mental health problems, was a cause of professional frustration for nurses who saw their efforts as exhausting, draining and ultimately futile. If nurses do not believe that their efforts are worthwhile or effective then job satisfaction is generally poor (Harrison & Zohhadi 2005, Nilsson *et al.* 2015). Nilsson *et al.* (2015) described instances of nurses who ignore a patient's screams or constant calls for attention because of the necessity of attending to other duties. The result is poor job satisfaction and avoidance of critical reflection in order to avoid burnout. Nurses can feel offended and irritated when they are insulted or physically abused by patients and such situations compromise both personal and professional integrity (Nilsson *et al.* 2015).

The time-consuming care of people with dementia places additional demands on nurses who are working in an environment which is already under intense pressure. Because there is inadequate time allocated to administer even routine care, nurses focus on getting the basic work done, and people with dementia are viewed as highly problematic because they absorb additional time resources (Borbasi *et al.* 2006, Goldberg *et al.* 2014, Harrison & Zohhadi 2005). Nurses need to feel that their work is valuable and respected by others but caring for people with dementia is often seen as unskilled, routinised, mundane and not prestigious which may also be a reflection of society's attitudes (Cowdell 2010b).

Discussion

This integrative review examined the existing literature on the experience of care in hospitals as perceived by patients with dementia and nurses. The majority of the articles suggest that the experience of being in hospital is very unsettling to the person with dementia and is poorly supported by hospital staff. A complex array of factors which include in some instances the nurses' lack of interpersonal qualities and education about dementia is blamed for this negative experience. Most of the studies discussed in the reviewed literature were too small to transfer the findings to other situations, however in combination the evidence from these small studies gathers weight (Rozas & Klein 2010).

In many of the articles the actions and interventions of the nurses and other health professionals were reported to have a significant impact on the patients. Interactions with nurses have the potential to be both helpful and stabilising or alternatively increase the patient's feelings of alienation. When nurses focus on tasks with minimal engagement with the patients, and the patients feel largely ignored, an already challenging experience can be made even worse. A consequence of the lack of preparedness of acute hospitals and staff to care for this patient group can be a poor quality experience for the patients and nurses alike.

People with dementia are already stigmatised by society in general (Blay & Peluso 2010); unfortunately this stigmatisation also appears to be prevalent in the hospital environment. An understanding of the part that their approach and attitude plays in influencing patient behaviour would be beneficial to nurses and other health professionals and positively affect the care of patients with dementia. Learning to use appropriate strategies would lead to a calmer environment for staff and patients. Stigmatising those who have this condition, including suggestions that they should be treated elsewhere, is pointless and delays addressing the issues. Nurses must learn to accommodate patients with dementia in general hospital wards, especially in relation to the specific needs created by the patients' compromised ability to understand new environments.

Greater inclusion of families in the care of people with dementia results in a better experience for patients, family carers and nurses (Adams & Gardiner 2005). The presence of family can allay anxiety in the patients and provide helpful information and an additional resource for time poor nurses. More research is needed in this area to identify clear strategies for health services to involve families in the care and support of patients with dementia in a more structured way.

Many nurses feel that they are lacking the skills required to manage patients with dementia and reported receiving very little education about dementia, relying instead on their own philosophies of care based on personal beliefs rather than knowledge (Arnold & Mitchell 2008, Borbasi *et al.* 2006, Moyle *et al.* 2011). Greater confidence in attending to physical care adds to the dominance of the physical rather than psychosocial focus. As a consequence of poor job satisfaction, nurses view caring for people with dementia as unskilled, not prestigious and low on the list of career aspirations (Cowdell 2010b, Griffiths *et al.* 2014). Improving education for nurses about dementia is an important priority which could improve confidence and skill in this area and potentially increase job satisfaction for nurses as well as improving the standard of care for people with the condition. Expecting nurses and other staff to care for people with dementia who require complex, time-intensive and skilled care without appropriate preparation to equip them for the role is unrealistic and doomed to fail.

Some nurses do not have the personal qualities including empathy and emotional intelligence necessary to meet the needs of people with dementia with complex health and behavioural issues (McPherson *et al.* 2016). There are opportunities for further research on aspects of nurse recruitment, education and support which would both identify ways to recognize staff who are appropriate for this role and then support and equip them during their practice. None of the articles in this review reported that the nurses received any significant mentoring or clinical supervision despite this being identified previously as beneficial (Edberg *et al.* 1996). Tom Kitwood (1997) wrote about the selection and support required for nurses working with people with dementia in his seminal work 'Dementia Reconsidered: the person comes first'. Kitwood pointed out that the staff must be looked after from a material, psychological and educational perspective in order to have the ability to care effectively for people with dementia. Recruitment of appropriate staff for the job should go beyond qualifications, to ensure that the employee has the appropriate attitude and disposition for the work (Kitwood 1997).

Despite none of the articles in this review reporting that the nurses in their studies had regular access to staff with specialist dementia or mental health skills, there is evidence in other literature that including specialist practitioners in the team improves care for people with dementia. Borbasi *et al.* (2006) and (Griffiths *et al.* 2014) advocate for the involvement of a range of staff qualified in this area including gerontology nurse practitioners and dementia-friendly volunteers. Initiatives such as The Dementia Friendly Hospital Initiative Education Program in the United States (Palmer *et al.* 2014) and The Dementia Champions Programme in Scotland (Banks *et al.* 2014) could be applied more widely to improve nurses' understanding and skills related to dementia. Similarly the experience of others in the implementation of specialist cognition nurses in acute hospitals could be consulted in order to improve support for nurses and patients (Elliot & Adams 2011, Griffiths *et al.* 2015). In some hospitals, initiatives involving the use of ward volunteers have been successful in engaging patients with dementia in conversation and activities, allowing the nurses time to attend to other duties (McDonnell *et al.* 2014).

Some positive experiences were identified in this review. Scerri *et al.* (2015) discussed the importance of supporting the care relationship between the nurse and the patient. Getting to know each other was beneficial to both parties: the nurses felt that they understood the meaning behind patient behaviour and the patients were more relaxed with staff who were known to them. The participants in this study spoke about the staff spending quality time with the patients and in some instances going the extra mile when they carried out actions which were not specifically part of their role (Scerri *et al.* 2015). The organisational determinants were also acknowledged, especially in relation to the additional staffing levels required for this type of care. However this was a barrier for many of the other hospitals in the reviewed articles which were disproportionately focused on discharge planning, risk management and the treatment of acute illness without due consideration or the financial resources for other factors. Whilst it is acknowledged that financial considerations are important it appears that in some instances, efficiency has been misinterpreted to exclude empathetic care.

This integrated literature review has some limitations. Despite being carefully and systematically undertaken, the process may not have uncovered all the relevant literature on this topic. Due to the small number of articles which met the inclusion criteria, and the similarity of methodological approaches, an element of bias may have been introduced.

The majority of the articles in this review were conducted in the United Kingdom, Sweden or Australia, with only one from the United States two from Ireland by the same author using the data from one study, one from Finland, one from Japan and one from Malta. The narrow range of locations makes transferability to other areas problematic. Notably there were no studies identified which examined the perspective of nurses or people with dementia in central European hospitals where there may be considerable differences in the care of people with dementia in hospital. The exclusion of articles written in languages other than English is a limitation which could have contributed to this omission. It has been reported elsewhere that in Spain, the care of people with dementia is managed largely by the family, although as in other cultures, the last 30 years have seen changes in family living arrangements which have added challenges to these arrangements (Rivera *et al.* 2009). Similarly in Greek society the focus on the close family relationships is reinforced when a parent develops dementia, making the expectation of all parties, that a family care arrangement will occur (Botsford *et al.* 2012). Addressing the issue of family involvement in hospital care more formally and improving the relationship between nurses and families may improve the hospital experience for the patients with dementia.

The experience of Japanese nurses discussed by Fukuda *et al.* (2015) has some parallels with those of nurses in the other studies; however there are some significant cultural differences in Japan which make direct comparisons difficult, notably the expectation of family involvement in the direct care of the patient, and the low nurse staffing levels and status (Fukuda *et al.* 2015). Other Asian countries are not represented in this review.

Conclusion

This review draws attention to the shortcomings of acute hospitals in providing care for people with dementia. Nurses are not appropriately supported by hospital administration, and the required resources are not consistently provided. The review identified that stigmatisation of patients with dementia occurs in hospital settings and that nurses feel ill-equipped to provide care to people with dementia. Furthermore, the fast-paced, noisy, acute hospital environment has the effect of increasing the disorientation and agitation of patients with dementia adding to the distress already caused by the disruption to normal routine.

Additionally the dominant medical model of care is focused on acute illness, and dementia is considered low priority.

Nurses require education and increased support from hospital administrators to better cope with the needs of patients with dementia. It is important that nurses apply the same empathetic care to this patient group as to all others; however dementia is currently a stigmatised condition along with mental illness and older age, and there is insufficient resources allocated to caring for this patient group. Lack of time and a culture unduly influenced by rapid discharge requirements, risk mitigation and fiscal restraint contribute to produce an environment unsuited to caring for people with dementia. Dementia as a co-morbidity is increasing in hospitals due to the aging of the population, thus systems must change to improve education and support for nurses, and improve the culture of hospitals to focus on genuine caring along with the other priorities. There is an urgent need for more research that focuses on this area in order to inform the development of appropriate care which addresses the needs of people with dementia.

Relevance to clinical practice

It is important for nurses to understand the complex needs of people with dementia admitted to acute hospital wards. Nurse education on mental health issues is greatly lacking, and the emotional and practical support provided is inadequate. Strong clinical leadership and role-modelling give nurses opportunities for clinical-based education and skill-development. The core values of nursing which include empathy and caring for patients regardless of diagnosis must remain a primary concern. Institutional factors including hospital culture which focuses on patient throughput, risk mitigation and fiscal restraint to the detriment of genuine caring is regrettable and requires wider system review.

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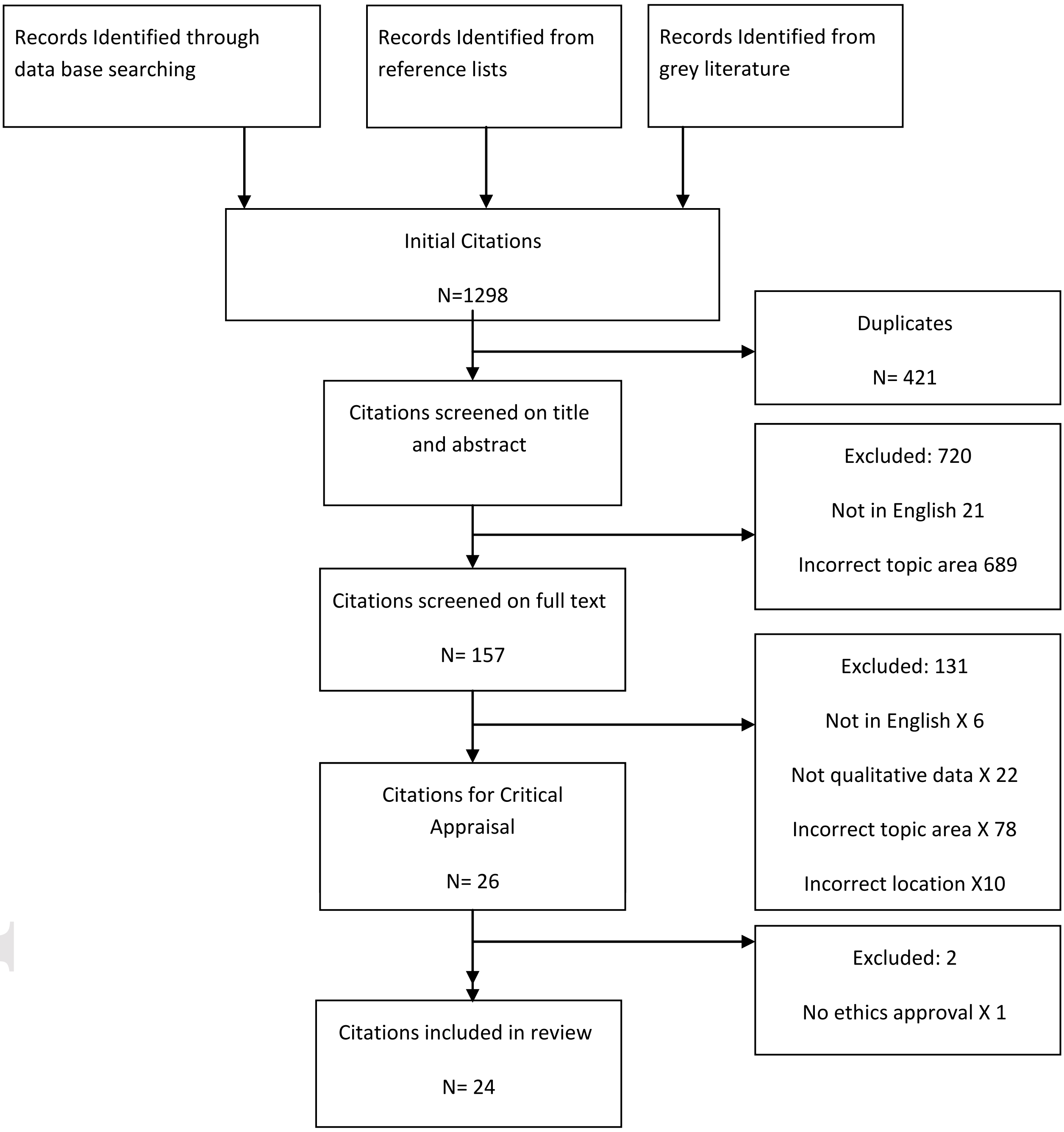
Figure 1: PRISMA flow chart of included studies investigating the experiences of people with dementia and nurses in hospital.



Article	Aim	Methodology and sample	Data collection techniques	Results	Weaknesses	Strengths
Patients						
Cowdell, F. (2010) U.K. The care of older people with dementia in acute hospitals	To explore the experiences of patients and nursing staff of the care received by older people with dementia in acute hospitals	Ethnography 11 patients with dementia, 25 Registered Nurses 33 Nursing assistants	125 hours of observation, Field notes, 18 interviews, opportunistic conversations with patients with dementia	Patients - being in hospital is stressful and difficult Nurses - constrained by organisational and environmental factors, lack of support and education. Nurse lack empathy and work within fixed habitus	Only one of the formal interviews was with a patient with dementia	Extensive observation period. Considered the effect of participation on participants
Cowdell, F (2010) U.K. Care of older people with dementia in an acute setting	To investigate the experiences of patients and nursing staff in relation to the care delivered to, and received by, older people with dementia in an acute hospital setting	Ethnography 11 patients with dementia, 25 Registered Nurses 33 Nursing assistants	125 of observation, Field notes, 18 interviews	Main themes surround the difficult and stressful experience of patients with dementia in hospital Nurses lack support, education and empathy	A small scale study conducted in one acute hospital	Good, succinct discussion Good explanation of ethical issues
Digby, R., Moss, C. and Bloomer, M. (2013) Australia Transferring from an acute hospital and settling into a sub-acute facility: the experience of patients with dementia	To understand how older patients with mild to moderate dementia experienced the transfer from acute to sub-acute care and the settling-in period	Qualitative description Eight patients with dementia	Eight in-depth semi-structured interviews	Five themes were identified: • Factors in settling in to the new environment. • Staff attitudes to people with dementia. • Loss of control • Family support • Anxiety about the future	Small study conducted in one facility Limited discussion of data analysis technique	Good discussion about interview techniques.
Digby, R. and Bloomer, M.	To elicit the perspectives of inpatients with	Qualitative	Eleven in-depth semi-	Seven themes were identified:	Small study conducted in	Good discussion about the case

(2013) Australia People with dementia and the hospital environment: the view of patients and family carers	dementia, and their family carers, about the environment/ design features of sub-acute hospitals that they believe are necessary for people with dementia and their family carers	descriptive study Seven patients with dementia and four unconnected family carers	structured interviews	• The quality of care is more important than the surroundings • Homeliness • Navigation and way-finding prompts • Privacy • The needs of family carers • Noise factors • Access to garden	one facility Limited discussion of data analysis technique	for inclusion of people with dementia on issues that affect them
Edvardsson, D., Nordvall, K. (2007) Sweden Lost in the present but confident in the past: experiences of being in a psycho-geriatric unit as narrated by persons with dementia	To illuminate meanings of being in a psycho-geriatric unit in a hospital	Open-ended research interviews interpreted using a phenomenological hermenuetic analysis Six people with mild to severe dementia	Six open-ended interviews	Four themes were identified: • Appearing lost in the present • Appearing confident in the past • Having one's private space invaded • Understanding the perspective of the person	Small study involving only six participants. Study conducted in one facility. Further exploration of themes.	Good justification of methodology Good discussion of findings
Edvardsson, D., Sandman, P., Rasmussen, B. (2011) Sweden Forecasting the ward climate: a study from a dementia care unit	To explore the psychosocial climate and its influence on the well-being of people with dementia in a psycho-geriatric hospital unit	Grounded Theory 24 beds occupied by patients with moderate to severe dementia	36 hours of observation	Variation in patient well-being was accounted for by staff presence or absence and their engagement with the patients. Staff were the catalysts for the psychosocial climate	No formal interviews with patients. One clinical setting only. Small scale study	Detailed observation and field notes
Norman, R. (2006) U.K. Observations of the experiences of people with dementia on general hospital	To explore how people with dementia are cared for in general hospital wards in the United Kingdom	Observational phase of a grounded theory study Three wards,	Unspecified number of hours of observation	Nursing practice must move away from constraint of patients with dementia towards their realisation Viewing the actions of people with dementia as a method of communication	Interviews with patients not discussed. Observation time unspecified. Small number of	Good discussion of findings Good use of quotes to support findings

wards		eight patients with dementia			patients(n=8)	
Porock, D., Clissett, P., Harwood, R. H. & Gladman, J. R. F. (2015) U.K. Disruption, control and coping: responses of and to the person with dementia in hospital	To gain insight into the experience of hospitalisation from the perspectives of the older person with dementia, their family caregiver and other patients sharing the ward	Ethnography 35 caregivers, 4 co-patients concerning the experiences of 38 patients	72 hours of non-participant observation on 11 wards,. 39 interviews with family carers and co-patients	Core problem: • Disruption from normal routine leading to difficulty and distress Core process: • Patient with dementia gaining a sense of control through constructive, disengaged, distressed and neutral behaviour	Patients with dementia not interviewed directly. No demographic data provided	Good justification of methodology
Nurses						
Arnold, M and Mitchell, T. (2008) U.K. Nurses' perceptions of care received by older people with mental health issues in an acute hospital environment	To explore a sample of nurses' perceptions of mental health services for older people in the acute care setting	Qualitative Grounded Theory 14 nurses	Three focus groups	Main themes surround stigma of people with dementia in hospital Nurses require more specific mental health education and support. Better team work between disciplines and collaborative working	Data analysis not fully explained. Single site study Demographic details of participants not included	Themes illustrated with pertinent examples from the focus group interviews
Atkin, K., Holmes, J. and Martin, C. (2005) U.K. Provision of care for older people with co-morbid mental	To explore the training needs of general nurses to care for people with co-morbid mental illness	Framework analysis 19 nurses	Three focus groups	Older people with mental illness are identified through their behaviour General nurses lack the skills needed to recognise and manage mental illness Nurses do not believe older people with mental illness get a good service in general hospitals	Demographic details of participants not included Very limited discussion	Good presentation of participant quotes in a table

illness in general hospitals: general nurses' perceptions of their training needs						
Borbasi, S., Jones, J., Lockwood, C. and Embden, C. (2006) Australia Health professionals' perspectives of providing care to people with dementia in the acute setting: toward better practice	To explore, understand, and interpret nurses' and health professionals' experiences of managing patients who have dementia and have been admitted to hospital for treatment of a non-dementia related illness, and to provide a rich description of current practice and perceived better/ best practice	Qualitative, constructivist. 25 healthcare professionals including nurses, doctors and allied health professionals	Semi-structured interviews	The hospital environment is unfamiliar and unsafe Medical model of care focuses solely on patients' acute condition The profile of patients, family and staff. The current management and the ideal management of people with dementia are incongruent There is a need for staff education, dementia-friendly staff, purpose-built facilities, multi-disciplinary approach to care, and volunteers More time must be allowed to deliver care	Diverse skill mix in staff interviewed. Other staff may have different opinions	Three hospitals involved in the study Large volume of data generated Good discussion of the issues raised
Byers, D.C. and France, N.E.M. (2008) U.S. The lived experience of registered nurses providing care to patients with dementia in the acute care setting; a phenomenological study	To explore the lived experience of RNs caring for patients with dementia in the acute care setting	Phenomenology Nine registered nurses	Interviews and field notes	Two themes: • Frustration and emotional exhaustion due to inadequate staffing, and remorse that care was left undone. Lack of time results in a focus on tasks. • Synthesis of unity - nurses carrying work home	Watson's theory of caring has a very specific focus. Long verbatim quotes with minimal commentary/ interpretation. No clear statement of the findings	
Clissett, Porock, Harwood and Gladman (2013) U.K. The responses of healthcare	To explore the responses of healthcare professionals to the admission of people with cognitive impairment to the acute hospital setting	Ethnography 72 hours of observation Interviews with 35 family caregivers	Observation, field notes and interviews	Two themes identified: The admission of a person with cognitive impairment causes disruption to the staff. Responses by the healthcare professionals to the disruption include embracing the personhood of the individual, protecting self without jeopardising personhood, and suspending the personhood of the confused older person	Most of the interviews were with the family carers rather than the person with dementia	Excellent discussion section Good explanation of data collection process and data analysis

professionals to the admission of people with cognitive impairment to acute hospital settings: an observational and interview study						Multi-site study
Fukuda, R., Shimizu, Y. and Seto, N. (2015) Japan Issues experienced while administering care to patients with dementia in acute care hospitals: A study based on focus group interviews	To explore the challenges nurses face in providing care to patients with dementia in acute care hospitals in Japan	Qualitative study 50 nurses working in acute hospitals in western Japan	Eight focus group interviews	Nurses found that the various problems and difficulties interacted in a burdensome cycle and they needed to adapt to the conditions despite feeling conflicted The necessity to care for patients' families and obtain their cooperation	Only one male nurse participant Possible selection bias as the head nurses nominated the nurses to participate	Multi-site study
Goldberg, S.E., Whittamore, K.H., Pollock, K., Harwood, R.H. and J.R.F. Graham. (2014) U.K. Caring for cognitively impaired older patients in the general hospital: A qualitative analysis of similarities and differences between specialist Medical and Mental Health Unit and standard care wards	To compare and contrast the behaviours of staff and patients on the Medical and Mental Health Unit (MHU) and standard care wards and to provide a narrative account that helps to explain the link between structure, process and reported outcomes	Analysis of field notes using the constant comparison method. 90 TEAM trial participants who had been identified as confused	Sixty observations (360 hours) using the Dementia Care Mapping observational tool Detailed field notes	Care in a specialist mental health unit compared to a standard ward improves the experience for the patient, but not their health status. Developing a relationship between staff and the patient with dementia takes time and expertise, and may be impossible Organised activities provide occupation and social interaction for the patients	Study conducted in one English NHS hospital only. Demographic data of patients and nurses/ carers not specified	Good discussion of the findings
Griffiths, Knight, Harwood and Gladman (2014)	To explore doctors, nurses and allied health professionals' perceptions of their preparation to care for confused older patients on general wards	Consensual Qualitative Research 60 staff including doctors, nurses	Semi-structured interviews using open-ended questions	Concerns about the quality of care for people with dementia in UK No staff training analysis has been done. Current education and training is inadequate More workplace training, more support from senior staff, and better access to specialist services is required	Participants all from one hospital	Multi-professional perspective Interviews carried out by independent researchers

U.K. Preparation to care for confused older patients in general hospitals: a study of UK health professionals		and allied health				
Harrison and Zohhadi (2005) U.K. Professional influences on the provision of mental health care for older people within a general hospital ward	1. To identify the factors and issues that nurses consider to be of relevance in meeting an individual's mental health needs 2. To provide data that will go on to inform the future stages of the action research process 3. To begin to develop an understanding of how the future practice developments can be achieved 4. To make the insights generated accessible and available to other practitioners	Phenomenology Nine members of staff including a ward manager, staff nurses, student nurses and healthcare assistants	Focus group	Nurses struggle to provide effective and patient-sensitive care The nursing needs are complex and require highly skilled practitioners A focus on providing holistic person-centred care is required	Small study One focus group interview from one unit Planned interviews with patients and carers were not undertaken for financial, time and practical constraints	Findings/ themes presented as a diagram as well as in text, contributed to clarity Excellent justification of methodology Good discussion of data analysis
Hynninen, N., Saarnio, R. and Isola, A. (2014) Finland The care of older people with dementia in surgical wards from the point of view of the nursing staff and physicians	To describe the care of older people with dementia in surgical wards from the point of view of the nursing staff and physicians	A qualitative, descriptive design 19 nurses 9 physicians	Unstructured interviews	The nurses interviewed did not have the skills required to provide good care for people with dementia Nurse education and training needs to be improved Additional resources are required to provide a safe environment Clinical written guidelines are needed	Small number of participants from one facility	Good explanation of data analysis and the trustworthiness of the study
Moyle, W., Borbasi, S., Wallis, M., Olorenshaw, R. and Gracia, N. (2010)	To explore management for older people with dementia in an acute hospital setting	A pragmatic, exploratory qualitative approach	Semi-structured in-depth, face to face audio-taped	People with dementia are not always provided with care that takes into account their individual needs Appropriately skilled staff are needed to provide both person-centred and dementia-	Small number of participants from one facility.	Excellent discussion section

Australia Acute care management of older people with dementia: a qualitative perspective		13 staff including a medical doctor, nurses and AINs	interviews	specific care Staff education is very important		
Nilsson, A., Rasmussen, B. and Edvardsson, D. (2013) Sweden Falling behind: a substantive theory of care for older people with cognitive impairment in acute settings	To develop a theoretical understanding of the processes hindering person-centred care of older people with cognitive impairment in acute settings	Grounded theory Patients, family members and staff	110 hours of observation, 100 informal interviews 11 formal interviews with 1 patient, 1 family member and 9 staff	High-quality PCC is difficult to achieve in settings where staff work without consensus, the organisation is disease-orientated and efficiency-driven, and the environment is busy and inflexible These factors contribute to patient suffering, family exclusion and staff frustration	Small study conducted in a 20-bed acute hospital ward	Good explanation of methods Results presented in a table and narrative form Good use of quotes to support results
Nilsson, A., Rasmussen, B. and Edvardsson, D. (2015) Sweden A threat to our integrity - Meanings of providing nursing care for older patients with cognitive impairment in acute settings	To illuminate meanings of caring for older patients with cognitive impairment in acute care settings as experienced by nursing staff	Phenomenology 13 nurses	Narrative interviews	Caring for older cognitively impaired patients in acute settings is a threat to nurses' personal-professional integrity. Nurses must be supported in providing dignified care Nurses need opportunities to reflect on and discuss care and how it impacts on their ethos and integrity and on the health of patients and families	Small study conducted in one hospital. Demographic information not included. Relationship between researchers and participants, not mentioned	Good explanation of data analysis Good use of quotes to illustrate themes
Nolan, L. (2007) Ireland Caring for people with dementia in the acute setting: a study of nurses' views	To explore nurses' experiences of caring for older people with dementia in an acute hospital setting	A thematic approach Seven nurses	Interviews	Environmental constraints and multiple demands on nurses' time make meeting the needs of people with dementia difficult in the acute hospital setting Nurses work hard to meet the needs of people with dementia Skilled, knowledgeable nurses are essential	Small study conducted in one purpose-designed unit of a large hospital not typical of acute wards	Good use of quotes to support findings

Scerri, A., Innes, A. and Scerri, C. (2015) Malta Discovering what works well: exploring quality dementia care in hospital wards using an appreciative inquiry approach	To explore the quality dementia care in two geriatric hospital wards using appreciative inquiry with formal care workers and family members of inpatients with dementia	Appreciative inquiry 33 Care workers including 16 nurses, 9 nursing aides and clerks, 8 other healthcare professionals and 10 family members	Interviews using open ended questions	Dementia care in hospitals is not optimal although there are positive experiences. Personal attributes of staff, and organisational, environmental and contextual factors influence care practices.	Nurses were not asked to discuss negative experiences, only positive. This has the potential to skew the results.	Good discussion of the issues