Mixed Methods Inquiry

To Explore

Nurses' Views and Opinions about Dementia Care Nursing

In

Non-Dementia Specific Wards/Units

Contained In Dedicated Health Care Services

For

Older Persons Linked to Acute Hospital Services

A dissertation submitted to the University of Dublin, Trinity College in part fulfilment of the requirements for a degree of Doctor of Philosophy.

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February 2019
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DECLARATION

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Summary

Background

The older population (>65 years) is increasing at an unparalleled level. There is a concomitant rise in the numbers of older persons living with dementia, as there is a distinct correlation between ageing and dementia with prevalence rates of approximately 25% for those over the age of 80 years. Dementia is frequently accompanied by three or more multi-morbidities. Statistics demonstrate that older persons with dementia, accompanied by multi-morbidities are amongst the highest consumers of health care services. As a consequence, nurses practicing in non-dementia specific wards/units that include acute, rehabilitation and residential, contained in dedicated health care services for the older person linked to acute general hospitals are encountering an increased number of older persons with a co-incidental dementia in their practice. Due to the demographic changes in the population along with the dearth of nursing research conducted in this unique research setting provided the impetus to undertake this research study. The aim of this two phase mixed methods sequential explanatory study was to explore nurses' views and opinions about dementia care nursing based on their experiences of caring for the older person with dementia in non-dementia specific wards/units that include acute, rehabilitation and residential contained in dedicated health care services for the older person linked to acute general hospital services in the Irish context.

Design

A sequential explanatory mixed methods research design was used in this study. The first phase was a quantitative survey of registered general nurses (n=129) that examined nurses' views and opinions about dementia care nursing based on their experiences of caring for older persons with dementia in non-dementia specific wards/units that include acute, rehabilitation and residential, contained in dedicated health care services for the older person linked to three acute general hospital services. Three established, valid and reliable questionnaires along with a demographic questionnaire were used to gather data relative to nurses' views and opinions about various aspects of dementia care nursing such as, knowledge of patients, personal and professional development and quality of care. Nurses' attitudes towards dementia and nurses' beliefs about the environment of care were also explored. This was followed by five focus group interviews within the same non-dementia specific settings. Altogether 25 registered general nurses participated in the five focus group interviews, comprising 13 clinical nurse managers and 12 staff nurses. The purpose of the focus group interviews was to elaborate on the quantitative responses from phase one which is compatible with the purpose of sequential explanatory mixed methods research design.

Findings

Key findings highlighted the need for organisational support to place an emphasis on access to specialist education to ensure that all nurses are adequately prepared to provide dementia care nursing. Positive attitudes, which are pivotal to the care that persons with dementia can expect to receive, correlated significantly with specialist qualifications, management grades and >11 years nursing experience. Specialist knowledge is critical to the provision of dementia care nursing and nurses who believed that they had a good knowledge of patients also correlated, with specialist qualifications. It was found that 37.5% of respondents held specialist qualifications. Constructive feedback and opportunities to reflect on practice are important elements in dementia care nursing. Findings, suggested that support related to opportunities to discuss psychological issues originating from practice and, work evaluation were believed to be inadequate. A significant finding was that in view of the many ethical dilemmas encountered in provision of dementia care nursing, nurses would welcome the opportunity to participate in clinical supervision and education specific to ethics to enhance their competencies in ethical decision making. The participants represented a culturally diverse group of nurses. A unique finding related to cultural understandings of dementia and dementia care nursing and their impact on dementia care nursing and the importance of recognising and addressing this at the point of integration into nursing roles. It highlighted the important role of specialist education to ensure that all nurses are providing dementia care nursing according to the philosophies of the organisation. Clinical nurse managers were found to be the most satisfied with opportunities to develop personally and professionally and they had the greatest numbers of specialist qualifications. While quality of care was believed to be of a good standard, perceived inadequate staffing levels challenged nurses in providing the level of person-centred care that they aspired to. Although many nurses expressed satisfaction with the environment of care, others voiced concern particularly in relation to the challenges of maintaining persons with dementia's safety and security.

Conclusion

Results of the study contribute to an understanding of nurses' views and opinions about dementia care nursing in the unique identified setting and, add to the body of nursing knowledge. Knowledge, skills and positive attitudes correlated significantly with specialist qualifications. To ensure that nurses are in a position to meet the organisational goal of person-centred dementia care nursing requires an emphasis to be placed on access to specialist education and training. Quality of care delivered is also dependent upon adequate staffing levels being provided and the physical environment of care must be capable of ensuring safety and security for persons with dementia.

Acknowledgements

I would like to thank my husband, John for his unstinting support, patience and belief in me and his delicious sense of humour which sustained me "when the going got tough".

I would like to thank and acknowledge the support of the participant nurses who so generously gave of their time and who made this study possible.

I would like to most sincerely thank my supervisor, Dr Louse Daly for her continuous support and encouragement and for sharing her expert knowledge in the area of dementia with me.

I would also like to thank my supervisor, Dr Margaret McCann for her support and guidance in the writing of this thesis.

I also would like to acknowledge Dr Catherine Tracey for her invaluable advice and support and giving so generously of her time. Sincere thanks are also due to Dr Helen Malone for sharing her expertise with me.

I would also like to thank Dr Myra O'Regan, Associate Professor of Statistics and Dr Angela McCourt both of TCD, for their invaluable statistical advice.

Finally, this thesis is dedicated to my family, Deborah, Aoibhínn, Dillon and Michael and also Mark, Liam, Rio and Amanda.

I would also like to acknowledge Professor Geralyn Hynes for her kindness and wisdom.

Abstract

Background - The older population (>65 years) is increasing in number. There is a concomitant rise in the numbers of older persons living with dementia, as there is a distinct correlation between ageing and dementia. Dementia is frequently accompanied by three or more multi-morbidities. Older persons with dementia accompanied by multi-morbidities are amongst the highest consumers of health care services. Due to these facts, nurses are encountering an increasing number of older persons with a co-incidental dementia in their daily practice. This includes nurses practicing in non-dementia specific wards/units that include acute, rehabilitation and residential, contained in dedicated health care services for the older person linked to acute hospitals. This is the area of interest in the current study. Due to the demographic changes in our population and, the increasing prevalence of dementia along with the dearth of nursing research conducted in this unique research setting, provided justification for the current study.

Research Aim - The aim of this two phase mixed methods sequential explanatory study was to explore nurses' views and opinions about dementia care nursing based on their experiences of caring for the older person with dementia in non-dementia specific wards/units that include acute, rehabilitation and residential, contained in dedicated health care services for the older person linked to acute hospital services in the Irish context.

Methodology - A mixed methods sequential explanatory design was used. Phase one involved a quantitative survey approach with nurses (n=129) from non-dementia specific wards/units that include acute, rehabilitation and residential, contained in dedicated health care services for the older person linked to three acute general hospitals. Three questionnaires along with a demographic questionnaire were used to gather data relative to the nurses' views and opinions about various aspects of dementia care nursing to include nurses' attitudes towards dementia and nurses' beliefs about the environment of care. Phase two involved, running five focus groups within the same non-dementia specific setting. Altogether 25 registered general nurses participated in the focus group interviews. The purpose of the focus groups interviews was to elaborate on the quantitative responses from phase one.

Findings - Nurses were found to be generally positive about dementia care nursing and positive attitudes correlated significantly with specialist qualifications, management grades and > 11 years of nursing experience, 37.2% of the respondents had specialist qualifications. Key findings highlighted the need for organisational support to place an emphasis on access to specialist training and education to ensure that all nurses are adequately equipped to provide dementia care nursing. A significant finding was that in light of the many ethical dilemmas encountered in dementia care nursing, nurses would welcome the opportunity to participate in clinical supervision and education specific to ethics to enhance their competencies in ethical decision making. The participants represented a culturally diverse group of nurses. A unique finding related to cultural understandings of dementia and dementia care nursing and the impact on dementia care nursing and the importance of recognising and addressing this at the point of integration into the nursing role. While many nurses expressed satisfaction with the physical environment of care, others voiced concern, particularly in relation to the challenges of maintaining persons with dementia safety and security within the ward environment. In relation to staffing levels, many nurses perceived that insufficient staffing levels resulted in challenges in providing the quality of dementia care nursing that they wanted to deliver and that they knew the person with dementia deserved.

Conclusion - Results of the study, contribute an overview of the experiences of nurses within the unique setting of non-dementia specific wards/units as identified. An array of complexities experienced by nurses in their practice of dementia care nursing, were identified. Specialist dementia education is critical to ensure that all nurses are providing dementia care nursing according to the person-centred philosophies of the organisation.

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Chapter One – Introduction and Background

1.1 Introduction and Background

Acute hospital services are experiencing increasing numbers of older persons with multi-morbidities accompanied by dementia (Timmons et al, 2016). Consequently, nurses working within non-dementia specific dedicated health care services for the older person linked to acute hospital services are encountering a growing number of older persons experiencing these complexities. Despite an increasing recognition of the range of modifiable factors that can lead to lowering prevalence figures for dementia, it is widely accepted that increasing age is the strongest risk factor (Cahill et al 2013; Matthews et al, 2013; Department of Health (DOH), 2014; Satizabal et al, 2016). While it is acknowledged that there may be a possible stabilization of dementia figures in Western Europe, older persons in high income countries, and those in low to middle income countries, will continue to be at high risk and the world-wide figures will continue to increase in line with the projected increase in life expectancy (Satizabal, 2016). Evidently, dementia remains predominantly a condition of ageing but it is not an inevitable part of the ageing process.

Due to the manifestations of dementia, acute hospital admission can be challenging both for older persons with dementia and the nursing staff caring for them. The increasing numbers of older persons with dementia (chapter 1, section 1.2.2) and the complexities involved in dementia care nursing (chapter 2, section 2.2) provided the impetus to undertake this sequential explanatory mixed methods study. These facts coupled with the reality that older persons with dementia are amongst the highest consumers of health care, justifies exploring nurses' experiences of dementia care nursing in the Irish setting. The study was undertaken with the purpose of exploring nurses' views and opinions about dementia care nursing based on their experiences of caring for the older person with dementia in non-dementia specific units that include acute, rehabilitation and residential contained in dedicated health care services for the older person linked to acute hospital services.

1.1.1 Research Question

The research question that this study addressed is "What are nurses' views and opinions about dementia care nursing based on their experiences of caring for older persons with dementia in non-dementia specific wards/units that include acute, rehabilitation and

residential, contained in dedicated health care services for the older person linked to acute hospital services?"

1.1.2 Research Aim:

- The aim of this two phase mixed methods sequential explanatory study was to explore nurses' views and opinions about dementia care nursing based on their experiences of caring for the older person with dementia in non-dementia specific wards/units that include acute, rehabilitation and residential, contained in dedicated health care services for the older person linked to acute hospital services.

1.1.3 Research Objectives:

- To explore and describe, nurses' views and opinions about dementia care nursing based on their experiences of caring for the older person with dementia in non-dementia specific wards/units that include acute, rehabilitation and residential, contained in dedicated health care services for the older person linked to acute hospital services.

- To investigate attitudes held by nurses towards dementia based on their experiences of caring for the older person with dementia in non-dementia specific wards/units that include acute, rehabilitation and residential, contained in dedicated health care services for the older person linked to acute hospital services.

- To obtain descriptions of nurses' beliefs about the environment of care and its impact on nurses' experiences of caring for the older person with dementia in non-dementia specific wards/units that include acute, rehabilitation and residential, contained in dedicated health care services for the older person linked to acute hospital services.

- To explore the associations between nurses' demographic characteristics and their views and opinions about dementia care nursing based on their experiences of caring for the older person with dementia in non-dementia specific wards/units that include acute, rehabilitation and residential, contained in dedicated health care services for the older person linked to acute hospital services.

The study took place within non-dementia specific wards/units that include acute, rehabilitation and residential, contained in dedicated health care services for the older person linked to three hospital sites, comprising two acute university teaching hospitals, and one hospital site which was affiliated to one of the two acute university teaching hospitals.

1.1.4 Dementia and Dementia Care Nursing

Dementia is an overarching term used to describe a condition that can include a wide range of symptoms, it is not a specific disease (Alzheimer's Association, 2017). It is a progressive

condition caused by damage to brain cells, which interfere with communication between the cells, effecting thinking, behaviours and feelings (Alzheimer's Association, 2017). Symptoms of dementia are characterised by decreasing levels of cognitive function with a concomitant decrease in the ability to perform activities of living (DOH, 2014). Behavioural and psychological symptoms may also develop, combined with memory loss, communication difficulties and spatial awareness problems (DOH, 2014). Dementia is often accompanied with three or more multi-morbidities that frequently result in acute hospital admission (Timmons et al, 2016).

These aforementioned complexities require specialist nursing input, to include appropriate professional nursing competencies (Traynor et al, 2011). It is accepted that optimal nursing management with the older person with dementia is dependent upon skilled, knowledgeable practitioners (Moyle et al, 2010; Traynor et al, 2011). Specialist skills and knowledge are needed to encompass an understanding of the manifestation of the dementia pathology and physical and psychological nursing care needs (Moyle et al, 2010). The Nursing and Midwifery Board of Ireland (NMBI) (2015) hold the position that the role of the nurse is pivotal to the delivery of best quality care for the older person and the older person with dementia (NMBI, 2015). Accordingly professional nursing competencies applicable to older person nursing have been developed for the purpose of providing a guiding framework for nurses caring for the older person and the older person with dementia (NMBI, 2015). Competencies for nurses who care for the older person include, professional ethical practice, holistic approaches to care and integration of knowledge, interpersonal relationships, organisation and management of care and personal and professional development. The set competencies are broad in nature but include specific references to caring for the older person with dementia, to include the necessity to follow best practice national guidelines in caring for a person with dementia, and recognition that all behaviour has meaning.

It is also recommended that nursing care should be delivered in a person-centred manner. The person-centred philosophy of care (chapter 2, section 2.3) promotes an approach that is based on values of respect for the person, an acknowledgement of an individuals' right to self-determination along with shared respect and understanding (McCormack and McCance, 2017). Similarly, the National Clinical Programme for Older Persons (NCPOP) recognises the importance of the role of the nurse in the provision of quality care for the older person with dementia and multi-morbidities (Health Service Executive (HSE), 2012). The NCPOP is

a joint programme between the HSE and the Royal College of Physicians of Ireland (RCPI) (HSE, 2012). The NCPOP is a multi-disciplinary programme and the discipline of nursing is headed up by a Director of Nursing. The role of the nurse is recognised within this team as contributing to care with the older person by utilising professional knowledge, skills and expertise in person-centred holistic care (HSE, 2012). The NCPOP have adapted the NMBI (2015) nursing competencies for use within the multi-disciplinary team (HSE, 2016). From a nursing perspective, Traynor et al (2011) identified a number of nursing competencies relevant to dementia care nursing originating from a variety of countries, thus demonstrating international acknowledgement of the crucial role of the nurse in effectively delivering care to persons with dementia.

As outlined previously (section 1.1) hospital admission can be challenging for the older person with dementia due to the manifestations of the dementia pathology. While it is acknowledged that older person care incorporating dementia care is the concern of the multi-disciplinary team in all areas (Traynor et al, 2011) it is the experiences of the nurse within the unique context of non-dementia specific wards/units contained in dedicated health care services for the older person linked to acute hospital services that is the focus of the current study. It is recognised that the nursing requirements of the person with dementia which include physical and psychological care are complex. Therefore, the nursing role needs to be explored to reach an understanding of the multifaceted nature of dementia care nursing. These facts provide support for conducting the exploration of nurses' experiences of dementia care nursing in the identified setting presented in this thesis.

The purpose of this chapter is to contextualise the study, reported within this thesis. To this end, the following sections will explore: demographics of non-dementia and dementia over 65 year population, health care provision for the older person in the Irish context, the Irish National Dementia Strategy, issues related to ageism, the contextual nursing workforce composition and skill mix. Finally, the summary includes: the method of inquiry, personal perspective and lastly the structure of the thesis.

1.2 Demographics of Non-Dementia and Dementia of the over 65 Year Population

As previously acknowledged, there is a distinct association between ageing and dementia (O'Shea, 2007). It is reported that the risk of developing dementia increases from approximately 1% in persons under the age of 65 years to over 25% for persons over 80 years

(O'Shea, 2007). For this reason, it is important to set the background and to explore relevant demographic information linked to the non-dementia and dementia of the over 65 year population.

1.2.1 Demographics of the over 65 Year Population

The older population in Ireland is increasing. According to the Central Statistics Office (CSO) the population over the age of 65 years has risen by 19.1% since 2011 from approximately 535,393 or 11.7% of the population to approximately 637,567 or 13.4% of the population (CSO, 2017). Annually, the number of people over the age of 65 years is increasing by 20,000 (DOH, 2016a). This scale of ageing is unparalleled in Irish history (TLDA, 2014).

Since 2005, life expectancy in Ireland has grown by 2.4 years (DOH, 2016a). There has been a narrowing of the gap between male and female life expectancy over the last decade. Irish women aged 65 years are expected to live for another 21.1 years, similar to the EU average (DOH, 2016a). Life expectancy for Irish men at age 65 years is 18.0 years, slightly higher than the EU average of 17.7 years (DOH, 2016a). The proportion of life expectancy, from age 65, to be lived in good health for both men and women in Ireland compares positively with the EU-28 average (DOH, 2016a). Although Irish women aged 65 years have a higher life expectancy than Irish men aged 65 years, men will have a marginally higher percentage of healthy life years (DOH, 2016a).

In line with global population figures, according to CSO population projections, the most striking change in the composition of the population in the coming years will be the increasing numbers of people aged 65 years and above (DOH, 2016a). It is projected that by 2022, 15.4% of the population will be over the age of 65 years. Projected figures predict that people aged 65-84 years will increase by 16.6% or 95,100 people and the over 85 years of age group will increase by 22.2% or 16,100 people (Smyth et al, 2017). An awareness of the population demographics for the over 65 year old group is extremely valuable, in terms of the provision of health care delivery and support, especially given the association between ageing and dementia.

1.2.2 Demographics of the over 65 Year Population with Dementia

It is beneficial to have estimated figures for policy makers and planning for dementia services but as Pierce et al (2014) cautions, the figures should not be used in a sensationalist manner to support a tsunami notion of dementia. A further risk in the production of prevalence estimates, is that it may lead to thinking about people with dementia as one homogenous group (Pierce and Pierse, 2017). This is in complete opposition to the person-centred approach as advocated by the Irish National Dementia Strategy (Pierce and Pierse, 2017). Notwithstanding, it is estimated that there are 47 million people living with dementia worldwide (Prince et al, 2016). These numbers are projected to increase to 131 million people by 2050 in line with the population growth of people over the age of 65 years (Prince et al, 2016). Within European countries, the numbers of people with dementia are currently 10.5 million and this number is expected to increase to 18.66 million by 2050 (Alzheimer's Research UK, 2016). Within Ireland, the estimated figure for people with dementia is currently calculated to be in the region of 55,000 people (HSE et al, 2017). The projected figures for 2046 are expected to be in the region of 157,883 people (Pierce and Pierse, 2017).

Despite the expectations that the figures for dementia will grow in accordance with increased life expectancy, it is suggested in a number of studies that prevalence rates might be subject to change in the opposite direction (Matthews et al, 2013; Jones and Greene, 2016; Satizabal et al, 2016; Wu et al, 2016). It is understood that conditions that cause damage to the heart or blood circulation can increase the risk of developing dementia (DOH, 2014). There is also growing awareness that social isolation and loneliness may be contributory risk factors. Other life style risk factors include physical inactivity, smoking, unhealthy diet and excessive alcohol intake (DOH, 2014). Therefore, it stands to reason that modifiable factors that may be responsible for decreasing the prevalence of dementia, include taking actions such as increasing physical pursuits and social engagement, reducing smoking and treating hearing impairment (Rees, 2017). Other influences that result in decreasing prevalence rates of dementia include increased participation in early life education and successful primary prevention of heart disease (Matthews, 2013; Jones and Greene, 2016; Satizabal et al, 2016) along with increased wealth (Jones and Greene, 2016; Satizabal et al, 2016). In a two decade comparison study of prevalence of dementia in individuals aged 65 years and over in three geographical areas in England, Matthews et al (2013) reported a 24% reduction in the prevalence of dementia. Satizabal et al's (2016) American study also found a percentage decline in the incidence of dementia over three decades, that is between late 1970s and early

1980s, 1990s and early 2000s, late 2000s and early 2010s prevalence reduced by 22%, 38% and 44% respectively (Satizabal, 2016).

However, it is argued that the overall rise in risk factors for increasing the prevalence of dementia may undermine the gains achieved through improved education, wealth and control of vascular risk factors (Matthews et al, 2013; Satizabal et al, 2016). According to Satizabal et al (2016) improvements in cardiovascular health were found solely in the group of participants with a high school education. While Matthews et al (2013) suggest that risk factors that might lead to an increase in the prevalence of dementia include obesity and diabetes and an increase in physical inactivity. Added to this, persistent inequalities in health across the life course and increased survival rates after stroke and heart disease are mooted as further risk factors (Matthews et al, 2013). Clearly, empirical evidence suggests that the potential for a lowering of dementia prevalence rates is counterbalanced by the continuing inequalities in health coupled with the increasing occurrence of cardiovascular assault survival rates and life style choices. However, the risk of developing dementia remains clearly associated with the ageing process (O'Shea, 2007) and this fact warrants undertaking an exploration of nurses' experiences of dementia care nursing to promote an understanding of ways in which it is delivered within non-dementia specific units. Health care provision for the older person in the Irish context will be outlined in the next section.

1.3   Health Care Provision for the Older Person in the Irish Context

A brief overview of the history of health care provision for the older person in Ireland is outlined in this section, in order to establish the origins of dedicated health care services for the older person. In particular, the content will explore the establishment of non-dementia specific units including acute, rehabilitation and residential situated in dedicated health care services for the older person linked to acute hospital services, in the Irish context. This is the unique environment of care within which the current study took place and where the nurses' views and opinions about dementia care nursing based on their experiences of caring for the older person with dementia were investigated.

There was a strong tradition of caring for older people in pre-Christian Ireland under the Brehon system of laws (O'Neill and O'Keefe, 2003). These laws became obsolete under the Normans in the 12th century and care of the older person followed a non-specific path up to the 19th century (O'Neill and O'Keeffe, 2003). In the mid 19th century, the British

government introduced the poor law or work house system into Ireland (Timonen and Doyle, 2007). The work houses were set aside for the poorest and were designed to be so austere that they would only attract those who had nowhere else to go (Timonen and Doyle, 2007). The work houses became the foundation for institutionalized care of the older person right up to the latter part of the 20[th]century (O'Neill and O'Keefe, 2003). It is argued that the low status often afforded to gerontological nursing can be partly attributed to the association between care of the older person and the work house system (Koch and Webb, 1996).

After the foundation of the Irish Free State in 1922, the work house system was dismantled and county homes were established (Government of Ireland, 1968). In theory, the county homes were instituted for the old and infirm but they soon included a range of people with both medical and social needs (Timonen and Doyle, 2007). In practice the change in status did little to improve the generally shoddy conditions, nor the institutional bias of public policy (O'Shea et al, 1991) whereby health care spending on care of the older person remained inadequate (O'Neill and O'Keefe, 2003). During the early years of the State, health services were not a governmental priority. Indeed up to 1970, the public health services were delivered through local government systems and funding was provided by the Irish hospital sweepstakes (Harvey, 2007). This fact led to an uneven distribution of health care services throughout the country due to the many agencies contributing to the health care needs of the population (Daly, 2012). In response to the absence of a comprehensive community care programme and the inferior standard of institutional care for the older person, the Interdepartmental Committee on Care of the Elderly produced, the Care of the Aged Report (Government of Ireland, 1968).

It is the recommendations from this report that emphasised the creation of a full range of non-dementia specific services that are of interest to this study. Dedicated health care services for the older person within acute general hospitals as recommended by the Care of the Aged Report (Government of Ireland, 1968) emerged in an attempt to address the lack of specialist facilities for care of the older person within acute general hospitals. Or more cynically as Nolan et al (2012) suggest, care of the older person medicine was given the status of a speciality as there was a need to free up medical and surgical beds within acute general hospitals. The term "geriatric department" was defined at the time by the National Council for the Aged (1985) as an area within a hospital which specialised in services exclusive to the person over the age of 65 years. The main function of this department as outlined by the

Government of Ireland (1968) was to provide a high level of medical and nursing skill, for the older person with and without dementia experiencing illness. This acknowledged that the older person experiencing illness, requires more in the way of individual care than would be expected in the general wards of a hospital (Government of Ireland, 1968). Care of the older person was acknowledged to be different in many ways from the care of others, to include multi-morbidities, dementia and differences in anatomy and physiology. There was also recognition that diagnosis can be difficult as disease can often be silent for the older person (Government of Ireland, 1968). The older person could expect to be more comprehensively assessed, treated and referred within non-dementia specific dedicated health care services for the older person and, the many problems associated with admission to the acute general hospital ward could be avoided. As such, non-dementia specific dedicated health care services for the older person, where they existed, were better placed to provide care to meet the needs of patients predominantly over the age of 75 years with and without dementia (National Council for the Aged, 1985).

In relation to rehabilitation services for the older person, when inpatient treatment was required, non-dementia specific dedicated health care services for the older person, within the acute general hospital provided a rehabilitation programme which in many instances led to a full functional recovery (National Council for the Aged, 1985). To achieve maximum functional recovery for the older person with and without dementia, a team approach which involved integration of medical and para-medical personnel along with nursing staff was recommended (National Council for the Aged, 1985). It was believed that work experience and training exposed the multi-disciplinary team to a particular attitude towards care of the older person, leading to a more positive attitudinal change in both medical and caring professions generally (National Council for the Aged, 1985).

The Care of the Aged Report (Government of Ireland, 1968) also recommended that non-dementia specific residential care under the remit of the dedicated health care services for the older person, should be placed either in or close to an acute general hospital and that a close link should remain between the two (Government of Ireland, 1968). This was in recognition of the fact that many of the residents in residential care required on-going medical care, thus a close link with the hospital was essential (Government of Ireland, 1968). According to the Government of Ireland (1968) residents within residential care settings required the services of physiotherapists, occupational therapists and medical staff along with a high level of

nursing staff. This was another reason for recommending the placement of residential care either in or close to acute general hospitals. In an effort to offset, the perennial difficulties of sourcing nursing staff for the residential units, it was recommended that nursing staff could rotate between residential and short stay units for the older person and that they should receive an additional financial allowance (Government of Ireland, 1968).

1.3.1   Contemporary Health Services for the Older Person

According to The Years Ahead Report (Robins, 1988) one of the most significant advances in care of the older person health care has been the development of non-dementia specific dedicated health care services for the older person, where they exist, within acute general hospitals. In reality, full implementation of the recommendations outlined in the report was slow to progress (Ruddle et al, 1997). More recently, the situation has remained mostly unchanged. According to O'Neill (2015) the majority of Irish acute general hospitals still do not have dedicated wards for geriatric medicine and O'Shea (2017) found that only 30% of identified acute general hospitals incorporated dedicated specialist geriatric care wards. This is despite the fact that specialist geriatric units are recognised as contributing to more effective care for the older person (Baztán et al, 2009; HSE, 2012; Briggs et al, 2016b). The HSE (2012) use the definition outlined by Ellis et al (2011) which describes such a unit to include acute and rehabilitation management under the care of a specialist multi-disciplinary team. This definition remains true to the philosophies outlined earlier in relation to geriatric care as mooted by the National Council for the Aged (1985). The distinctive features of non-dementia specific specialist geriatric units include adequate staffing levels (chapter 2, section 2.4.2) and specialist training (chapter 2, section 2.5.1).

The following section will explore the prevalence of persons with dementia and non-dementia admitted to acute, rehabilitation and residential units for the older person, in order to focus this study on these particular settings.

1.4   Health Service Utilisation Specific to Acute, Rehabilitation and Residential Units, Related to the Over 65 Year Population with Dementia and non-Dementia

The evidence demonstrates that the risk of developing dementia increases with age and the probability of using health services is also noted to increase exponentially with age and the population over the age of 65 years are the predominant consumers (DOH, 2016a). The increased reliance on health services by the older person is due to a variety of health concerns

to include multi-morbidity, dementia and frailty or a combination thereof (Briggs et al, 2016a; Timmons et al, 2016). Multi-morbidity or the coexistence of more than two chronic conditions is more widespread among older adults, with estimates of 65-98% for people over the age of 65 years with concomitant implications for health care utilisation (Glynn et al, 2011). Health care utilisation by the over 65 population, as recorded by the 2011 census, established that, 6% or 31,054 older people were residing in communal establishments with 15% (4,783) receiving hospital care while two thirds of this group were identified as being resident in nursing homes. The remaining 5,379 were living in religious communities (CSO, 2011). These facts demonstrate general health care patterns for the over 65 population.

As stated previously, the settings for the current study included, non-dementia specific acute, rehabilitation and residential units within dedicated health care services for the older person linked to acute general hospital services. The following section will present the estimated figures of older persons with dementia and non-dementia using these services.

1.4.1   Acute General Hospitals

Persons with dementia are amongst the highest users of acute hospital services (Sampson et al, 2009). The estimated prevalence of older persons receiving hospital care with a co-incidental dementia ranges from 29-42% in the Irish setting (de Siún et al, 2014). Although this may be an underestimation as according to Afzal et al (2010), in their retrospective Irish study undertaken to explore end of life care for the person with dementia, just over half of people over the age of 65 years had a cognitive test completed. This point is reflected by Cahill et al (2012) where it was reported that a large percentage of patients have no information in their admission documents to indicate that they have a dementia, either because it has not been diagnosed or because it has not been recorded. Consequently, this creates a difficulty in estimating the number of persons with dementia receiving acute hospital care at any given time (Cahill et al, 2012). When it comes to gender and age, it is noted that the hospitalised older person with dementia is more likely to be female and 4 to 7 years older than the older person with no dementia (Jackson et al, 2017). These figures correspond with a large UK hospital based study, where it was found that 16.4% of men and 29.6% of women aged between 70-79 years increasing to 48.8% of men and 75% of women over the age of 90 years had a dementia diagnosis (Sampson et al, 2009).

1.4.2   Residential Services

The principal reason for admission to a residential unit is dementia (DOH, 2013). Overall, it is estimated that the numbers of persons with dementia in residential services is between 15,000 and 20,000 people and almost half of all residents (47%) have dementia (Pierce and Pierse, 2017). Statistically, the majority of residents throughout residential services are over the age of 80 years with 20.8% aged 80-84 years increasing to 50.2% for those aged 85 years and above (DOH, 2016a). As to be expected from the breakdown of male and female >65 years statistics, figures from the DOH (2013) illustrate that the majority or 65.4% of residents requiring residential services are female (DOH, 2013). The majority of residents (76.7%) over the age of 80 years are female (DOH, 2013).

Residential services are provided and supported by a mix of public, voluntary (religious orders and charities) and private providers (Cahill et al, 2012; DOH, 2013). The voluntary sector plays a substantial role and this is similar to many areas of health provision in Ireland (Research and Information Service (RaISe), 2013). Nationally, the total number of residential beds is 29,060 and the majority of beds are provided by the private sector (21,713) followed by the HSE (6,046) and centres operated by the HSE (1,301) (Health Information and Quality Authority (HIQA), 2015). Residents who require long stay care are normally amongst the frailest of older people (HSE, 2012). Generally, the HSE provide residential services for the older person experiencing serious chronic illness, requiring on-going multi-disciplinary input and a high level of nursing attention (Cahill et al, 2012; DOH, 2013). The focus for the current study is residential care units within the remit of the HSE ie non-dementia specific residential care units contained in dedicated health care services for the older person linked to acute general hospital services.

1.4.3 Rehabilitation and Limited Stay Facilities

In addition to residential units, there are a number of limited stay facilities including 372 dedicated to rehabilitation and 685 that provide respite care. Over half or 63.8% of the service users are over the age of 80 years and 6.2% have a recognised dementia (DOH, 2013). The majority of rehabilitation and respite services are provided by the HSE: 245 and 411 respectively (DOH, 2013). In respect of limited stay facilities, 59.6% of the population are female (DOH, 2013). Rehabilitation is a fundamental element in the practice of care of the older person involving the multi-disciplinary team. Rehabilitation should be an essential element of the care of all older people admitted to the acute care setting (HSE, 2012).

Taking all of the above factors from the previous section into consideration, it is evident that there are a high number of older persons with dementia represented in non-dementia specific acute, rehabilitation and residential facilities. As a consequence, nurses practicing in these services find themselves working increasingly with the older person with dementia accompanied by multi-morbidities. In brief, older persons with dementia accessing health care services are representative of the oldest members of society, oftentimes experiencing both dementia and multi-morbidities in other words both multiple and chronic conditions which require skilled and knowledgeable nursing input. Older persons with dementia who reside in HSE residential units linked to acute general hospital services are amongst the frailest of all older adults (Cahill et al, 2013; DOH, 2013). These facts strengthen the need to explore nurses' experiences of dementia care nursing in these settings, in order to advance understandings of the practice of dementia care nursing.

In terms of policy documents relative to dementia, the Irish National Dementia Strategy was published in 2014. The publication of this document and implementation of the stated priority actions contained therein, will influence both the public and health professionals' understandings of dementia and is therefore, of interest to the current study. An overview of the Strategy is presented in the following section

1.5   The Irish National Dementia Strategy

A number of reports already presented in this discussion including Government of Ireland, (1968) Robins (1988) and Ruddle et al (1997) made recommendations for the development of a policy for dementia in Ireland. However, the most influential documents in relation to the development of dementia policy are considered to be An Action Plan on Dementia (O'Shea and O'Reilly, 1999) and Implementing Policy for Dementia Care in Ireland – The time for Action is Now (O'Shea, 2007). The key point to emerge from these documents was that dementia should be made a national health priority (O'Shea, 2007). In reference to the delay in the development of this initiative, the Alzheimer Society of Ireland (ASI) (2015) argued that dementia had been a neglected, health issue in Irish health and social services, up to recent times. While O'Connell (2012) contended that ageist attitudes amongst health care professionals and society in general culminated in dementia being kept off the national agenda over the years. Further issues relative to ageist attitudes in both society and health care are explored in section (1.6). Eventually, in 2010, the Programme for Government gave a commitment to developing a National Dementia Strategy (Cahill et al 2013). The

development of the Strategy involved the Department of Health along with a wider combination of stakeholders (Cahill et al, 2012).

In 2014 the DOH published Ireland's first National Dementia Strategy (DOH, 2014)

> "The aim of the strategy is to improve dementia care so that people with dementia can live well for as long as possible, can ultimately die with comfort and dignity and can have services and supports delivered in the best way possible" (p 8).

The overarching philosophies underpinning the strategy are personhood and citizenship. The inclusion of these philosophies marks a distinct move away from the traditional biomedical model of care towards a more holistic, person-centred culture of care (O'Shea et al, 2017). The publication of the strategy is a welcome development but as O'Shea et al (2017) caution, devising principles and putting them into a document is the easy part. Implementing a paradigm shift from the current provider driven, service-led model of care to an individualised, person-centred ethos of care is the challenge (O'Shea et al, 2017). The paradigm shift, if implemented, will influence ways in which nursing care with the older person is delivered within non-dementia specific wards/units in the context of the current study. Traditionally, the Irish experience of implementation of policy for the older person has been slow (O'Shea et al, 2017) as demonstrated earlier in relation to the development of dedicated health care services for the older person within the acute hospital setting.

The six Priority Action Areas contained in the National Dementia Strategy (2014) include: better awareness and understanding; timely diagnosis and intervention; integrated services, supports and care for people with dementia and their carers; training and education; research and information systems; leadership (DOH, 2014). The priority actions outlined in the Strategy, if implemented, have the capacity to improve both the public and health professionals' understanding of dementia and decrease the stigma attached. The strategy also has the potential to improve the person with dementia's journey through the health and social care systems (Cahill et al, 2013; ASI, 2015). Projects aimed at augmenting the potential of the National Dementia Strategy have been undertaken by the HSE & Genio Dementia Programme with support from the HSE and the Atlantic Philanthropies. The three major components of the projects include (1) Community based supports for people with dementia (2) Integrated care pathways (ICP) in acute hospitals for people with dementia (3) Supporting the implementation of the National Dementia Programme (Genio, 2015).

The implementation of the priority actions contained in the Dementia Strategy will undoubtedly influence nurses' experience of dementia care nursing, particularly within the units relevant to the current study. For example, recommendations from the Strategy propose that care staff should receive on-going education to ensure that they have the prerequisite skills to deliver care that is person-centred (DOH, 2014). The NMBI (2014a) in their response to the Strategy, endorse the view that nurses have a pivotal role to play in supporting the person with dementia and their family. In particular, they emphasise the crucial role that nurses will have in implementing the translation of integrated pathways across the care continuum. They further highlight the role of the nurse as a change agent and dementia champion (NMBI, 2014a). However, there are no discussions offered by NMBI (2014a) as to how these roles are to be implemented and supported. The findings of the current exploration of nurses' experiences of dementia care nursing, within non-dementia specific units illuminated, to a certain extent, nurses' awareness and contribution to the NMBI (2014a) vision. For example, access to specialist education was explored along with staffing levels.

1.6 Ageist Attitudes in Relation to Dementia

Any study of dementia has to also look at the wider social understandings of being 'old' and the myths of old age including ageism (Innes, 2009). These ideologies will influence the expectations that society, to include family and paid caregivers will have about the care experiences that the person with dementia can expect (Innes, 2009; Benbow and Jolley, 2012). Ageism was originally defined in 1969 by Dr Robert Butler an American gerontologist, he defined it as stereotyping and discrimination against people simply because they are old, just as sexism and racism accomplish this with gender and skin colour. Ageism, combined with negative responses to dementia culminates in a double discrimination (Brooker; 2004; Benbow and Jolley, 2012). A further discrimination, for consideration in a world that worships youth and intact cognitive function, is that of hyper cognitivism or dementia-ism where the recipients are older persons with dementia (Brooker, 2004).

There is no doubt that ageist attitudes still hold in society and are perpetuated within health care systems (Phelan, 2011; Kagan and Melendez-Torres, 2015). Ageism, when internalised by the discipline of nursing, results in poor nursing care for the older adult (Phelan, 2008; Phelan, 2011; Kagan and Melendez-Torres, 2015). It is suggested that the low status given to dementia care in the acute care setting may be a reflection of societal attitudes (Cowdell,

2010a). There continues to be a very low status given to the caregivers of the older person, particularly the older person with dementia resulting in feelings of powerlessness which makes it very difficult to bring about change in the culture of care (Innes, 2009; Kagan and Melendez-Torres, 2015). This view is reinforced in Cowdell's (2010a) qualitative study which explored nursing staff's experience of care delivery. The participant nurses maintained that caring for the person with dementia is viewed as relatively unskilled and not prestigious (Cowdell, 2010a). This point ties in closely with Benbow and Jolley (2012) who state that staff who work with the person with dementia are under-valued in comparison with staff working in other areas of health care. In concurrence with Innes (2009) Benbow and Jolley (2012) further comment that institutional ageism has the propensity to negatively affect service status, resources and staffing levels. Discrepancies in resources which places care of the person with dementia low in the list of priorities is discrimination in action. This is further compounded by a failure to value, educate and support staff caring for the older person with dementia (Benbow and Jolley, 2012). Ageism also has a negative influence on scientific research (Kagan and Melendez-Torres, 2015). According to Kagan and Melendez-Torres (2015) as a result of ageism in scientific research, there is a dearth of evidence with, which to direct the care of the older person. There is no doubt that working with persons with dementia is extremely demanding (Innes, 2009; DOH, 2014) and carers need to be knowledgeable and innovative (Griffiths et al, 2015). However, as Innes (2009) comments as long as dementia is misunderstood and persons with dementia continue to be stigmatized and marginalised, those who work with them will similarly be marginalized and devalued. As the current study explores nurses' experiences of dementia care nursing in the acute care general hospital setting, many points raised in this section are of particular interest to the current study. For example, it is suggested that institutional ageism results in lack of support for education, along with poor staffing levels and resources. These points were explored in the current study. They were explored in order to provide a greater understanding of these aspects of dementia care nursing from the perspective of nurses' experiences in the identified setting ie non-dementia specific wards/units contained in dedicated health care services for the older person linked to acute hospital services.

To bring about a comprehensive understanding of the nursing personnel who care for the older person with dementia, the next section will present a description of the nursing workforce composition and skill mix in the Irish health care context. There is widespread

recognition that the nature of the workforce is a crucial consideration in both older person and dementia specific care.

1.7   Contextual Nursing Workforce Composition and Skill Mix

Nurse shortage is an international problem and Ireland is no different. The majority of immigrant nurses globally are recruited from Asian countries with India and the Philippines making up the main source for Western countries (Xu, 2007). Ireland began actively recruiting nurses internationally in 2000 in an effort to offset the national shortage of nurses. Between 2000 and 2010, 35% of new recruits into the health system were non-EU registered migrant nurses with numbers reaching 11,481 (Humphries et al, 2012) and during 2002, Ireland became a major destination for nurses from the Philippines (Yeates, 2004). Indeed during the period 2000 and 2010, the numbers of nurses recruited internationally (14,546) were not too far behind the numbers of nurses educated in Ireland (17,264) (Humphries et al, 2012). As noted, the majority of migrant nurses are recruited from India and the Philippines and a number of Dublin hospitals identified that 50% to 80% of their nursing staff are migrant workers (Humphries et al, 2009). Ireland has become more heavily dependent upon international nurse recruitment than the UK, New Zealand or Australia (Humphries et al, 2009). Nurses educated outside of Ireland, make up 47.1% of the Irish work force compared to 3.5% in the UK, 22.1% in New Zealand and 16.4% in Australia (Humphries et al, 2012). During 2016, of the 3,877 nurses and midwives registered to enter the Irish health system 2,055 were overseas registrations, this represents a 98% increase from 2015, while the remainder 1,822 comprised Irish educated applications (NMBI, 2017a). The figures for 2017 up to 21st February 2017, add up to a total 630 with 540 overseas registrations (NMBI, 2017a).

There are no figures available specific to the numbers of non-EU migrant nurses in the Irish care of the older person health care services. However, according to Walsh and O'Shea (2010) in the Irish older person and social care sector, migrant care workers feature strongly and this is noted to be a new area of practice for non-EU migrant nurses. Potentially, according to de Siún and Manning (2010) for the non-EU migrant nurse, practicing in the older person care sector can be demanding. Problems can be experienced with language proficiency, which can be further exacerbated by the use of colloquialisms which can result in communication challenges. Added to this a lack of knowledge of Irish culture can pose difficulties in establishing reference points in communication. These issues can be

particularly problematic in the delivery of a person-centred approach to care (de Siún and Manning, 2010). It is conceded that specialist education can go some way to resolving these issues (de Siún and Manning, 2010) and provision of specialist education is explored in the current study.

1.7.1   Nurses' Skill Mix and Older Person Services

As the current study focus is on dementia care nursing, an exploration of the current nursing workforce composition and skill mix is required to provide a contextual backdrop. Nursing skill mix in the Irish context is defined as a mix of education combined with training, experience and skills within the nursing team to include both registered nurses and unregistered health care assistants (HCAs) (DOH, 2016b). The role of the unregistered HCA, is defined as providing patient care under the direct supervision of a registered member of nursing staff (DOH, 2016b). The use of unregulated workers, assisting nurses has long been a characteristic of older person care in the Irish health system (Coffey, 2004). It is suggested that nursing skill mix is not always easy to identify given the difficulties in clearly defining the role of the registered nurse and there is considerable overlap between the role of the registered nurse and the HCA (Shannon, 2012). For example, assisting a patient with nutrition can be undertaken by an unregistered HCA but depending upon the patient's medical diagnosis and treatment, it can be more appropriate for a registered nurse to take on this task to ensure the patient's safety and welfare (Shannon, 2012). Another point of note is that the ratio of registered nurses to HCAs has shifted from 85/15 to 75/25 over recent years (DOH, 2016b). Arguably, this shift from registered to unregistered staff members will have a negative impact on patient care (Currie, et al, 2005). This view is supported by evidence that has found that higher proportions of registered general nurses can lower the incidence of adverse events for patients (Griffiths et al, 2013; Bell et al, 2014).

Other members of the nursing team in older person services include, clinical nurse specialists (CNS) and registered advanced nurse practitioners (RANP). In order to provide a full contextual understanding of the nursing skill mix, the role of the CNS and RANP will now be presented. Clinical nurse specialists (CNS) undertake formal recognised post-registration education relevant to his/her area of specialist practice at Level 8 or above on the National Qualifications Authority Ireland (NQAI) framework (higher diploma or an honours bachelor degree as distinct from an ordinary level degree). Such formal education is underpinned by extensive experience and clinical expertise in the relevant specialist area. Care delivery is

delivered in line with the core concepts of clinical focus, patient advocacy, education and training, consultancy and audit and research (National Council for the Professional Development of Nursing and Midwifery (NCNM) (2008). There are a number of CNSs practicing in both dementia care nursing and care of the older person nursing in Ireland, the exact numbers are unavailable.

Registered advanced nurse practitioners (RANP) are described as expert practitioners with exemplary clinical leadership. Advanced practice in Ireland refers to registered nurses who engage in continuing professional development and clinical supervision to practise as expert practitioners and demonstrate exemplary clinical leadership (NMBI, 2017b). Registered advanced nurses practitioners work within an agreed scope of practice and meet established criteria set by NMBI to register as a RANP. RANPs undertake formal recognised post-registration education to his/her area of specialist practice at Level 9 on the NQA1 framework (Master's Level). RANPs have a broad base of clinical experience relevant to the advanced field of practice (NMBI, 2017b). There are a number of RANPs practicing in care of the older person nursing in Ireland. Again, the exact numbers are unavailable.

A fairly recent development significant to dementia care nursing is the introduction of the dementia champion. The specialist role of a dementia champion is recognised as providing guidance and support regarding best practice in the provision of dementia care nursing (Timmons et al, 2016). According to Dublin City University (DCU) (2015), a dementia champion possesses the prerequisite specialist knowledge and skills necessary to advance competent practice in dementia care, provide advocacy for the person with dementia and ensure promotion of person-centred dementia care hospital policies and procedures (de Siún et al, 2014; DCU, 2015). DCU offer a Dementia Champion Module (DCU, 2015) but not all hospital staff who identify as dementia champions have undertaken specialist training (de Siún et al, 2014). The nursing workforce and skill mix involved in care of the older person and care of the older person with dementia represents all registered nursing grades along with unregistered health care assistants. However, it is the views and opinions of registered nursing grades about dementia care nursing based on their experiences that are of interest to the current study.

1.8   Summary

In summary, an exploration of Irish population demographics demonstrated that the over 65 years' population is increasing at an unparalleled level (TILDA, 2014). Evidently, there is a distinct association between ageing and dementia and consequently, there is a concomitant rise in the numbers of older persons living with dementia. Dementia is frequently accompanied by three or more multi-morbidities (Timmons et al, 2016). The relevant statistics demonstrate that older persons with dementia are amongst the highest consumers of health care services, including non-dementia specific acute, rehabilitation and residential facilities. Consequently, nurses practicing in age related services linked to acute hospital services are encountering an increasing number of older persons with multi-morbidities accompanied by dementia. Hospital admission is stressful for the older person with dementia and challenging for the nursing staff responsible for their care, due to the many manifestations of the dementia pathology, including spatial awareness problems (Timmons et al, 2016).These facts underpin the importance of exploring nurses' experiences of dementia care nursing in the identified care setting of non-dementia specific wards/units to bring about a greater understanding of the complexities involved.

Dedicated health care services for the older person linked to acute general hospital services, incorporating acute, rehabilitation and residential units, were introduced to Ireland in the 1960s (Government of Ireland, 1968). Dedicated health care services were developed in recognition of the complexities experienced by the older person, such as multi-morbidities including dementia. In spite of these evidential findings, the development of non-dementia specific dedicated health care services for the older person, linked to acute hospital services has remained slow to progress (O'Shea, 2017). According to Baztán et al, (2009), HSE, (2012) and Briggs et al, (2016b) specialist geriatric units or non-dementia specific dedicated health care services are recognised as contributing to more effective care for the older person both with and without dementia. A key element within dedicated health care services for the older person is identified as healthcare staff, including nurses with specialist knowledge and experience in dementia care (Briggs et al, 2016b). To date, little is known about the experiences of nurses caring for the older person with dementia in non-dementia specific wards/units contained in dedicated health care services for the older person linked to acute general hospital services. This gap in knowledge, justifies conducting the current study.

While older person care to incorporate dementia care is the business of the multi-disciplinary team in all areas (Traynor et al, 2011; HSE, 2012), it is the experiences of the nurse within

the unique setting of non-dementia specific wards/units contained in dedicated health care services for the older person linked to two university teaching hospitals and one affiliated hospital site that was the focus of this study. Nurses are recognised as pivotal team players working in partnership, at all times, with the multi-disciplinary team (HSE, 2012). They perform a fundamental role in supporting the person with dementia by providing care underpinned by a competency framework (NMBI, 2015) and the philosophies of person-centred care as envisaged by both professional and governmental bodies (DOH, 2014; NMBI, 2015). Additionally, it is proposed that nurses will play a crucial role in implementing the roll out of integrated care pathways across the care continuum as determined by the Irish National Dementia Strategy (NMBI, 2014a). It is acknowledged that optimal dementia care nursing is dependent upon skilled, knowledgeable practitioners (Moyle et al, 2010; Traynor et al, 2011). The combination of specialist skills and knowledge encompass an understanding of the manifestations of the dementia pathology including the likelihood of behavioural and psychological symptoms. Unquestionably, nurses are key to the quality of care that the older person with dementia can expect to receive during a hospital admission. While there is evidence to illuminate care of the person with dementia in wards within the acute general hospital setting which will be presented in the following chapter, there is very little evidence to date, specifically related to the experiences of nurses in providing care for the older person with dementia in the unique setting of non-dementia specific ward/units for older persons linked to acute general hospital services.

Thus, I identified a clear mandate for an exploration of nurses' views and opinions about dementia care nursing based on their experiences of caring for the older person with dementia in the unique environment of non-dementia specific wards/units contained in dedicated health care services for the older person linked to acute hospital services. Through exploration of this phenomenon, the nature of nurses' experiences was illuminated, indicating possibilities for nursing practice development and further research so as to ultimately enhance the health, wellbeing and quality of care received by older persons with dementia. The increasing prevalence of dementia amongst older persons and the dearth of research related to nurses' experiences of dementia care nursing in this unique environment provided strong justification for undertaking the current study.

1.8.1 Method of Inquiry

A sequential explanatory mixed methods approach was employed to address the research question. This method involves the combination of quantitative questionnaires and qualitative interviews within one study (Creswell, 2009). This form of mixed methods approach is recommended when qualitative data regarding experiences enrich data collected by way of questionnaires from a larger number of participants (Creswell, 2009). The current study involved two separate phases, the quantitative followed by the qualitative. To achieve the study aim and objectives, the quantitative phase involved using four questionnaires exploring, nurses' demographic characteristics, nurses' views and opinions about dementia care nursing, nurses' attitudes towards dementia and nurses' beliefs about the environment of care. The qualitative arm of the study entailed running five focus group interviews. The focus groups permitted an exploration of the findings to emerge from the quantitative phase of the study.

1.8.2   Personal Perspective

I have practiced in the specialist area of older person nursing since 1999 following a number of years in general practice both hospital and community based. The majority of my nursing career up to that time, regardless of the practice area, encompassed care of the older person oftentimes, care of the older person with a co-incidental dementia. I have always maintained a keen interest in dementia care nursing. My preference in clinical practice has always been the 'hands on' evidence based approach as opposed to the more technological areas of nursing practice. I believe that there is great potential for the discipline of nursing to play a leading role in the care of the older person with dementia and multi-morbidities. It is an area where the essence or focus of nursing is preserved (Henderson, 1980). A further determining factor in my choice of nursing preference, relates to the writings of Nolan and Tolson (2000) who suggest that gerontological nursing is a practice area where nurses can have a considerable influence. My professional interest in dementia care combined with my belief that nursing can play a leading role in dementia care, culminated in making a conscious career choice to transfer to a dedicated health care department for the older person within an acute university teaching hospital. The department was under the direction of several consultant geriatricians with specialist multi-disciplinary team members including nursing. The department quite uniquely, included acute, rehabilitation and residential units for the older person. I was initially employed as a staff nurse within a rehabilitation non-dementia specific ward, prior to taking up a clinical nurse manager post in an acute admission non-dementia specific ward. While studying for the MSc in Gerontological Nursing, I undertook clinical placements within all three specialist areas within the department. As a result, I

experienced nursing practice throughout the different areas. The older person with dementia accompanied by multi-morbidities was represented in all of these areas, thus dementia care nursing was the concern of all nurses practicing within the dedicated health care department for the older person. Consequently, the complexities of provision of dementia care nursing were evident throughout.

The dedicated health care department for the older person was located within an acute university teaching hospital and the overall culture of the acute hospital philosophy of care permeated the entire organisation. In relation to governance and accountability, nursing policies and procedures were developed in the hospital's nursing practice and development unit (NPDU). Policies and procedures were generally hospital wide and not distinct to the specific speciality. This fact led to the potential of obscuring the uniqueness of the department and nursing care of the older person to include dementia care nursing.

I moved into an academic role as a lecturer/practitioner in gerontological nursing in 2007. This is a joint role between the university and the hospital. This gave me the opportunity to develop my research interest in dementia care nursing which has culminated in the present study.

1.9 Structure of the Thesis

The thesis is divided into nine chapters. The construction of the thesis is a reflection of the progression of the study. Each chapter is designed to clearly signpost the research journey with reference to the study undertaken.

Chapter one provides an introduction and background to the research problem. The chapter laid the foundation for the need to explore nurses' experiences of dementia care nursing. It sets out a clear rationale for the study and outlines the study aim and objectives.

Chapter two presents the literature review. This chapter provides a review of the literature and exploration of the theoretical basis of the body of research relevant to dementia care nursing.

Chapter three outlines the chosen conceptual framework used to interpret the findings which is, the Socio-technical System Theory (STS). A summary of the evolving worldview that forms the foundation for system theory is presented and justification for choosing the STS is provided.

Chapter four communicates the strategy of inquiry, the sequential explanatory mixed methods approach.

Chapter five outlines the methods and procedures applied to this study.

Chapter six reports the findings from phase one, the quantitative phase.

Chapter seven presents the findings from phase two, the qualitative phase.

Chapter eight presents the discussion which integrates the quantitative and qualitative data. The discussion chapter was underpinned by the Socio-technical System theory (Trist, 1981).

Chapter nine concludes the thesis, by providing the implications and recommendations that emerged from the current study.

Chapter Two - Literature Review

2.1   Introduction

The purpose of this narrative literature review was to identify, analyse, assess and interpret constructions of nurses' experiences of dementia care nursing. This is consistent with the aims of a narrative literature review (Coughlan and Cronin, 2017). A methodical approach to the narrative literature review was undertaken as evidenced by details of the search strategy employed as presented in section 2.1.1. The major themes identified in the literature and discussed in this chapter are:

- Complexities of Dementia Care Impacting on Dementia Care Nursing

- Evolution of Person-Centred Care

- Nurses' Experiences of Dementia Care Nursing in Acute Care Settings

- Nurses' Attitudes Towards Dementia in Acute Care Settings

- Environment of Dementia Care Nursing in Acute Care Settings

2.1.1   Search Strategy

The search strategy was carried out in two stages, stage one related to the complexities of dementia, the hospital experience of the older person with dementia and dementia care nursing. Stage two focused on the experiences of nurses caring for older persons with dementia with a particular focus on dementia care nursing in acute care settings. To locate literature relevant to the experiences of nurses caring for older people with dementia in non-dementia specific wards/units that include acute, rehabilitation and residential contained in dedicated health care services for the older person linked to acute hospital services, a systematic search of the literature was conducted. The systematic search, using Boolean operators (OR and AND) was carried out within the following data bases Cumulative Index to Nursing and Allied Health Literature (CINAHL) Pub Med, Applied Social Sciences Index and Abstracts (ASSIA) and the British Nursing Index (BNI). Time limitations were not applied to ensure the results obtained were as broad and complete as possible. MESH descriptors were used exclusively within the Pub Med data base and key search terms were combined throughout all data bases as follows:

(1) "dementia care nursing" OR "nursing staff" OR "geriatric nurse" OR "dementia nurse" OR "nursing" OR "geriatric nursing" OR "dementia nursing" OR "gerontological nursing"

(2) AND person centred care [OR "patient centred care" OR "relationship centred care" OR "patient-centred care" OR "person centred" OR "patient centred"]

(3) AND hospital OR ["acute care" OR "ward" OR "environment" OR "medical" OR "geriatric care" OR "age related care"]

(4) AND dement* [OR alzheimer's disease OR cognitive impair* OR vascul* OR confus* OR memory*]

To further sharpen and guide the focus of the literature review, the following inclusion and exclusion criteria were applied:

The criteria for inclusion included:

- nursing care of older persons with dementia within the acute general hospital setting
- experiences of nurses caring for older persons with dementia in the acute general hospital setting
- articles written in the English language
- peer reviewed articles to include qualitative, quantitative and mixed method approaches

The criteria for exclusion included:

- nursing care of the older person with dementia out-with the acute general hospital setting such as community services
- nursing care of the older person in the acute general hospital setting but not the older person with dementia
- nursing care of the older person in the acute general hospital setting experiencing delirium without dementia

The literature search flow diagram is outlined in Appendix One. Abbreviated details of the search outcomes are outlined in table 2.1:

Table 2.1   Search Outcomes

Search Engine	Articles Retrieved	Articles Included in Literature Review
CINAHL	179	6
Pub Med	187	7
ASSIA	128	8
British Nursing Index	146	2

A total of 23 articles were considered for inclusion. A further six papers were retrieved following searches of pertinent literature reference lists and a final total of three were included. Therefore, 26 papers were included in the literature review section presented in this chapter. The 26 studies were critically analysed for their contribution to the experiences of

nurses caring for older people with dementia in non-dementia specific wards/units that include acute, rehabilitation and residential contained in dedicated health care services for the older person linked to acute general hospital services. The review established that currently there is a dearth of studies in relation to the experiences of nurses caring for older persons with dementia in this unique setting. This gap in the literature justifies the focus and uniqueness of my study. To bring about an understanding of the experiences of nurses caring for the older person with dementia, studies which took place within the acute general hospital care environment but did not take place in non-dementia specific wards/units situated within dedicated health care services for the older person linked to acute general hospital services were included.

An exploration of the Irish health repository (Lenus) and the Electronic Thesis Online Service (EThOS) managed through the British Library using the same search terms and inclusion and exclusion criteria, was also conducted. Additionally, a variety of other potential sources of information were searched both electronically and manually. These included unpublished theses, discussion papers, policy documents and papers, research reports and books. For example, the search included significant grey literature produced by the following sources:

- Department of Health (DOH) Ireland
- Dementia Services Information and Development Centre (DSIDC)
- Health Service Executive (HSE)
- Health Information and Quality Authority (HIQA)
- Alzheimer Society of Ireland
- Alzheimer's Research UK
- Alzheimer Europe
- Alzheimer's Disease International
- WHO

An exploratory review of these works provided a broad overview of dementia care in the acute general hospital setting. These works also served to provide demographic information and hospital admission rates which were presented in chapter one (sections 1.2, 1.3, 1.4).

To situate the study, stage one of the chapter will begin by providing an exploration of the complexities of dementia in acute care settings; the hospital experience of the older person with dementia followed by an overview of person-centred care. The purpose of presenting these topics is to explore their potential impact on dementia care nursing. Stage two presents the reviewed empirical literature specific to nurses' experiences of dementia care nursing in acute care settings.

2.2   Complexities of Dementia Care Impacting on Dementia Care Nursing

Dementia is predominantly a disease of older age (O'Shea, 2007; Bunn et al, 2015) and is ultimately a terminal condition (Sampson et al, 2006). People with dementia are amongst the highest users of hospital services (Sampson et al, 2009). It is also acknowledged that the older person with dementia often has three or more multi-morbidities (Timmons et al, 2016). As a consequence of these facts, nurses working in non-dementia specific wards/units within dedicated health care services for the older person in acute care settings, are encountering an increasing number of older persons with dementia accompanied by multi-morbidities in their daily practice. Providing high quality care for the older person with dementia means that, nurses have to be aware and attuned to the many complexities associated with the condition (Jenkins et al, 2016).

The older person with dementia often experiences multi-morbidities which can include conditions such as, chronic obstruction pulmonary disease, diabetes, vascular or heart disease (Bunn et al, 2015) these are important considerations for dementia care nursing. Multi-morbidities, as well as increasing the risk of delirium create a greater challenge in the care of the person with dementia in acute care settings (Briggs et al, 2016a). For example, a deteriorating condition such as diabetes which can lead to increasing confusion can be wrongly attributed to worsening of dementia. Potentially, this scenario has the propensity to lead to inappropriate or delayed care (Bunn et al, 2015). Thus, highlighting the complexities of dementia care nursing.

Another factor that impacts on dementia care nursing is that the older person with dementia experiences longer hospital admission and more severe acute physical illness (Timmons et al, 2016) – that is, 31.0 days compared to 14.1 days for those without dementia (Briggs et al, 2016a). During hospitalisation, the person with dementia is at an increased risk of adverse events such as falls and delirium (Briggs et al 2016a; Jackson et al, 2017) and iatrogenic

harm and greater functional decline post hospital admission (Sampson et al, 2009; Jackson et al, 2017). There is also evidence to suggest that the incidence of urinary and faecal incontinence, constipation and epilepsy occur much more frequently in the person with dementia (Bunn et al, 2015). Unquestionably, to provide quality dementia care nursing in acute care settings, all of these factors have to be taken into consideration during hospital admission. A further complexity for consideration in relation to nursing care of the older person with dementia is the condition of frailty which is defined as a progressive decline in several physiological systems over a lifetime (Bunn et al, 2015). A recent Irish study revealed that 74% of in-patients had a co-existing dementia and frailty (Briggs et al, 2016a). This is an important finding when exploring nurses' experiences of dementia care nursing, as it is acknowledged that the older person with co-existing dementia and frailty is more vulnerable to stressors such as minor surgery, infection, or a new drug therapy (Bunn et al, 2015).

Another significant consideration for provision of quality dementia care nursing during acute care hospital admission is the ability of the person with dementia to manage chronic conditions. It is acknowledged that dementia impacts negatively on a person's ability to manage chronic conditions and to look for assistance for the new onset of both physical and emotional difficulties, thus new symptoms have the propensity to be overlooked (Afzal et al, 2010; Timmons et al, 2016). This finding supports the view that dementia should not simply be regarded as another diagnosis on the list of a patient's medical conditions, it should underpin the focus and organisation of the management of all of the other nursing and medical issues in the context of routine care in acute care settings (Afzal et al, 2010; Timmons et al, 2016; Bunn et al, 2017). Yet according to Briggs et al (2016a) as a result of delirium or advanced dementia, undertaking a comprehensive assessment in the acute care setting, to include physical examination or direct history taking may be impossible. The points raised so far bring into sharp focus the many challenges in the provision of quality dementia care nursing in acute care settings, to include multi-morbidities, chronic illness, emotional difficulties and the condition of frailty. These elements provided further impetus for an exploration of dementia care nursing in the identified setting, leading to an enhanced understanding of the challenges experienced by nurses

To further understand the experience of the nurse in relation to dementia care nursing in acute care settings, it is important to explore issues relating to mortality and palliative care. It is recognised that acute hospitalisation for the older person with dementia as a consequence of

comorbid physical illness is often a critical event, carrying with it disproportionately high mortality rates (Afzal et al, 2010). In the Irish context, patients with dementia are reported to be more than twice as likely to die following an acute presentation compared to those with no dementia (Briggs et al 2016a). According to de Siún et al (2014) approximately one in every 12 persons with dementia will die while receiving care as an in-patient in the acute hospital setting. Yet, health care professionals do not appear to regard dementia as a terminal illness (Sampson et al, 2006).

In relation to palliative care, it is suggested that although the person with dementia might well benefit from palliative forms of care, evidence reveals that many fail to access such care at the terminal stage of their life (Ryan et al, 2011). In concurrence Sampson et al (2006) and Afzal et al (2010) make the case that the older person with dementia is less likely to be referred to palliative care specialists and they are prescribed less palliative care medications, than those persons with no dementia. These findings are reflected in the Irish National Audit of Dementia Care in Acute Hospitals (35 hospitals described as acute were included) where it is reported that only 9% of patients with dementia were referred to specialist palliative care (de Siún et al, 2014). It is widely accepted that a major part of palliative care is control of pain but according to Sampson et al's (2006), reported findings from a study which took place within an acute medical ward, pain is poorly controlled in patients with dementia. Consequently, lack of recognition by healthcare professionals of untreated pain can lead to unnecessary distress and behavioural and psychological symptoms of dementia (BPSD). The latter may in turn lead to the inappropriate use of neuroleptic medications (Sampson et al, 2006). Despite evidence based findings that support the view that treating BPSD pharmacologically with benzodiazepines or antipsychotic drugs is linked with a nearly three-fold increased risk of mortality, this form of treatment is still frequently prescribed during hospital admission (Jackson et al, 2017). The points raised in this section are significant to the current study, as they highlight the complexities of dementia which consequently influence nurses' experiences of dementia care nursing in the acute hospital setting. The next section examines the use of antipsychotic medications associated with acute hospital admission of the older person with dementia.

2.2.1 Anti-psychotic Medications

In relation to antipsychotic medications, de Siún et al (2014) found from the Irish National Audit of Dementia Care in Acute Hospitals, that despite the high use of anti-psychotics

during hospital admission, the reason for their use was only recorded in 50% of all cases. Table 2.2 outlines the use of anti-psychotics on admission and the numbers of new prescriptions during hospital admission (de Siún et al, 2014).

Table 2.2 - Use of Anti-psychotics During Acute Hospital Admission

Use of Anti-psychotics During Acute Hospital Admission

- 19% of patients admitted from home were already prescribed anti-psychotics.
- 46% of patients admitted from nursing homes were already prescribed anti-psychotics.
- 23% of patients were prescribed an anti-psychotic medication via PRN during admission
- 19% of patients were administered an anti-psychotic medication via PRN during admission
- 16% of patients were given a new regular prescription for anti-psychotic medication

In view of the poor adherence to record keeping, de Siún et al (2014) recommended a need for improved review and monitoring of the use of anti-psychotics in the acute general hospital setting. A study of interest to dementia care nursing was conducted by Briggs et al (2016b) with the objective of clarifying if admission to a specialist geriatric ward or non-dementia specific age related ward can lead to improvements in aspects of acute medical care for persons with dementia. The study used data from de Siún et al's (2014) National Audit and O'Shea et al's (2015) Northern Irish Audit of Dementia Care. In relation to anti-psychotic medications, it was reported, that there were no differences found in the proportion of anti-psychotic medications across non-dementia specific wards in the older person settings compared to non-specialist wards. However, it was also reported that non-dementia specific age related wards, were shown to perform better in some aspects of care such as recording of medication, identifying cognitive decline along with co-ordination of discharge planning (Briggs et al, 2016b). They did not perform well in some significant areas, to include compliance with multi-disciplinary assessments and delirium and anti-psychotic screening (Briggs et al, 2016b). These findings have direct implications for the current study, as they relate to dementia care nursing practice.

2.3   Evolution of Person-Centred Care

For nurses currently practicing in age related services in Ireland, the philosophies of person-centred care (PCC) are highly relevant. The Irish National Dementia Strategy, Department of Health (DOH, 2014), the Health Information & Quality Authority (HIQA) (2015) and the Nursing and Midwifery Board of Ireland (NMBI) (2015) direct, that nursing care of the older person must be underpinned by the principles of person-centred care. As such PCC influences many aspects of the nurses' experiences of dementia care nursing in acute care settings and is therefore of relevance to the current study. The following sections will trace the evolution of PCC and provide an overview of its impact on gerontological nursing and dementia care nursing in acute care settings. As PCC is the recommended philosophy of care as advised by the DOH (2014), the NMBI (2015) and HIQA (2015) in the identified settings in the current study, an exploration of this concept was believed to constitute an essential aspect of the literature review.

Traditionally, treatment of dementia has been dominated by the biomedical model and it is widely accepted that Western medicine is based on Cartesian logic. The biomedical model is an example of the biological reductionism which continues to hold influence in Western medicine (Harding and Palfrey, 1997; Kitwood, 1997; Beard 2004; George and Whitehouse, 2013). This results in disregard of the socio-cultural or emotional component of the illness, and leads to investigations of illness through enquiry into the pathological process in cells and organs (Harding and Palfrey, 1997; Kitwood, 1997; Beard 2004; George and Whitehouse, 2013). Personhood or philosophies of what it means to be a person can be traced back to the Enlightenment period and the beliefs of logical empiricist philosophers such as Rene Descartes and John Locke (Bartlett and O'Connor, 2007). Personhood, according to the philosophies of logical empirical thinkers such as Descartes and Locke is dependent on intact cognitive abilities for example, memory, rationality and the ability to communicate (Bartlett and O'Connor, 2007). As a result, it was theorised that because the person with dementia sustains a gradual loss of cognitive ability they also experience loss of personhood (Bartlett and O'Connor, 2007; Dewing, 2008). Building on from these assertions, it is contended by Dewing (2008) that Westernised values about the attributes of personhood tend to ignore or place less value on sentience (ability to feel and perceive) and semiotics (systems of communicative behaviour such as gestures and sign using behaviour). However, the pioneering work of two social psychologists, Tom Kitwood (United Kingdom) and Steven Sabat (United States), undertaken independently, began to express alternative views to the

biomedical understandings of dementia. Their work places the individual with dementia at the centre of both academic and practice dialogue (Innes, 2009).

2.3.1 Tom Kitwood and Steven Sabat and Dementia Care

Kitwood's work originates from an exploration of the nature of being and his overall assertion is that a person with dementia remains as a person throughout the trajectory of their experiences with dementia (Davies, 2004). Kitwood (1997) rejected the dominant Cartesian duality and introduced the philosophy of person-centred care for persons with dementia, based on his conception of personhood. The concept of personhood is embedded in an existential ontology that challenges mind/body dualism, rather the view is that who the person is and who the person can be, are situated in the context of authentic relationships (Penrod et al, 2007). The theory of person-centred care has its roots in phenomenology and the subjective reality of the individual (Brooker, 2004). Kitwood drew on work from the world of psychotherapeutic practices, and in particular the influence of the American Psychologist and Psychotherapist, Carl Rogers (1902-1987) in relation to person centred counselling, communication and authentic contact (Kitwood, 1997).

Kitwood wrote extensively about dementia and dementia care resulting in a body of influential work. The main focus of Kitwood's writing is that the development of dementia is not only dependent on the extent of the brain damage and gradual loss of cognitive function sustained but upon various factors which include biography, social psychology, and neurological impairment. Kitwood (1997) arrived at his definition of personhood as a relational concept which emphasises the interconnectedness and interdependence of human life following his exploration of the three major sources of discourse of the term personhood which include transcendence, ethics and social psychology. The definition he proposed was that:

> "it is a standing or status that is bestowed upon one human being,
> by others, in the context of relationship and social being. It implies
> recognition, respect and trust. Both the according of personhood and the
> failure to do so, have consequences that are empirically testable" (Kitwood, 1997, p.8).

Kitwood (1997) believed that against the backdrop of extreme individualism which has emerged in Western societies since the years of the Enlightenment, inclusion of the

personhood club, or what it means to be a person, has been reduced to two characteristics, autonomy and rationality. Kitwood (1997) strongly refuted this notion and argued that a balanced definition of personhood must be linked with the attributes of emotions, feeling and the capacity to live in relationships. The recurring theme in Kitwood's work which was partly influenced by the work of the Austrian born existential philosopher Martin Buber (1878-1965), was his interest in the nature of being human and personhood. Kitwood (1997) is dismissive of analytical theories of personhood and instead champions the notion of experience. Here Kitwood (1997) acknowledged Buber's conceptualisations of relationships which refer to the contrast between the I-It and I-Thou form of communication.   I-It refers to a relationship that is built on detachment and coolness whereas the I-Thou form of relationship encompasses warmth and spontaneity and the notion that personhood is sustained through reaching out to the Other. Kitwood (1997) is very clear in his belief that in order to understand dementia, personhood must be conceptualised in relational terms in other words the I-Thou mode of meeting. Kitwood recognised the self to need nourishment through response and recognition by others. He believed that interaction supports the self as a validated being in the structure of social interaction (Davies, 2004). Maintenance of personhood must encompass a dialectical interplay in which both psychological and neurological approaches are employed, otherwise there is an acceptance of the Descartes mind body split (Kitwood, 1997). Kitwood (1997) was of the opinion, that if dementia is seen as a purely organic disease which develops according to its own dynamic, it does not provide an explanation for the many anecdotal accounts of the onset of dementia following major life crisis. Especially bereavement or the rate of increase in the severity of symptoms following changes in the care or in the environment of the person with dementia (Kitwood, 1997).

The major thrust of Sabat's (2008) work on PCC is concerned with exploring dementia in the moderate to severe stages to take account of the intact cognitive and social abilities of the person. A further concern is the individual experience of having the disease and ways in which communication between the person with dementia and their caregivers can be augmented (Sabat, 2008). In a similar manner to Kitwood (1997) Sabat (2008) questions medical hegemony within dementia studies. Kitwood (1997) and Sabat (2008) do not question that there is brain pathology involved in dementia but argue that a person with dementia retains a sense of self and this conceptualization of self has to be promoted within practice situations in order for meaningful care to take place (Sabat and Harré, 1992; Sabat

and Harré, 1995; Sabat, 2008). The use of a personhood lens has ensured that the person with dementia has been brought explicitly and effectively into the forefront of the dialogue (Bartlett and O'Connor, 2007; Clare et al, 2014). The work of Kitwood (1997) and Sabat (2008) clearly has implications for dementia care nursing as experienced by nurses in the identified care setting and the following section will explore PCC in practice.

2.3.2 Person-Centred Care in Practice

The work of Kitwood and Sabat offers an alternative view to the purely physical care of the person with dementia (Innes, 2009; George and Whitehouse, 2013). However, according to Kitwood (1997) and Cowdell (2010a), nurses have received little more than the mechanistic medical model of care which prioritises physical care and maintenance. It is suggested that care staff, are trained to carry out physical care and the culture of the organisation values physical care and maintenance over and above psychosocial support mainly because it is observable and measurable (Kitwood, 1997; Cowdell, 2010a). However, more recently, the importance of specialist dementia education and training has been recognised by both governmental (DOH, 2014) as referred to in (section 1.5) and professional bodies (NMBI, 2015) (section 1.1.4). Notwithstanding, it is proposed by Bartlett and O'Connor (2007) that caring can at times have a stronger relationship with the concepts of power and control than those of giving and trust. This view is reiterated by Epp (2003) who cautions that institutional control combined with the roles and responsibilities of staff, can potentially cause staff to be in conflict with the core of person-centredness. It is suggested by Cowdell (2010a) and Clissett et al (2013a) that prioritising physical care leads to the person with dementia being kept at a distance (I-it) with no chance of a real relationship with the carer being developed and interactions between the nurse and the patient consist mainly of the nurse giving instructions. According to Sabat and Harré (1992), Kitwood (1997) and Morton (1999) this has serious implications as a person's self is to a large extent influenced by the way others interact and perceive that person. As Kitwood (1997, p.8) states "both the according of personhood and the failure to do so, have consequences that are empirically testable".

There is no doubt that dialectical understandings such as the work of Kitwood (1997) and Sabat (2008) of the dementia process, have made a significant contribution in redirecting attention away from the exclusive biomedical model of care to psychosocial approaches to take account of the subjective experiences of persons with dementia and the notions of PCC. However, despite the fact that PCC is the maxim of dementia services, it is proposed that it

remains a rarity in practice (Hughes and Beatty, 2013; Goldberg et al, 2014). A key criticism of person-centred care is that it detracts from the many challenges faced by caregivers in the acute care setting and can lead to feelings of distress and guilt if they fail to transform this philosophy into a reality in daily practice (Davies, 2004). Furthermore, the notion of one person bestowing personhood on another may be conceptualised as the creation of an unequal playing field (Bartlett and O'Conor, 2004). As Dewing (2008) contends, it is suggestive of the person with dementia being in an inferior position and dependent upon others without dementia to accord the standing or status of personhood upon them. Communication is seen as unidirectional which implies that the person with dementia is a passive player dependent upon others to initiate dialogue (Clissett et al, 2013a). As Nolan et al (2004) comment, quality relationships are those that are reciprocal and where the needs of all the participants in the relationship have to be acknowledged and accorded status.

Importantly, from the perspective of practitioners, it is acknowledged that the concept of PCC remain tenuous (Kirkley et al, 2011) and abstract, often described in terms of quality rather than in guidelines for how that quality can be achieved (Epp, 2003). In concurrence Brooker (2004) comments that the concepts of PCC are difficult to comprehend or articulate in an easy to understand manner. As a result, practitioners face difficulties in understanding the benefits and focus of person-centred care (Epp, 2003). Consequently, PCC can have various meanings within various contexts to various people (Brooker, 2004; Kirkley et al, 2011). Understandings for some can mean individual care, for others it can be viewed as a value base. For other people it is understood as a group of techniques to underpin practice with people with dementia. It can also be understood as a phenomenological perspective and a way of communication (Brooker, 2004). As outlined, the concept of PCC remains elusive and ambiguous with a paucity of theoretically sound and empirically robust studies (Brooker, 2004; Edvardsson et al, 2008; Clissett et al, 2013a). Lack of clarity in defining PCC is also an important consideration in relation to empirical research (Dewing and McCormack, 2016). These authors argue that in order to develop and test theories resulting in a robust framework, a clear definition of the concepts involved is a prerequisite (Dewing and McCormack, 2016). A current definition of PCC offered by McCormack and McCance (2017) is presented later in this chapter.

However, notwithstanding the noted limitations, PCC has much to offer by way of provision of nursing care for the person with dementia that is grounded in ethical and humanitarian

values, the challenge according to the literature is the accomplishment of turning this concept into practice (Edvardsson et al, 2008; Innes, 2009; McCormack and McCance, 2017). Unquestionably, the challenge of provision of PCC impinges on the role and experiences of the nurse in the practice of dementia care nursing, particularly in the acute care setting and requires further exploration. This is particularly pertinent to the current study, in view of the fact that the DOH (2014), HIQA (2015) and the NMBI (2015) advocate that nursing care with the older person with dementia must be underpinned by the philosophies of PCC.

2.3.3   Person-Centred Care and Gerontological Nursing

Within gerontological nursing, the major tenet of PCC has been identified as the creation of therapeutic relationships between the older person, their significant others and professional carers (McCormack, 2003; Dewing, 2004; Nolan et al, 2004). The notion of a therapeutic relationship is consistent with Kitwood's (1997) work. Within the discipline of nursing a number of conceptual nursing frameworks have been developed for the purpose of guiding PCC in practice. Amongst the most prolific writers on the topic are Professor Brendan McCormack and Professor Mike Nolan both professors of gerontological nursing. Given that PCC is the stated approach to care in the identified settings of the current study, it is relevant to provide a succinct overview of the pertinent conceptual frameworks. This will be presented in the following section.

2.3.4   Conceptual Frameworks

According to McCormack and McCance (2006) and McCance and McCormack, (2017) the practice of PCC is reflected in their person-centred framework which also takes account of the influence of nurses' attitudes and the context of care. The framework was derived from previous work undertaken by McCance (2003) on a conceptual framework which originated from an exploration of caring in nursing, whilst McCormack's (2003) person-centred conceptual framework was developed from a study of autonomy amongst older people. The underpinning principles of the frameworks are consistent with humanstic philosophies which centre on individual choice, responsibility, freedom and holism; different ways of knowing; the importance of time and space and relationships. The four constructs needed to underpin person-centred nursing care include:

1. Pre-requisites: focus on the attributes of the nurse
2. Care Environment: focuses on the context in which care is delivered

3. Person-centred Processes: focuses on delivering care through a range of activities
4. Expected Outcomes: the central component of the framework, are the results of effective person-centred nursing (McCance and McCormack, 2017).

To reach the goal of effective person-centred outcomes, the relationship between the constructs must be considered. In the delivery of person-centred care, firstly the Prerequisites must be deliberated, along with consideration of the Care Environment for provision of successful care through the care processes (McCance and McCormack, 2017). According to McCormack et al (2010) the achievement of person-centred nursing has to move beyond the inter-relationships between the older person, family carers and professional carers to take account of the whole context of care to include issues within nursing and the environment within which health services are undertaken. To understand the impact of the context of care from the nurses' perspective, it was considered to be expedient to explore nurses' experiences of dementia care nursing, to include nurses' attitudes towards dementia care and their beliefs about the environment of care in the current study.

According to Nolan et al (2004), it is not possible to provide PCC without due consideration of a relationship-centred care approach which includes all parties involved in the decision making within the caring process. RCC emerged in the USA in recognition of the influence of the power of relationships between health care providers and their patients, the community and other practitioners on health care experiences and outcomes (Tresolini and the Pew-Fetzer Task Force, 1994). The major tenet of RCC is focussed on the central role of all relationships in the experience and outcomes of care and is influenced by theories from the disciplines of sociology, social psychology and psychiatry (Soklaridis et al, 2016). However according to Ryan and Nolan (2016) whilst Tresolini and the Pew-Fetzer Task Force (1994) were instrumental in the development of the concept of RCC, they did not produce a framework by which the RCC model could be used in practice. In recognition of this gap, work was undertaken by Nolan et al (2004) which resulted in the Senses Framework. The Senses Framework represents a move beyond the dyadic relationship between the person and the carer and instead encompasses a triadic approach or relationship centred approach involving the older person, family care givers and professional carers (Nolan et al, 2004). Recognition of the personhood of both the carer and the cared for are essential components of RCC along with an appreciation of the importance of their intertwined relationships (Brown Wilson, 2013). The Senses Framework (Nolan et al, 2004) is underpinned by the belief that

all parties involved in the caring process should experience relationships which promote a sense of:

1. a sense of security – to feel safe
2. a sense of continuity – to experience links and connections
3. a sense of belonging – to feel part of things
4. a sense of purpose – to have a goal(s) to aspire to
5. a sense of fulfilment – to make progress towards these goals
6. a sense of significance – to feel that you matter as a person

Consideration of the Senses Framework leads to the creation of an enriched environment of care when the six senses are experienced by all those involved in the caring process (Nolan et al, 2004; Brown Wilson et al, 2013). To take account of the importance of the environment of care as outlined, it was considered to be relevant to explore nurses' beliefs about the unique environment of care identified within the current study, in order to increase understandings of this aspect of dementia care nursing.

According to Hughes and Beatty (2013), the level of substantial conceptual differences between PCC and RCC is debatable. Within gerontological practice, person-centred or relationship-centred care provides a concept on which practice with older people can be built. However, as Dewing (2004) observes, these frameworks are complex conceptual maps which emphasise the importance of knowing the person and forming an enabling relationship. This is challenging work and Dewing (2004) ponders how inexperienced nurses in the field of gerontological nursing can successfully gain the expertise needed to become competent operators of these frameworks. Dewing (2004) also highlights that there is a lack of clarity as to how relationships can be maintained with the older person with dementia. It has to be considered that as the dementia process progresses, it results in a gradual loss of the older persons' cognition and the disintegration of self-identity (Dewing, 2004). It is also recognised that being person-centred within the context of contemporary and performance dominated health care systems bring tensions and challenges (Dewing, 2004; McCormack, 2004). These studies suggest that there are many tensions and challenges experienced by nurses in delivery of person-centred care in the acute care setting. To understand nurses' experiences and to bring about an understanding of potential tensions and challenges, related to delivery of person-centred dementia care nursing in the unique environment of care identified in the current study justified exploring this aspect of dementia care nursing in the current study.

As previously stated, in the Irish health care setting, the stated approach to nursing care advocated by the DOH (2014), HIQA (2015) and the NMBI (2015) is that of PCC. While these recommendations are laudable, it is argued by McCormack and McCance (2017) that until there is an organisational culture of care that fully embraces these ideals it will be difficult to implement them. In a similar vein, Kirkley et al (2011) point out that while person-centred care is strongly promoted by professional bodies and is prescribed in policy documents, many organisations who subscribe to the philosophies of person-centred care, do so without a fundamental shift to make this a reality. A current definition offered by McCormack and McCance (2017) with a focus on organisational culture draws together the criteria necessary for person-centred care to take place:

> "person-centredness is an approach to practice established through the formation and fostering of healthful relationships between all care providers, service users and others significant to them in their lives. It is underpinned by values of respect for persons (personhood), individual rights to self-determination, mutual respect and understanding. It is enabled by cultures of empowerment that foster continuous approaches to practice development"
> (McCormack and McCance, 2017: 3).

This definition is not fixed and it continues to be reviewed (McCormack and McCance, 2017).

2.3.5   Person-Centred Dementia Care

Person-centred or relationship-centred models of care as described in this review are broadly advocated within gerontological nursing and developed by Professors of Gerontological Nursing. However, the VIPS framework is specific to person-centred dementia care and was originally developed by Dawn Brooker, Professor of Dementia Care Practice and Research at the Bradford Dementia Group (Brooker, 2004). The VIPS framework is based on the work of Kitwood and in it, person-centred care is described as encompassing four major themes (Brooker, 2004). The themes represent different threads of PCC and include:

1. A value base that asserts the absolute value of all human lives regardless of age or cognitive ability (V)
2. An individualised approach, recognising uniqueness (I)
3. Understanding the world from the perspective of the person identified as needing support (P)
4. Providing a social environment that supports psychological needs (S)

When the different elements are brought together they represent an effective method to support personhood for the person with dementia (Brooker and Latham, 2016). The VIPS framework offers direction on person-centred approaches that nurses can use to provide quality care for the person with dementia (Jenkins et al, 2016). The framework is not specific to a particular discipline, it has been developed for use by all those involved in care provision for the person with dementia (Brooker and Latham, 2016). As such, its use is recommended in all areas that provide a service for people living with dementia, to include acute hospital care. It is appropriate to refer to the framework within the current study as the VIPS framework specifically offers guidance and support and ways to respond to persons with dementia using a person-centred approach (Brooker and Latham, 2016).

The previous sections have brought about a greater understanding of the context of dementia care nursing in the acute care setting. The complexities of dementia which include decreasing levels of cognitive function which may be accompanied by behavioural and psychological symptoms unquestionably, requires nurses to have specialist skills and knowledge to deliver appropriate dementia care nursing underpinned by the philosophies of person-centred care. According to Kirkely et al (2011) and McCormack and McCance (2017) the principles of person-centred care must be supported by an appropriate organisational culture of care. It seems, therefore, useful to investigate nurses' experiences of dementia care nursing to bring about a fuller understanding of nurses' experiences of dementia care nursing in the identified care setting.

The following sections present the literature, specifically in relation to nurses' experiences of dementia care nursing in the acute care setting. It further established the foundation for the current study and determined the relevant consistencies and gaps in the literature and assisted in identifying, refining and formulating the study aim and objectives.

2.4   Nurses' Experiences of Dementia Care Nursing in Acute Care Settings

This section provides a review of the literature and exploration of the theoretical basis of the body of research relevant to nurses' experiences of dementia care nursing. The review places the current study within the context of the national and international body of knowledge relative to the experiences of nurses caring for older persons with dementia in the acute care setting. Within the context of the literature review, organisational influences were found to be of relevance to nurses' experiences of dementia care nursing.

2.4.1 Organisational Influences

The purpose of this section is to explore organisational influences on nurses' experiences of dementia care nursing in acute care settings. Nurses' perceptions and opinions of patients are influenced by organisational systems and a positive link has been found between supportive organisational systems and nurses' commitment to their nursing practice (Brown et al, 2008; McCance and McCormack, 2017). Additionally, a positive relationship is associated with effective nursing practice, quality patient outcomes and greater staff satisfaction (McCance and McCormack, 2017). In relation to dementia care nursing, Cowdell (2010b) found that the provision of quality dementia care nursing is dependent upon supportive organisational systems in acute care settings. According to McCance and McCormack (2017) supportive organisational systems should encompass such issues as adequate staffing levels and professional development programmes to enhance nurses' competencies and experiences of nursing care delivery. Staffing levels and professional competence pertinent to dementia care nursing will be explored in the sections that follow. Professional competence is explored under the sub headings: specialist dementia education and training, nurses' specialist knowledge and skills related to dementia care nursing and nurses' individual philosophies of care.

2.4.2 Impact of Staffing Levels on Nurses' Experiences of Dementia Care Nursing in Acute Care Settings

The person with dementia has higher needs for maintenance of function than patients with no dementia and greater needs require more resources to achieve similar outcomes (Clissett et al, 2013a). So in order to ensure that the unique value of the person with dementia is maintained, nursing staff need adequate staffing levels and sufficient time to provide quality dementia care nursing (Clissett et al, 2013a). Yet, the most frequently mentioned barriers to provision of quality dementia care in the acute general hospital setting are reported to be insufficient staffing levels resulting in inadequate time to spend with the person with dementia (Eriksson and Saveman, 2002; Atkin et al, 2005; Borbasi et al, 2006; Nolan, 2007; Byers and France, 2008; Clissett et al, 2013a; Baillie et al, 2016; Pinkert et al, 2017; Tropea et al, 2017). The studies reviewed and presented in the following sections, relative to the impact of staffing levels on nurses' experiences of dementia care nursing were conducted in a number of different countries, using a variety of research methods.

From the acute care setting, it was reported that dementia care nursing takes place within busy task orientated environments (Eriksson and Savemen, 2002; Clissett et al, 2013a; Pinkert et al, 2017; Tropea et al, 2017) which have insufficient staffing levels and consequently a high work load (Clissett et al, 2013a) where the focus is on provision of physical needs (Clissett et al, 2013a; Pinkert et al, 2017). The work in the ward is described as being performed within a specific routine which the person with dementia disrupts, they demand too much of the nurses' time (Eriksson and Savemen, 2002; Atkin et al, 2005; Clissett et al, 2013a; Pinkert et al, 2017). In a qualitative Swedish study conducted by Eriksson and Saveman (2002) the participants, RGNs (n=12) from five acute wards and one emergency department within one acute general hospital, described the overnight situation where only two members of staff were available to look after 20 acutely ill patients. This situation resulted in persons with dementia being placed outside the ward, in the corridor, in order to allow the patients with no dementia to sleep (Eriksson and Saveman, 2002). Nurses explained that they would like to have the time to carry out thorough assessments in order to formulate a care plan to best treat the patients with dementia but due to the fixed routine of the acute environment and a lack of staff this was not possible (Eriksson and Saveman, 2002). This concurs with the findings from Borbasi et al's (2006) Australian study where participants reported that due to a lack of time, they were unable to provide even basic nursing care and they described how oral medication can take three times longer to dispense to the person with dementia as compared to those persons with no dementia. The study took place within three large Australian teaching general hospitals, using a qualitative interpretive approach with respondents from the multi-disciplinary team (n=25) including registered nurses (RNs) (n=13).

In relation to staffing levels, the RNs (n=9) in Byers and France (2008) qualitative American study, located within a number of medical and surgical units situated in an acute general hospital, suggested that in order to provide quality dementia care nursing in the acute care context, nurses need to be at the bedside of the patients. It was argued that this level of nursing input requires a patient nurse ratio of 1:3 rather than the existing 1:7 (Byers and France, 2008). Conclusively, as evidenced by the foregoing studies, poor staffing levels can have a detrimental effect on nurses' experiences of dementia care nursing in the acute care setting. However, given the diversity of research settings in the reviewed studies, to reach an understanding of the situation within the unique setting of the current study, provided

justification for conducting the current study. This was considered essential, given the implications of poor staffing levels on delivery of dementia care nursing.

Additionally, a number of studies identified the emotional effects of poor staffing levels on nurses' experiences of dementia care nursing in the acute care setting (Eriksson and Saveman, 2002; Borbasi et al, 2006; Byers and France, 2008; Clissett et al, 2013a; Nilsson et al, 2016; Pinkert et al, 2017). According to Eriksson and Saveman (2002) there is a constant demand from hospital management to reduce care time. This is despite the fact that the older person with dementia is recognised as needing adequate time to meet their unique needs (Clissett et al, 2013a). Another identified difficulty according to Pinkert et al (2017) is that there is a lack of hospital management/organisational support by way of acknowledgement of the nurses' increased workload with the person with dementia. According to Eriksson and Saveman (2002) and Pinkert et al (2017) lack of organisational support, leads to nurses experiencing feelings of powerlessness, inadequacy and feelings of failure, as they are unable to take care of the person with dementia as they feel they ought to. The literature findings report that the majority of nurses want to provide best quality care and to have enough time to build a relationship with their patients (Eriksson and Saveman, 2002; Nolan, 2007; Pinkert et al, 2017). However, it is argued that in order to achieve this goal, the person with dementia requires an individual nursing approach to meet their needs (Clissett et al, 2013a; Pinkert et al, 2017). Provision of this level of care is not always achievable, due to both insufficient staffing levels and consequently a lack of time (Pinkert et al, 2017; Tropea et al, 2017) and attempting to balance time between the acutely ill patient with dementia and acutely ill patients with no dementia can lead to nursing staff experiencing conflicted feelings (Borbasi et al, 2006; Byers and France, 2008; Clissett et al, 2013a). Participants in Pinkert et al's (2017) study undertaken in Austria and Germany within nine acute general hospitals, described experiencing feelings of conflict and discomfort in their efforts to engage in psychosocial activities, such as looking at photo albums with the patient with dementia. As a result of working within busy task orientated acute care environments, dominated by standardised care plans and inflexible routines, attempting to engage in psychosocial activities rather than abiding by organisational limitations that hamper the delivery of person centred care resulted in nurses experiencing feelings of great uncertainty (Pinkert et al, 2017). Although it has to be acknowledged that not all of the participants in Pinkert et al's (2017) study were interested in providing psychosocial activities, some stated that they were more interested in the technical aspects of care.

In order to provide safe, holistic nursing care to enable quality patient outcomes, organisational systems need to provide an appropriate level of staffing (Byers and France, 2008). As Nilsson et al (2016), contend theoretically, all patients should receive high quality nursing care appropriate to their needs. When a gap exists between the real quality of care and the ideal quality of care that can be achieved, this can result in nurses experiencing a threat to their personal-professional integrity (Nilsson et al, 2016). The greater the gap, the more the nurses' personal-professional integrity is challenged. Nilsson et al (2016) argue that in order to support, protect and develop nurses' personal-professional integrity requires a supportive organisational system. It is argued that in the absence of a supportive system, nurses can experience signs of burnout and a deadened conscience which subsequently has the potential to lead to a poor quality of care (Eriksson and Saveman; 2002; Nilsson et al, 2016). Evidently, in the experiences of the nurses, providing quality dementia care within the acute general hospital setting can be extremely challenging both physically and emotionally. Consequently, this can lead to nurses expressing feelings of powerlessness and burnout which can ultimately result in a poor quality experience for both the patients and the nurses. To understand the influence of organisational support on nurses' experiences of dementia care nursing within the unique environment of the current study, especially given the association between lack of organisational support and nurses' experiences of both physical and emotional distress, requires further exploration. This mixed method study aimed to address this gap in the literature.

2.4.3 Dementia Care Nursing and the Use of 'Specials' in the Acute Care Setting

A further consideration in relation to the impact of staffing levels on nurses' experiences of dementia care nursing is the use of 'specials' to sit with and observe the person with dementia (Wilkes et al, 2010). Despite the frequency of this practice, there is no clear definition of what is meant by 'specialing' (Dewing, 2013). The limited research that has been undertaken to explore the use of 'specials' took place in Australia within two acute hospital settings (Moyle et al, 2010; Wilkes et al, 2010). Within these small qualitative studies with registered nurses (n=9) and (n=7) respectively, 'specialing' was taken to mean, close observation undertaken to provide one to one observation or care in response to persons with dementia manifesting responsive behaviours (Moyle et al, 2010; Wilkes et al, 2010). Points raised by the participants in both studies included the view that caring for an older person with dementia who is manifesting behaviours that challenge was not perceived as falling within the remit of regular nursing care, instead it was deemed to be a duty to be undertaken by a

'special' (Moyle et al, 2010; Wilkes et al, 2010). It was found that hospital management viewed the role of the 'special' as custodial and observational (Wilkes et al, 2010) which was referred to as 'baby-sitting' which facilitated the nursing staff to prioritise care to persons with no dementia (Moyle et al, 2010). A recommendation from the Wilkes et al (2010) study and in concurrence with Dewing (2013) is that an in-depth nursing assessment should be undertaken prior to the request being made for a special. However, as discussed earlier (section 2.4.2) due to insufficient staffing levels and the fixed routine of the acute care environment, the time needed to complete in-depth nursing assessments is not always available (Eriksson and Saveman, 2002; Borbasi et al, 2006). These research findings seem to suggest that there is an assumed separation between nursing care and care of the older person with dementia who manifest behaviours that challenge. No studies were found that explored the practice of employing a 'special' to look after persons with dementia experiencing episodes of confusion within the unique environment of the current study. As the role of the 'special' impacts on the experiences of nurses caring for older persons with dementia, this was noted as a distinct gap in the literature and justified further exploration in the current study.

To summarise, dementia care nursing in the acute care setting is challenging both physically and emotionally (Eriksson and Saveman, 2002) and as noted, the provision of quality dementia care nursing is dependent upon supportive organisational systems (Cowdell, 2010b). However, the empirical evidence serves to highlight the deficiencies within organisational systems in the acute general hospital care environment. Essential resources such as adequate staffing levels are not consistently provided and consequently, nurses have insufficient means to achieve their goal of providing quality dementia care nursing. When nurses are hampered in their pursuit of quality nursing care by a lack of essential support, the potential consequence leads to nurses experiencing burnout. Only two of the included studies took place solely in acute age related wards within acute general hospitals, Nolan (2007) and Cowdell (2010b), these are Irish and English based studies. Rehabilitation and residential care wards/units within age related units were not research sites in either Nolan (2007) or Cowdell (2010b) studies. The remainder of the studies, took place within a variety of wards/units within acute general hospital settings within a number of different countries. The variability of the study settings limits generalizability. The lack of evidence based research from non-dementia specific age related wards/units that include acute, rehabilitation and

residential units linked to acute general hospital services supported the need to explore nurses' experiences of dementia care nursing in this unique setting.

2.5 Professional Competence

Supportive organisational systems should encompass professional development to support nurses' levels of professional competence. Elements should include an emphasis on in-service and continuing education (McCance and McCormack, 2017). Professional nursing competence is described as possessing the appropriate skills, knowledge and attitudes to practice safely and effectively (NMBI, 2014; McCance and McCormack, 2017). The following sections will explore the literature related to specialist dementia education and training and the resultant influences on the experiences of nurses' provision of dementia care nursing in the acute care setting.

2.5.1 Specialist Dementia Education and Training in Acute Care Settings

It is well established in the literature that providing quality nursing care for the older person with dementia in acute care settings, is complex and challenging (Borbasi et al, 2006; Nilsson et al, 2016; Pinkert et al, 2017). This is due to the fact that symptoms of dementia are characterised by decreasing levels of cognitive function, combined with memory loss, communication difficulties and spatial awareness difficulties. Behavioural and psychological difficulties may also develop (DOH, 2014). Taking all of these factors into consideration, it is recognised that specialist skills and knowledge have a direct bearing on the nurses' ability to care effectively for the person with dementia in the acute care setting (Eriksson and Savemen, 2002; Borbasi et al, 2006; Nolan, 2007; Nilsson et al, 2016). The importance of specialist dementia education, and training is recognised by both professional (NMBI, 2015) and governmental bodies (DOH, 2014; HSE, 2016) (chapter one, section 1.1.4). Yet, the outcome of a Dementia Education Needs Analysis Report (de Siún and Manning, 2010) found that amongst the 632 participant nurses, the majority (83%) had not received education in dementia care. From the acute sector, of the 114 participants, only six or 5% had received specialist training. The Irish National Audit of Dementia Care in Acute Hospitals (de Siún et al, 2014) reported that just over half (52%) of the 31 hospitals audited had provided specific training for nurses in the previous 12 months. This is a significant finding in relation to the current study as it highlights that there remains a lack of organisational support by way of specific education for nurses providing dementia care nursing. From the reviewed literature, it is suggested that many nurses practicing within the acute general hospital care

environment, would welcome education and training programmes specific to dementia and dementia care nursing (Atkin et al, 2005; Fessey, 2007). Furthermore, it is argued that in order to ensure that education programmes and in-service training are successfully implemented, it is recommended that they should be provided on an on-going basis to ensure that knowledge is current (Atkin et al, 2005; Fessey, 2007; Cowdell, 2010a; de Siún and Manning, 2010).

Similar findings are reported by Surr et al (2016) who argued that despite the ample existence of evidence to suggest that there are deficits in current dementia skills and knowledge within the acute general hospital workforce, a low priority continues to be given to dementia training and education in comparison to mandatory and statutory programmes. Even when dementia training is provided, lack of organisational support by way of staffing shortages inhibits the numbers who can attend (de Siún and Manning, 2010; Baillie et al, 2016). Added to this anomaly, when specialist dementia education and training programmes are provided by the organisation, there is consensus in the literature that the strategies recommended to improve care, such as time and resources, are simply not available (Borbasi et al, 2006; de Siún and Manning, 2010; Baillie et al, 2016). It is argued by Cowdell (2010b) that it is debatable if this situation would be tolerated in other areas of practice.

In relation to educational and practice development strategies, Cowdell (2010b) argues that traditional knowledge based education is unlikely to be successful in improving nurses' experiences of delivering quality dementia care nursing in the acute care setting (Cowdell, 2010b). She proposes that there is a need to use education and practice development strategies that engage staff on an emotional level to enable them to start changing the ways in which they think about the person with dementia (Cowdell, 2010b). This view is supported by Clissett et al (2013a) and Handley et al (2017) who recommend that educational strategies should incorporate an exploration of emotional intelligence. Clissett et al (2013a) hypothesises, based on research findings, that an examination of emotional intelligence should equip nurses with a more complete understanding of how to meet the emotional, social and interpersonal demands of their role. Support by way of clinical supervision is also suggested as a means of facilitating nurses with opportunities to reflect and discuss the nursing care that is provided and additionally provide support to nurses on an on-going basis (Clissett et al, 2013a; Nilsson et al, 2016). Nurses must be given the opportunity to reflect on the ways in which their practice and integrity impacts on patient care and this can be achieved

through reflective practice (Nilsson et al, 2016). Thus it is conjectured that reflective practice through clinical supervision may support nurses to protect and develop their personal-professional integrity which in turn will positively influence nurses' experiences of dementia care nursing and patient care (Nilsson et al, 2016). In concurrence with Nilsson et al (2016) it is suggested by Handley et al (2017) that this should be blended with opportunities for staff to share their experiences of dealing with behaviours that they find challenging and adapting person-centred practices within ward routines and priorities.

While Tropea et al (2017) who conducted a study aimed at determining hospital staff perceived barriers and enablers to implementing quality dementia care, advocate for the development of educational interventions that employ multiple methods, for example, employing multi-media presentations, using clinical scenarios, and vignettes as well as interventions that increase the interactivity of the sessions will have greater impact on uptake of knowledge and best practice dementia care (Tropea et al, 2017). Recommendations proposed by Moyle et al (2010) to improve both patient and nurses' experiences, include encouraging an academic environment through integration of clinical care with education and research. Thus, it is evident from the reviewed literature, that programmes of specialist education and training in relation to dementia and dementia care nursing are essential to ensure nurses' are equipped with the necessary competence to provide quality dementia care nursing in the acute care setting. This is significant in terms of the nurses' experiences of dementia care nursing in the current study and prompted an exploration of specialist qualifications held by nurses, to bring about an understanding of the position in the unique identified environment of care.

2.5.2 Nurses' Specialist Knowledge and Skills Related to Dementia Care Nursing in Acute Care Settings

Evidence from the acute care setting, suggests that many nurses believe that as a result of inadequate educational support, they do not possess appropriate levels of adequate specialist knowledge and skills to provide skilled dementia care nursing and a lack of specialist dementia knowledge is a common theme (Atkin et al, 2005; Arnold and Mitchell, 2008). Findings suggest that this problem extends to the rest of the team to include medical staff (Atkin et al, 2005; Arnold and Mitchell, 2008). A recent Australian quantitative study conducted within two large acute general hospitals further endorse these findings (Tropea et al, 2017). It was identified that the organisation did not provide adequate levels of specific

education. As a result, the majority of the participants (112 respondents, 54 were nurses) did not believe that they had sufficient knowledge of dementia and added to this, the respondents stated that they lacked understanding of the most basic management strategies such as communication strategies with the person with dementia (Tropea et al, 2017). Nurses work within a task orientated environment where the physical needs of older persons with dementia take precedence over psychological care (Atkin et al, 2005; Arnold and Mitchell, 2008) and lack of specialist dementia knowledge and skills can lead to the situation where problems are identified by behaviours rather than by skilled assessment (Atkin et al, 2005).

In order to ensure that the needs of the person with dementia are met and to co-ordinate both physical and mental health requirements, requires competent practitioners who have the ability to undertake highly skilled assessment and care planning (Clissett et al 2013a; Nilsson et al 2013). Yet, according to Atkin et al (2005) and Arnold and Mitchell (2008) nurses feel inadequately prepared, due to knowledge deficits, to effectively conduct mental health assessments on persons who present with a degree of cognitive impairment. As Moyle et al (2010) caution, due to a lack of nurses' understanding, there is always the danger that the person with dementia can be blamed for their behaviour. On a similar theme, Clissett et al, (2013a) reporting from an observational study conducted within two sites within a large 1800 bed English teaching hospital, found that when the meaning of a behaviour is not explored, needs are left unmet which can potentially lead to an exacerbation of behaviours and new needs (Clissett et al, 2013a). In contrast from an acute age related unit, the participants in Nolan's (2006) hermeneutic study recognised the importance of not blaming the person with dementia for their behaviours, instead responsive behaviours were understood to be a manifestation of the dementia pathology.

The limited research that has been undertaken within age related units (Nolan, 2006; 2007; Cowdell, 2010a; 2010b; Scerri et al, 2015) report conflicting findings in relation to nurses' perceived levels of skills and knowledge. The nurse participants in Cowdell's (2010b) ethnographic study which was undertaken to explore the experiences of patients and nursing staff in three specialist age related acute wards within one acute English hospital, stated that they lacked knowledge with which to deliver quality dementia nursing care. Lack of knowledge was attributed to poor organisational support by way of specialist education. The nursing participants included registered general nurses (n=25) and the remainder of the staff participants were nursing assistants (n=33). The study also included patients with dementia

(n=11). While findings from Cowdell (2010a; 2010b) support the results from the acute care setting, these findings are somewhat contradicted by the participants in studies undertaken by Nolan (2007) and Scerri et al (2015). Nolan (2007) reported that the participant RGNs (n=7) in her phenomenological study, stated that they had satisfactory knowledge regarding provision of dementia care nursing. This finding according to Nolan (2007) is partly influenced by the setting, an age related acute admission ward within one Irish university teaching hospital with an emphasis on continuous education and professional development. It is also suggested by Nolan (2007) that as the nurses were exposed to the philosophies of rehabilitation nursing, following the resolution of the acute illness, this fact may have broadened their understanding beyond the acute model of care.

This is supported to a certain degree, by findings from Scerri et al's (2015) appreciative enquiry study undertaken in two age related rehabilitation units linked to one acute hospital in Malta. The participants, RNs (n=16) along with healthcare professionals and their aides (described as occupational therapists, pharmacists, physiotherapists, speech language pathologists, physiotherapist aides and occupational therapist aides (n=8) and nursing aides and clerks (n=9)) reported that they were confident in providing care for the older person with dementia which encompassed both physical and psychological care. For example, participants identified that engaging the older person with dementia in meaningful activities is a useful strategy in attempting to meet their psychological needs. While overall specialist education and training was lacking, it was reported that a limited number of healthcare professionals had attended in-house training which was provided by the consultant geriatrician (Scerri et al, 2015). The results are not divided into demographic strata in the studies conducted by Cowdell (2010b) and Scerri et al (2015) which limits the generalizability of the results to the experiences of the RNs. Due to the differing methodologies, samples and health care organisations (England, Ireland and Malta) utilised in Cowdell (2010b) Nolan (2007) and Scerri et al's (2015) studies it is not possible to compare and contrast the results. However, in totality, the findings would appear to suggest that if nurses' are exposed to nursing philosophies beyond the acute model of care, in this case, rehabilitation care, this experience may broaden their understanding of dementia care nursing. This has implications for the current study, were participants were exposed to nursing philosophies, including dementia care nursing within acute, rehabilitation and residential units linked to acute general hospital services.

As well as specialist dementia education as referred to earlier, further elements which can enhance nurses' skills and knowledge in the acute care setting, include having access to experienced staff in the area of gerontology and dementia care (Borbasi et al, 2006; Handley et al, 2017). Borbasi et al (2006) reported that participants clearly saw the benefits of drawing upon staff from the multi-disciplinary team with specialised knowledge and skills in the area such as geriatricians. The appointment of a gerontological-dementia nurse specialist was also seen to improve dementia care within the organisation (Borbasi et al, 2006). These findings are consistent with the work of Handley et al (2017) who conclude that in order to consolidate specific dementia training, staff need to be supported by senior members of staff with expertise in the area. These are key factors in improving patient outcomes and care practices (Handley et al, 2017). Such findings are significant, given that the current study was undertaken within age related services for the older person, where nursing staff have access to experienced staff within the multi-disciplinary team to include geriatricians.

2.5.3 Nurses' Individual Philosophies of Care Related to Dementia Care Nursing in Acute Care Settings

In the context of nurses' specialist skills and knowledge and the evidence above on limited educational input, it is contended that in many instances where pockets of good practice do exist, they tend to be based on the nurses' individual philosophies of care, personal beliefs and experience rather than theoretical knowledge and education (Borbasi et al, 2006; Cowdell, 2010b; Clissett et al, 2013b; Pinkert et al, 2017). These points are outlined by Scerri et al (2015) where it was reported that positive care experiences were attributed to the personal characteristics of health care workers. Qualities such as patience and calmness in negotiating care situations in response to patients' responsive behaviours were identified as essential traits by both staff and family members (Scerri et al, 2015). These views concur to a certain degree, with the findings presented in Nolan (2006) and Cowdell's (2010b) studies, where it was reported that some participants stated that they deliver care, as they would like a family member or themselves to be treated, rather than from a particular evidence base. Although many staff were observed to deliver care with kindness, as Cowdell (2010b) argues, in an oblique reference to the work of Tom Kitwood, kindness does not always equate with respect. In a similar vein, some of the participants in Nolan's (2006) study suggested that delivering care in a familial manner, although originating from a beneficent perspective could be perceived as a paternalistic approach to nursing practice, an approach that may not be ethical nor professional. The findings presented in this section are relevant to nurses'

experiences of dementia care nursing in the unique environment of the current study. This is particularly important, given the implications of findings in relation to nurses' theoretical knowledge and individual practitioners' philosophies of care on the provision of dementia care nursing. Given the importance of nurses' theoretical knowledge in relation to dementia care nursing, there is a need to explore these aspects of dementia care nursing, to promote a deeper understanding within the unique identified environment of care in the current study.

Finally, in relation to specialist education and training specific to dementia, many of the foregoing points are brought together and presented in a qualitative constructionist approach study undertaken within an English Trust to include two large hospitals and community services (Baillie et al, 2016). The study was undertaken to explore the education of a health service workforce about dementia and to promote a person-centred approach to care (Baillie et al, 2016) which is clearly of interest to the current study. In concurrence with Handley et al (2017), the importance of support from senior staff in relation to dementia related education along with adequate staffing levels was brought to the fore in this study. The support and leadership of the chief nurse was perceived to underpin the importance of the topic. The aim of the study was to educate a health force about dementia by initially showing a filmed drama 'Barbara's Story' which depicts the hospital experience of an older lady with dementia. Attendance at the film was mandatory (n=11,054) and both clinical and non-clinical staff attended but the follow up series of films was not mandatory and attendance dropped quite dramatically to (n=4,190). The drop in attendance was linked to pressure of work in the clinical environment thus, demonstrating very clearly the disparity between mandatory and non-mandatory attendance at educational sessions. An exploration of staff perspectives of the film was investigated through 26 focus groups and four individual interviews. Nursing staff included both registered nurses of differing grades and non-registered nursing assistants. Participants in both phases of the study identified a cultural change within the Trust which highlighted that care staff, need to spend more time with persons with dementia to achieve quality care. However, significantly it was found that due to staffing shortages and a consequent heavy workload this time was simply not available.

According to Baillie et al (2016), while it was perceived that improvements in clinical practice had occurred resulting from the educational programme there was no official evaluation. It was concluded that in order for quality dementia care to become embedded within the organisation, transformation of the organisational culture is necessary to include

involvement of senior leadership (Baillie et al, 2016). This view is endorsed by a number of authors (Moyle et al, 2010; Handley et al, 2017; Pinkert et al, 2017) who state that if changes are to take place and be sustainable, organisational change must be facilitated by way of support from senior staff. Education and training must go beyond education of individuals and move to being a facilitator of positive organisational change (Moyle et al, 2010). Transformation of the organisation cannot be achieved by focusing on individual staff members (Baillie et al, 2016).

To summarise, the findings of the studies reviewed in relation to the influences of organisational support on nurses' experiences of dementia care nursing, demonstrated that due to limited exposure to specialist education, a lack of specialist skills and knowledge are consistently associated with nurses' experiences of dementia care nursing in the acute care setting. Nurses would generally welcome specialist educational programmes and on-going in-service support in relation to dementia and dementia care nursing yet, it was found that this level of organisational support is generally lacking. This situation has the propensity to impact negatively on both the experiences of nurses and the quality of dementia care nursing. Exceptions to the foregoing were to be found in Nolan (2006; 2007) and Scerri et al's (2015) small qualitative studies which were undertaken in an age related unit within one Irish university teaching acute general hospital and two age related rehabilitation units linked to one Maltese acute general hospital respectively. Nolan (2007) reported that the participants in her study, felt well-equipped to provide care to the older person with dementia. It was believed this was as a result of working within an environment that supported continuous education and professional development (Nolan, 2007). While Scerri et al (2015) concluded that quality care experiences have the propensity to be positively influenced by staff attributes such as calmness and patience. There is a limited evidence base from the perspective of age related wards/units within the acute general hospital setting in relation to organisational support and the resultant influences on nurses' experiences of dementia care nursing. Consequently, to enhance understanding of these issues from the nurses' perspective, within the unique environment of the current study strongly justified the need for the current study.

2.6   Nurses' Attitudes' Towards Dementia in Acute Care Settings

It is important to understand the attitudes of nurses' towards the older person with dementia as according to Kang et al (2011) and Pinkert et al (2017) attitude underpins the nursing care

that the person with dementia can expect to receive. Attitude is defined as a response to a stimulus which includes affect, behavioural and cognitive components (Breckler, 1984). Positive attitudes held by nurses' result in a high quality of care and promotion of psychological well-being for the person with dementia (Kang et al, 2011; Pinkert et al, 2017). Conversely, negative attitudes, may lead to an emphasis on the physical aspect of care and highlight the persons' deficits in dementia (Kang et al, 2011; Pinkert et al, 2017).

The only study sourced that specifically measured nurses' attitudes towards dementia was Kang et al (2011). The setting was acute care wards in two acute general hospitals in Korea. A further Swedish attitude study included care staff and nurses (Nilsson et al, 2012). The remainder of the studies allude to health care staff attitudes (Nolan, 2006; de Siún and Manning, 2010; Clisett et al, 2013a, 2013b; Surr et al, 2016; Pinkert et al, 2017) and attitudes relating to patients' behaviour (Eriksson and Saveman, 2002; Borbasi et al, 2006; Cowdell, 2010a; 2010b; Nilsson et al, 2012; Nilsson et al, 2013; Scerri et al, 2015; Nilsson et al, 2016). A number of studies used the Lintern et al (2000) Approach to Dementia Questionnaire (ADQ). These studies included de Siún and Manning (2010) and Surr et al (2016) Irish and English respectively. Whilst Kang et al (2011) used a Korean version of the ADQ. It has to be noted that there is an inevitable amount of cross over or fusion between the literature relevant to nurses' attitudes towards dementia and previous themes reviewed earlier in this chapter, such as nurses' specialist knowledge about dementia. The cross over between nurses' attitudes towards dementia and nurses' specialist knowledge will become evident in the following sections.

The main sub themes derived from the reviewed literature relating to attitudes include: the relationship between nurses' knowledge and nurses' attitudes towards dementia in the acute care setting and the culture of labelling the person with dementia in the acute care setting.

2.6.1   The Relationship between Nurses' Knowledge and Nurses' Attitudes towards Dementia in Acute Care Settings

In the Irish context the Dementia Education Needs Analysis Report (de Siún and Manning, 2010), referred to earlier (section 2.5.1) was undertaken to develop and implement a national dementia education programme for nursing staff. Participants included 632 RGNs and 541 care attendants. The RGNs were described as clinical nurses, nurse managers and other nursing and the care attendants included health care assistants, multi-task attendants, home

helps and other care attendants. The participants were drawn from seven different areas of work to include acute care, residential care, community setting, practice nurses, intellectual disability, mental health and the private and voluntary sector. The Approaches to Dementia Questionnaire (ADQ) (Lintern et al, 2000) was used to measure the participants' attitudes towards dementia. The ADQ (Lintern et al, 2000) measures overall attitudes and the two subscales measure (a) the extent to which a person-centred approach to care is adopted and (b) hopefulness for the person with dementia. It was reported that the three nursing groups were combined to form one group and similarly the care attendants were brought together as one group. This decision was reached following statistical analysis by way of independent t-tests following completion of the ADQ, which revealed that no significant differences were found within the scores between the different nursing groups and similarly between the different attendant groups. When it came to the seven areas of practice surveyed, again statistical analysis did not reveal significant differences in the scores between the different areas of practice and the seven areas were collapsed into one. These findings are surprising given the diversity of the participants and research settings.

Overall, it was reported that the general approach and person-centred scores were found to be at the upper end of the ADQ scale (Lintern et al, 2000), this revealed that the respondents had a generally positive attitude towards dementia. The scores for hopefulness were more mid-range, demonstrating that while the majority of the respondents embraced a person-centred philosophy of care, fewer respondents had a high degree of hopefulness for the person with dementia. Statistically, the nurses' scores were significantly higher than the care attendants on all scores, indicating that the nurses had a significantly more positive attitude towards dementia care than the care attendants. Additionally, mean scores for those nurses (n=109) who had received education and training were compared with those nurses (n=523) who had not received training within the last five years. Findings revealed that higher attitude scores correlated with nurses who had received specialist training in the previous five years. It was also found that there were no significant difference between the general approach or the hope subscale but there was a significant difference in scores on the person-centred subscale. Thus, it would seem that training influenced the nurses' person-centred philosophy of care but did not influence the degree of hopefulness that they felt for the person with dementia. While the findings are of interest, given that the practice areas included residential care, community settings, practice nurses, intellectual disability, mental health and the private and voluntary sector along with the acute setting, it would be difficult to transfer the results solely

to the unique environment of non-dementia specific wards/units contained in dedicated health care services for the older person linked to acute hospital settings.

However, similar findings in relation to the association between positive attitudes towards dementia and specialist education were reported by Kang et al (2011). The study took place within medical and surgical wards in two large acute Korean general hospitals with RGNs (n=100). Data was collected by way of the Attitudes toward the Elderly questionnaire (AED) (Kuduzkiewicz et al, 2008) and the ADQ (Lintern, 2000). Data analysis demonstrated that higher attitude scores were achieved by participants working in medical wards compared to participants in the surgical wards. Findings indicated that the participants in the medical wards were more likely to have taken part in gerontological training. Kang et al (2011) also identified that nurses with specialist education, had greater perceived competence in providing dementia care nursing resulting in decreased levels of stress and increased job satisfaction. Higher positive attitudes demonstrated by the participants from the medical wards were also believed to stem from the fact that participants working in medical wards are less challenged or distracted with high-tech nursing interventions than nurses working in surgical wards and it was contended that this factor allows the nurses in the medical wards to spend more time with the person with dementia (Kang et al, 2011). Added to this, participants from the medical wards had more nursing experience than those in the surgical wards and, according to Kang et al (2011) this may have led to a more positive attitude towards dementia. Cultural influences were also thought to contribute to the attitude scores. Within Korean Confucian culture, the older person is greatly respected and honoured and prestige and honour is equated with old age (Kang et al, 2011). It was also reported that within Korean tradition, while the older person with dementia is hospitalised, a family member remains with the person and assists with their basic needs in relation to activities of living. Family presence provided support for the nursing staff which consequently gave them more time to attend to high-tech nursing interventions (Kang et al, 2011). The findings presented by Kang et al (2011) are of significance to the current study as they suggest that nurses with specialist training and years of nursing experience correlate with more positive attitudes towards dementia. However, the identified weaknesses such as the small sample size, the possibility of social bias and the different cultural influences limit transferability.

Evidently, specialist knowledge and education related to dementia is associated with more positive attitudes towards dementia (de Siún and Manning, 2010; Kang et al, 2011). In

relation to delivery of specialist dementia training programmes, it was found that short programmes can successfully impact on participants' attitudes towards dementia care (Surr et al 2016). A study by Surr et al (2016) was undertaken to explore the effectiveness of a specialist training programme for acute hospital staff in relation to delivering person-centred dementia care. The objective of the training programme was to improve attitudes, satisfaction and feelings of caring efficacy. The programme was delivered on two levels. It took place over a 3-4 month period and comprised, Foundation (0.5) day, followed by Intermediate which took place over three days. The study used a repeated measure design, which involved, completing measures prior to training, after completion of Foundation training and finally following Intermediate training. Attitude was again measured using the ADQ (Lintern et al, 2000). The study took place in one NHS trust in the North of England and included 85.4% nurses (n=35). In relation to attitudes, the results demonstrated that Foundation (0.5) day, level training was effective in improving person-centred attitudes and increasing a sense of hope for the person with dementia. The results concur with de Siún et al (2010) in relation to improving person-centred care attitudes following training but unlike de Siún et al (2010) Surr et al (2016) reported that training also increased the participants' sense of hopefulness for the person with dementia. Limitations of the study noted by the authors include the fact that the impact on the participants' practice was not measured, therefore, no conclusions can be drawn as to whether the care delivered following the training programme improved. Additionally, 39% of the participants were senior nurses (n=16), with over 20 years' experience of working in the acute sector. So although the participants were drawn from a variety of departments within the Trust, they may not be representative of the overall acute hospital staff. Significantly, specialist educational programmes in relation to dementia effectively improves staff attitudes towards dementia. The correlation between the positive influences of specialist education on nurses' attitudes towards dementia led to exploring this topic in the current study. This was considered to be especially important given that negative attitudes may be associated with an emphasis on the physical aspect of care which highlights the persons' deficits in dementia and is contrary to a person-centred approach to care.

Positive attitudes towards dementia are described by Pinkert et al (2017) as nurses 'becoming involved' or 'breaking routines'. The central focus of this study was the different ways in which registered nurses provide care for the person with dementia in the acute general hospital care environment (Pinkert et al, 2017). The study took place within five German hospitals and four Austrian hospitals using qualitative secondary analysis with RGNs (n=68).

'Becoming involved' is described by Pinkert et al (2017) as individual nurses with positive attitudes endeavouring to develop relationships with the patients by seeking biographical material either from the person with dementia or their relatives. While 'breaking routines' which is also dependent upon positive attitudes is described as individual nurses trying to alter the usual routine in an attempt to customise care for the older person with dementia (Pinkert et al, 2017). Breaking routines is recognised as shifting the perspective of the organisation from disease orientated to person-centred. It is an approach of the individual nurse as they are not acting on the basis of written protocols (Pinkert et al, 2017).

In a similar manner Clissett et al (2013a) refers to health care professionals (no details of the health care professionals were given but staff nurses and nurse managers were quoted) with positive or person-centred approaches to care as 'preserving the personhood of the individual'. 'Preserving the personhood of the individual' involves such actions as promoting familiarity and validation. It is suggested by Clissett et al (2013a) that providing this level of care has the benefit of providing the health care professional with a sense of achievement. This is contrasted with healthcare professionals who suspend the personhood of the person with dementia which Clissett et al (2013a) believes to be related to staff burnout. According to Scerri et al (2015) positive attitudes which result in worthwhile experiences for persons with dementia can be achieved by nurses 'going the extra mile' or recognition of the necessity to go over and beyond the call of duty. For example, participants described ensuring that patients' had access to their own clothes and jewellery, thus identifying and promoting the individuality of the patients (Scerri et al, 2015). The study took place within age related rehabilitation units linked to an acute general hospital in Malta. The points raised in relation to nurses' experiences of delivery of dementia care nursing demonstrate various approaches to care which appear to be dependent upon the individual nurses' attitudes. These reviewed studies are relevant to the current study as they sought an understanding of the influences of attitudes towards dementia care but due to the differing health care systems within the various countries, transferability of results cannot be assumed. Thus, nurses' attitudes towards dementia care nursing remains unclear in non-dementia specific wards/units as identified which provides support for exploring nurses' attitudes in the current study.

Nurses' attitudes to and experiences of dementia care nursing are also associated with nurses' perception of strain in provision of dementia care nursing (Nilsson et al, 2012). The aim of Nilsson et al's (2012) cross sectional study was to explore the attitudes of staff working with

patients with dementia aged 70 years and over in 12 medically orientated wards in one Swedish university hospital and to explore factors associated with negative attitudes (Nilsson et al, 2012). The survey employed three valid and reliable self-reporting questionnaires: Strain in Nursing Care (SNC), Satisfaction with Nursing Care and Work (SNCW) and the Person-centred Climate Questionnaire (PCQ-S). Of interest to the current study was that the SNCW (Hallberg et al, 1994) was used to measure staff experiences of care and work with persons with dementia. The participants included registered nurses (n=205) assistant nurses (n=125) allied health workers (n=16) and physicians (n=26). Factors associated with negative attitudes towards the older person with dementia, included higher perceived strain in provision of care and a higher perceived prevalence of persons with cognitive impairment on the ward along with being younger and being employed as an assistant nurse (Nilsson et al, 2012). In this study, assistant nurses were the main providers of support with intimate personal hygiene. As Nilsson et al (2012) contend, distressed behaviours are generally more prevalent during provision of intimate personal body care. Therefore, the negative attitudes expressed by the assistant nurses were thought to be associated with closer contact with the patients and the on-going behavioural difficulties (Nilsson et al, 2012). This is important in the Irish context as RGNs practicing in Ireland maintain a close working relationship with persons with dementia, to include support with personal hygiene. On the other hand, staff who reported less strain in caring for the older person with dementia expressed more positive attitudes towards their patients (Nilsson et al, 2012). These views concur with Kang et al (2011) where it was reported that participant nurses who were found to have lower levels of stress held more sensitive and positive attitudes towards the older person with dementia (Kang et al, 2011). The results were not categorised by participants' demographics in Nilsson et al's (2012) study, therefore it cannot be definitively stated that there were distinct differences between the various participant disciplines apart from the assistant nurses.

2.6.2 Culture of Labelling the Person with Dementia and Nurses' Attitudes towards Dementia in Acute Care Settings

The manner in which the person with dementia behaves, contributes to the attitude developed by nursing staff in the acute care setting with the available evidence, suggesting that patients with lower functional abilities, attract various types of labels and engender negative attitudes (Eriksson and Saveman, 2002; Borbasi et al, 2006; Cowdell, 2010a; 2010b; Nilsson et al, 2012; Clissett et al, 2013a; 2013b; Nilsson et al, 2016). A culture of labelling the person with dementia is discussed by Cowdell (2010a) and Nilsson et al (2016) and the resultant label

dictates the type of nursing care that the person with dementia can expect to receive (Cowdell, 2010a). Reported findings demonstrate that patients who are perceived to be 'sweet' and undemanding are regarded positively (Cowdell, 2010a; Nilsson et al, 2016) while negative labels such as being frightening or crazy are applied to patients with dementia who attack verbally, sexually or physically (Nilsson et al, 2016). If the person with dementia is labelled as 'difficult' they engender negative attitudes and the nursing staff, keep that person at a distance (Cowdell, 2010a). Similarly, patients who are labelled as 'only social admissions' attract negative attitudes and remain at the bottom of the hierarchy of care and are often overlooked by staff (Eriksson and Saveman, 2002; Cowdell, 2010a). Persons with dementia, who are labelled as 'social' admissions to the acute care setting, are generally admitted due to social problems such as a family carer being unable to provide the level of care required and do not usually have a medical diagnosis (Eriksson and Saveman, 2002). Research suggests that 'social' admissions to an acute ward are considered inappropriate (Cowdell, 2010a; Eriksson and Saveman, 2002) with nursing staff reporting feelings of powerlessness and negativity as they did not believe that they had the skills necessary to care for these patients (Eriksson and Saveman, 2002).

Further examples of labelling the person with dementia as 'disruptive' and 'unruly' are referred to in the literature. Persons with dementia are labelled as disruptive as they are viewed as disrupting the ward routine (Clissett et al, 2013a; Pinkert et al, 2017) by manifesting unruly behaviour such as walking around the ward and disturbing other patients by interfering with them (Eriksson and Saveman, 2002) or interfering with medical equipment (Nilsson et al, 2013). Consequently, according to a participant in Clissett et al's (2013a) study, the person with dementia may be placed inappropriately in a side room to prevent interference with the other patients in the ward. This action has the propensity to be interpreted as banishment by the person with dementia (Clissett et al, 2013a). While Pinkert et al (2017) found that management of the situation where patients were viewed as disturbing the ward routine may result in some nurses using measures such as physical restraint or sedation.

In contrast, nurse participants (n=7) in Nolan (2006) study which was conducted within one age related acute admission ward, were aware that there was a risk of persons with dementia being subject to stigmatisation and labelling. Consequently, the need to protect the person was frequently expressed and nurses referred to their role as advocates in the care relationship

(Nolan, 2006). Perceptions of the person with dementia as a person did not diminish with admission to the acute context or the degree to which the dementia had advanced (Nolan, 2006). This contrasts sharply with the Cowdell (2010b) study where it was found that nursing staff have a propensity to transpose the person with dementia from person as individual to person as other, a person who is incapable of forming relationships, an object of care, rather than a valued person to be respected. She cautions that if nursing staff do not connect with the person with dementia, it is possible that they will retreat into themselves and decrease their efforts to communicate (Cowdell, 2010a). Similar points are raised by Nolan (2006) and Clissett et al, (2013b). For example, social isolation can occur as a result of care withdrawal (Nolan, 2006) and as a result of social isolation, the person with dementia can become increasingly confused, very quickly (Clissett et al, 2013b). The points raised highlight the association between nurses' attitudes towards dementia and the quality of dementia care nursing in acute care settings. Positive attitudes equate with care delivered in a person-centred approach, in contrast negative attitudes may lead to the situation where the needs of the person with dementia are overlooked. There is a paucity of research conducted to specifically explore nurses' attitudes towards dementia in acute care settings. Consequently, there is a need to further increase the understanding of nurses' attitudes within the unique environment of non-dementia specific wards/units as identified within the current study.

In summary of nurses' attitudes, the reviewed international literature which explored nurses' attitudes towards dementia, in the acute care setting produced inconsistent findings. Evidently, knowledge and education or the cognitive components of attitude appear to lead to more positive attitudes, and a greater belief in the person-centred philosophy of care (de Siún and Manning, 2010: Surr et al, 2017) and a greater degree of hopefulness for the person with dementia. (Surr et al, 2017). Yet, positive attitudes are also associated with nurses' personal attitudes regardless of theoretical knowledge and education (Scerri et al, 2015; Pinkert et al, 2017). Despite the differences in findings, it is generally accepted that positive attitudes appear to correlate with specialist knowledge, thus delivery of specialist educational programmes, as discussed in the literature is to be commended. While the literature report that these programmes positively influence the person-centred philosophy of care and an increased sense of hopefulness for the person with dementia, it is unclear how the newly acquired knowledge translates into practice and further research is recommended (Surr et al, 2016).

Affect or behaviour towards the person with dementia is also related to the way in which the person presents, with persons with higher dependency levels engendering negative attitudes. However, the results are difficult to substantiate due to the diversity of studies to include design, setting and country. Three studies were conducted within dedicated health care settings for the older person (Nolan, 2006; Cowdell, 2010a, 2010b; Scerri et al, 2015) to include acute admission wards and rehabilitation units. To bring about an understanding of nurses' attitudes towards dementia, in the unique environment of non-dementia specific dedicated health care services for the older person, to include acute, rehabilitation and residential units linked to acute general hospital services justified exploring this topic in the current study. The final section of this literature review is concerned with an exploration of the environment of dementia care nursing.

2.7   Environment of Dementia Care Nursing in Acute Care Settings

The delivery of nursing care is heavily influenced by the physical characteristics of the ward/unit (Adams et al, 1995; McCance and McCormack, 2017). Ideally the physical environment in the acute care setting should be aesthetically pleasing, incorporate adequate space for the patient, satisfactory facilities for families and staff members and provision of appropriate equipment (Adams et al, 1995; Moyle et al, 2010; Grey et al, 2017; McCance and McCormack, 2017). Additionally, a dementia friendly design within the acute care setting should incorporate the design of services and products, to include the built environment which takes cognisance of the cognitive, physical and sensory needs of persons with dementia (Grey et al (2017). Recommendations for a dementia friendly ward according to Brooke and Semlyen (2017) Cox and Eastham (2017) and Grey et al (2017) are outlined in Appendix Two.

Within dementia care nursing research, the empirical literature reviewed in relation to the environment of dementia care nursing in acute care settings included the following papers. Two English studies (Brooke and Semylen, 2017; Cox and Eastham, 2017) were undertaken independently of one another to explore the impact of dementia friendly ward environments on the care of older persons with dementia within two acute general hospitals. A number of the studies included in the review, allude to the environment of care (Eriksson and Saveman, 2002; Borbasi et al, 2006; Nolan, 2007; Clissett et al, 2013a;Goldberg, 2013; 2014; Pinkert et al, 2017). Three of these studies were exclusive to RGNs (Eriksson and Saveman, 2002; Nolan, 2007; Pinkert et al, 2017). Two studies took place in age related services, Nolan

(2007) and Brooke and Semlyen (2017). From the reviewed literature, the emergent themes were (i) general ward environments and (ii) dementia friendly ward environments as the following sections will now illustrate.

2.7.1 General Ward Environments in Acute Care Settings

The physical care environment within the acute care setting is not designed for the person with dementia, as it is unsafe, unfamiliar and strange for the person with dementia (Eriksson and Saveman, 2002; Borbasi et al, 2006). These factors make it difficult for the person with dementia to make sense of what is happening around them (Borbasi et al, 2006). Difficulties can be experienced due to such issues as bathrooms being located at a distance from the persons' bed which can result in not being able to find the bathroom or getting lost on route (Borbasi et al, 2006). Environmental factors such as difficulties in 'way finding' for the person with dementia, also presents a challenge to nurses as patients moving freely around an environment that is not designed for this purpose can be unsafe (Nolan, 2007). With regard to maintaining safety for the person with dementia, participants in Eriksson and Saveman's (2002) study explained that they had to occasionally close the front doors of the ward which annoyed the other patients. When the doors were open, the persons with dementia had to be supervised and the nursing staff did not have time for this activity (Eriksson and Saveman, 2002). This situation led to nursing staff seeking help to manage this situation which potentially could lead to the person with dementia being transferred to the psychiatric clinic (Eriksson and Saveman, 2002).

These points are reflected in Nolan's (2007) study, where participants stated that they were conscious of the need to be constantly watchful to ensure that patients remained safely in the ward. As a consequence of this level of vigilance and the consequent nursing time that this activity required, care for the other patients on the ward was adversely affected (Nolan, 2007). In order to protect the patients in their care, nurses may have to constrain them and limit their independence which in turn leads to frustrations for both parties (Eriksson and Saveman, 2002; Nolan, 2007). In other words environmental constraints impact heavily on the nurses' experiences of dementia care nursing. Thus the literature demonstrates that the environment of care impacts heavily on nurses' experiences of delivery of dementia care nursing. This led to exploring the nurses' beliefs about the environment of care in the unique identified setting of the current study to understand the impact of the environment of care on nurses' experiences of caring for older persons with dementia.

It is acknowledged that the person with dementia needs a peaceful and quiet environment (Eriksson and Savemen, 2002) as their capacity to manage environmental stressors such as sensory overload is reduced as a consequence of the dementia pathology (Nolan, 2007). These points are discussed in studies conducted by Borbasi et al (2006) and Nolan (2007). It was found that the constant activity and the level of noise in the acute setting can exacerbate the person with dementia's confusional state (Borbasi et al, 2006) leading to overstimulation (Nolan, 2007). There was recognition by the nurses that overstimulation can result from routine ward activities, such as visiting times or doctors' ward rounds which suddenly increase the numbers of unknown people in the environment (Nolan, 2007). Participants in the study by Nolan (2007), with an understanding of the practice of dementia care nursing were frustrated by the limitations and constraints on their caring role due to the overstimulated environment. The effects of the overstimulated care environment can be far-reaching for the person with dementia and ultimately influences the nurses' experience of dementia care nursing. In view of the research findings that demonstrate that the environment of care impacts on nurses' experiences of dementia care nursing, justified exploring the environment of care in the unique setting of non-dementia specific wards/units contained in dedicated health care services for the older person linked to acute general hospitals.

Items such as clocks and calendars play an important role in providing orientation cues for the older person with dementia while in hospital (Brooke and Semlyen, 2017). However, de Siún et al (2014) found from the Report of the National Audit of Dementia Care in Acute Hospitals, that the physical environment of many wards, have a lack of orientation cues, including clocks, calendars or personal possessions. This is despite the fact that it is acknowledged that the presence of familiar objects, support a sense of identity and continuation of self for the person with dementia (Brooke and Semlyen, 2017). Clissett et al (2013b), contend that familiar objects also serve the purpose of promoting conversation both for the family/friend and staff members and serve as reminders of the individuality of the person with dementia and additionally promote feelings of homeliness.

In an effort to familiarise the environment, participants in Borbasi et al's (2006) study spoke of providing photographs of family members and friends. They also tried to create a more homely atmosphere by placing a clock on the wall and involving family members in the patients' care (Borbasi et al, 2006). Yet, these modifications have to be considered within the

context of the particular environment (Borbasi et al, 2006; Cox and Eastham, 2017). For instance, issues such as patient confidentiality limit the extent of personalisation at the bed side (Cox and Eastham, 2017) along with limited physical ward/unit space (Borbasi et al, 2006). This concurs with the findings from Pinkert et al's (2017) study where it was observed that even for nurses who provide some form of PCC, the hospital physical environment imposed environmental constraints. These authors suggest that the care that nurses are capable of delivering is very much dependent upon the physical environment of care and the organisational structure. The findings from their study established that it is only possible to deliver quality dementia care nursing if the underlying organisational strategies provide the necessary support and hospital leaders provide adequate resources. The conclusion reached is that hospitals must minimise constraints to give every nurse the chance to perform quality dementia care nursing (Pinkert et al, 2017). These findings are significant to the current study.

2.7.2 Inclusive Dementia Friendly Wards in Acute Care Settings

Inclusive dementia friendly wards have to take into account both the complex physical and psychological care needs and the environmental requirements of persons with dementia (Cox and Eastham, 2007). In relation to the creation of dementia friendly wards, three English studies, Goldberg et al (2013; 2014), Brooke and Semlyen (2017) and Cox and Eastham (2017) reported a number of similar findings. The aim of the Brooke and Semylen (2017) qualitative study was to gain an understanding of the impact of dementia friendly ward environments on nurses' experiences of caring for acutely unwell patients. Participants included junior staff nurses (n=17) and health care assistants (n=21). The study took place within three recently refurbished wards within an English district general hospital. The aim of the Cox and Eastham (2017) mixed methods study (n=8) participants, was to explore the design features of a recently refurbished dementia friendly ward within an English hospital trust, along with staff views on the implications of daily activity engagement for patients with dementia. Participants represented the multi-disciplinary team and included occupational therapists (n=2), nurses (n=2) physiotherapists (n=2), occupational therapist assistants (n=2). A randomised controlled trial was conducted by Goldberg et al (2013) with the aim of contrasting care in a specialist medical and mental health unit (MMHU) with care for older people with cognitive impairment admitted to general medical wards in one English hospital. It has to be noted that the MMHU in preparation for the study, had been allocated enhanced staffing levels to include, specialist staff such as psychiatric nurses and activities co-

ordinators and there was a programme of therapeutic activities. Staff also received specialist dementia education and training, a more appropriate care environment was created and an inclusive and proactive approach to family carers was initiated (Goldberg et al, 2013).

It was found that the dementia friendly wards provided a homely atmosphere where persons with dementia could familiarise themselves with their bed space and interaction was promoted both with persons' with dementia and their families (Goldberg et al, 2013; Brooke and Semlyen, 2017; Cox and Eastham, 2017). Contrasting colour schemes along with clear ward signage enabled persons with dementia with 'way finding' (Goldberg et al, 2013; Brooke and Semlyen, 2017; Cox and Eastham, 2017) mobility, independence and daily personal hygiene activities (Cox and Eastham, 2017). Supportive design features such as the well-equipped activity rooms and social areas contributed to the person with dementias' increased use of activity items (Cox and Eastham, 2017). While, some of the participants believed that the environmental changes enabled the delivery of person-centred care and had a positive effect on the person with dementia's behaviour and psychological symptoms (Brooke and Semylen, 2017). Conversely, other participants did not understand why the environmental changes had been implemented and as a result could not associate such elements as a change of colour scheme to issues that they thought were challenging when caring for a person with dementia (Brooke and Semlyen, 2017). While dementia training programmes were offered by the hospital, it is not known if the participants took part. The participants commented that due to staff shortages, the environmental changes and the provision of new techniques and resources were difficult to adopt (Brooke and Semlyen, 2017).

While positive staff interaction was believed by some participants in the Cox and Eastham (2017) to encourage daily activity engagement, conversely 25% of the participants believed that patient engagement in self-care activities was far more significantly influenced by staff attitudes and encouragement alone rather than any of the design features. Another view purported that the greater aesthetic appeal of the new design features contributed to more positive staff attitudes and increased staff morale resulting in greater staff interaction with persons with dementia. In concurrence with findings earlier in this chapter (section 2.6.1) positive attitudes may also be attributed to the fact that the staff had received specialist dementia training (de Siún and Manning, 2010; Kang et al, 2011; Surr et al, 2016; Cox and Eastham, 2017).

The overall findings from Brooke and Semlyen (2017) and Cox and Eastham (2017) suggest that the creation of dementia friendly environments is fundamental to providing quality dementia care in acute settings. However, it was concluded (Brooke and Semlyen, 2017) that any environment that is well designed to be dementia friendly can be undermined by inadequate organisational support and poor staff knowledge. Weak organisation by way of insufficient staffing levels was noted in both Brooke and Semlyen (2017) and Cox and Eastham (2017) studies and deficient staff knowledge was evident from (Cox and Eastham, 2017) where some staff did not understand the relevance of the environmental changes on dementia care nursing.   The culture and commitment of an organisation influences both positively and negatively job satisfaction, empowerment and involvement of nurses (Brooke and Semylen, 2017). Although it has to be noted that according to Goldberg et al (2014) due to the complex needs of persons with dementia, staff, were not always able to meet their requirements. The study findings highlighted the challenging nature of dementia care nursing and the fact that meeting basic physical needs of patients took up most staff time and physical needs were prioritised over psychological needs (Goldberg et al, 2014). While these studies provide important and insightful findings and contribute to the body of knowledge relative to the impact of dementia friendly environments, it would be difficult to generalise the findings due to the particular environmental context. Another point of note is that of the overall participants (n=46) in the Brooke and Semylen (2017) and Cox and Eastham (2017) studies less than 50% represented the discipline of nursing (n=19) (Brooke and Semylen, 2017; Cox and Eastham, 2017).

In summation, the international literature regarding the physical environment of care for the older person with dementia presents remarkably similar results. It is acknowledged that provision of quality dementia care nursing is complex and challenging regardless of whether it is provided in a dementia friendly environment or a traditional ward within a general hospital setting. Inadequate organisational support appears to be a major barrier. As Pinkert et al (2017) stress, dementia care nursing is not the sole responsibility of individual nurses, it is dependent upon organisations providing appropriate staffing numbers, specialist education, supportive management structures and an overall organisational commitment to the delivery of dementia care nursing. Two studies were conducted in acute admission wards situated within dedicated health care services for the older person in the acute hospital setting (Nolan, 2007; Brooke and Semylen, 2017). In view of this gap in the literature, further research was warranted to reach an understanding of the impact of environmental issues in relation to

dementia care nursing in the unique setting of the current study which comprised acute, rehabilitation and residential units within age related services linked to acute general hospitals.

2.8   Summary

The reviewed literature demonstrates the deficiencies in acute hospital organisations in providing support for dementia care nursing.   Nurses are not provided with adequate organisational support and the necessary resources are not consistently available. The review identified that shortcomings experienced by nurses in the delivery of dementia care nursing include, inadequate staffing levels and limited access to educational programmes resulting in nurses feeling poorly equipped to provide dementia care nursing. Additionally, there is a distinct relationship between positive attitudes held by nurses and specialist knowledge (de Siún and Manning 2010; Kang et al, 2011) thus clearly highlighting the importance of specialist education. Dementia care nursing takes place within noisy, overstimulated, chaotic environments.   The older person with dementia has a reduced capacity to manage environmental stressors.   The acute care environment can potentially increase the older person with dementia's confusion, thus the environment of care does not provide optimal conditions for dementia care nursing.   Furthermore, findings demonstrate that dementia friendly environments provide an improved physical environment but the perennial problem of staffing shortages persists. When staffing levels are depleted, the nursing focus return to physical care and the undertaking of psychological care is no longer attainable. Additionally, the acute hospital care environment is task focussed and there is little organisational acknowledgement given of the increased workload associated with dementia care nursing (Pinkert et al, 2017).

Overall, the findings of the literature review must be interpreted carefully with reference to the following points. The studies have taken place in a variety of different countries and care environments. Countries ranged from European countries to Asian along with American and Australian. They all took place within acute general hospital settings or environments linked to acute general hospital services. The care environments encompassed settings as diverse as Korean medical and surgical wards (Kang et al, 2011) Swedish general medical wards, oncology and neurological clinics (Nilsson et al, 2016) English accident and emergency services (Surr et al, 2016) and Austrian and German medical wards (Pinkert et al, 2017). Three studies took place in dedicated health care services for the older person and these will

be referred to separately. The majority of the studies are descriptive and context specific with small numbers of participants and they utilise a variety of designs. A limited number of studies are exclusive to registered nurses (Atkin et al, 2005; Fessey, 2007; Byers and France, 2008; Arnold and Mitchell, 2008; Kang et al, 2011; Pinkert et al, 2017). Despite the various anomalies, there is a distinct uniformity of findings which adds credibility to the results but the variability of health services and research methodologies, as outlined, limits transferability. Amongst the most authoritative and widely quoted are Eriksson and Saveman (2002) Clissett et al (2013a; 2013b) Borbasi et al (2006) Swedish, English and Australian respectively.

As noted only three studies took place in non-dementia specific wards/units contained in dedicated health care services for the older person (Nolan, 2006; 2007; Cowdell, 2010a; 2010b; Scerri et al, 2015) Irish, English and Maltese respectively. Both Nolan's (2006; 2007) phenomenological study and Cowdell's (2010a; 2010b) ethnographic study were conducted within acute wards. Scerri et al's (2015) appreciative inquiry took place within two rehabilitation units for the older person linked to acute general hospital services. All three studies were conducted exclusively within one setting particular to the study, with small samples and they were conducted using differing methodologies within different health care systems. Nolan's (2006; 2007) studies are the only studies exclusive to RGNs. As a result the findings cannot be compared and contrasted and these factors limit transferability of the findings. Notwithstanding, Nolan (2006; 2007) and Cowdell (2010a; 2010b) make valuable contributions to understandings of dementia care nursing and they are both widely quoted in the relevant research literature. It is evident therefore that further study is needed to determine nurses' experiences of dementia care nursing within the unique environment of non-dementia specific wards/units, that include acute, rehabilitation and residential care contained in dedicated health care services for the older person linked to acute hospital services. The current study was conducted in response to this gap in the research literature in relation to dementia care nursing and thus adds to the body of knowledge pertinent to dementia care nursing in the acute care setting.

The current study is unique in that it is the first to explore, nurses' views and opinions about dementia care nursing based on nurses' experiences of caring for the older person with dementia in non-dementia specific wards/units that include acute, rehabilitation and residential, contained in dedicated health care services for the older person linked to acute

hospital services using a mixed methods approach. The majority of the reviewed studies were conducted qualitatively (19), one was conducted using a mixed methods approach and six were undertaken using quantitative methods. The ADQ (Lintern et al, 2000) was successfully used to explore nurses' attitudes towards dementia in three of the quantitative studies. The SNCW (Hallberg et al, 1994) was effectively employed in Nilsson et al's (2012) study, to measure staff experiences of care and work with persons with dementia in the acute care setting. Thus, two valid and reliable tools were identified from the literature review and subsequently used in the current study. The following chapter will outline the conceptual framework used to underpin the interpretation of the study findings

Chapter Three - Conceptual Framework

3.1   Introduction

The conceptual framework underpinning the interpretation of the study findings is the Socio-technical System theory (STS). The purpose of this chapter is to briefly explore the theoretical underpinnings of general system theory as informed by von Bertalanffy (1972). This will be followed by an overview of two such systems, the Neuman Systems Model (NSM) (Neuman, 2011) and the Socio-technical System theory (STS) (Trist, 1981) which were both considered as conceptual frameworks for underpinning the interpretation of the study findings in the current study. The strengths and weaknesses of the NSM and the STS will be presented and a summary of the STS will then be outlined. This will be followed by an overview of the STS from a nursing perspective which will highlight the compatibility of the STS with the current study and justify its use as a conceptual framework. Finally a summary of the chapter will be presented.

3.2   General System Theory and the Current Study

The aim of this mixed methods sequential explanatory study was to explore nurses' views and opinions about dementia care nursing based on their experiences of caring for the older person with dementia in non-dementia specific wards/units as identified. According to the findings of the literature review, dementia care nursing takes place within complex organisational systems and is dependent on a number of interacting elements, such as, nurses' competencies (Eriksson and Saveman, 2002; Nilsson et al, 2016) and their attitudes towards dementia and dementia care nursing (Kang et al, 2011; Pinkert et al, 2017). Nurses' experiences are also influenced by the level of organisational support that they receive, for example, appropriate staffing levels, access to specialist dementia education and supportive management structures (McCance and McCormack, 2017). The physical features of the environment of care in acute care settings also have a powerful impact on nurses' experiences of dementia care nursing (Brooke and Semylen, 2017; Cox and Eastham, 2017). According to Neuman (2011) within all complex organisational systems the properties of an element are determined to an extent by the whole that contains it. This means that each element must be viewed as part of the whole and no part can be considered in isolation (Neuman, 2011). This is consistent with general system theory which is defined as a group of elements standing in interrelations between themselves and within the environment (von Bertalanffy, 1972).

According to Kast and Rosenzweig (1972) a system is made up of inter-related elements or parts and all systems are composed of at least two interconnected parts. This is the case for every system to include mechanical, biological or social (Kast and Roseenzweig, 1972). According to Cordon (2013) system theories are helpful in understanding organic systems or systems involving people such as health care systems. The following section will present a brief overview of system theory to explore why it was considered as an organising framework for underpinning the interpretation of the study findings.

3.3   Overview of System Theory

Historically, system theory originated from the works of early philosophers such as Aristotle (384-322 BC) and Descartes (1596-1650) (von Bertalanffy, 1972). Both Aristotle and Descartes conceptualised and developed theories designed to best explore systemic multifaceted questions (Cordon, 2013). Aristotle introduced the holistic perspective that the whole is greater than its parts and considered the importance of viewing systems as a whole. In contrast, Descartes presented the reductionist approach of solving problems by breaking down every problem into as many separate simple components as is possible (von Bertalanffy, 1972). Moving forward, the concept of general system theory was initially introduced by von Bertalanffy, a theoretical biologist in the 1930s. The concept of system constituted a new paradigm or a new philosophy of nature and general system theory entailed the scientific exploration of wholes or wholeness (von Bertalanffy, 1972). According to von Bertalanffy (1972) in order to comprehend the organised whole, it is essential to identify both the elements and the relations between them.

General system theory emphasises the inter-relatedness and interdependence of subsystems interacting within their environments and the notion of systems as integrated wholes (von Bertalanffy, 1972). There is an emphasis on the relationship between parts, general system theory describes how parts function and behave and there is a trend towards equilibrium (von Bertalanffy, 1972). Temporary changes in the system environment will cause a reaction to compensate for the change, in order to maintain equilibrium (von Bertalanffy, 1968). von Bertalanffy identified the need to develop a general system theory that is applicable to any system irrespective of the properties or components of that system (Cordon, 2013). The aim of the general system theory was to assimilate various sciences such as social and natural sciences with the goal of addressing the metaphysical fields of science (Cordon, 2013). As a result, the concepts of general system theory can be applied universally by scientists from

many disciplines (von Bertalanffy, 1972). According to Cordon (2013) organisations and people such as health care systems, are complex systems and general system theories can assist in increasing understandings of ways in which people interact with one another and their environment. As extrapolated to the current study, general system theory should assist in bringing about an understanding of nurses' experiences of dementia care nursing, within the complex health care environment of acute care settings.

A number of theorists have drawn from the work of von Bertalanffy's general system theory to include: Johnson's Behaviour System Theory, Roy's Adaption Model, Orem's Self-Care Deficit Model (Tomey and Algood, 2002). For the purposes of my study, I considered two system theories: the Neuman Systems Model (NSM) (Neuman, 2011) which comes from the discipline of nursing while the second, the Socio-technical System theory (Trist, 1981) originates from the perspective of behavioural sciences. These identified theories were considered due to their widely reported applications within the literature, suggesting their suitability as conceptual frameworks. The following sections will explore and justify the chosen conceptual framework.

3.4   Neuman Systems Model

The Neuman Systems Model (NSM) (Neuman, 2011) was initially explored as a potential conceptual framework to underpin the discussion element of this current study because the model is based on general system theory. The NSM was originally developed by Betty Neuman in the 1970s as a teaching model or holistic framework to organise nursing knowledge (Neuman, 2011). It has subsequently become one of the most popular nursing practice models in the world and has also been widely used to underpin a variety of diverse nursing research studies (Fawcett, 2004; Neuman, 2011). The NSM is influenced by von Bertalanaffy's general system theory (Neuman, 2011). Symbolically, the system is conceptualised as an open and dynamic system in total interface with both the internal and external environment (Neuman, 2011). The systems perspective can include a single client, a group or a community or research participants (Memmott et al, 2000). The system is composed of five interacting system variables (psychological, spiritual, sociocultural, development and physiological) (Neuman, 2011). Characteristically, the system is represented as having a basic structure which is the foundation of the interacting system variables surrounded by successive rings which constitute lines of defence to include a flexible line of defence, a normal line of defence and lines of resistance.   Each protective concentric boundary or line of defence is a composite of the interacting system variables.

Systems react to stressors in the environment, stressors are referred to as intrapersonal, interpersonal and extra-personal, ideally there is optimal system stability (Neuman, 2011). Stressors can be constraining or facilitating (Skillen et al, 2001). Constraining factors are described as stressors and facilitating factors are described as eustress (Neuman, 2011).

According to the literature review, nurses providing care for persons with dementia in acute care settings, continuously experience environmental stressors or constraining and facilitating factors. The open system characteristics of the NSM, encompassing the system interacting in a reciprocal manner with the created environment has the potential to contextualise the complexities and the unpredictability of situations experienced by nurses (system) providing care for persons with dementia within the acute environment of care. Furthermore, the NSM's main focus on the perception of environmental factors as being either positive or negative, offers a framework for exploring the strengths, the relationship and the degree of stability between the interacting variables. The way in which nurses perceive environmental factors will influence their experiences of nursing practice. This was demonstrated in Grant and Bean (1992) and Skillen et al's (2001) studies, where they organised the collected data into constraining and facilitating factors within the created environment framework. This could potentially have provided a method of clearly illustrating the findings of the current study. A summary of the strengths and weaknesses of the NSM is presented in table 3.1.

Table 3.1 - **The Neuman Systems Model, Strengths and Weaknesses**

	Strengths	**Weaknesses**
The Neuman Systems Model	NSM provides a framework for theory development, research and nursing practice (Stepans and Knight, 2002). NSM provides the nurse with a basic wholistic system. It is comprehensive and flexible enough to provide a basis for all nursing inquiry and it also promotes individual interpretation (Ume-Nwagbo et al, 2006). NSM is a comprehensive model, capable of encompassing a broad range of nursing problems (Günüşen et al, 2009). NSM provides a framework from which to analyse barriers inherent in nursing roles and functions (Pines et al, 2011). NSM is a suitable model for guiding nursing studies and practices in terms of offering a systems-based comprehensive conceptual framework and providing an holistic viewpoint (Bademli and Duman, 2017).	There is a need to further refine the operational definitions of stressors and variables (Grant and Bean, 1992) The relations among Neuman's variables are highly complex and require a great degree of specification at both the conceptual and empirical levels (Gigliotti, 1999). A major weakness of the model is the need for further clarification of terms used. Intra-personal, inter-personal and extra-personal stressors need to be more clearly delineated (Gonzalo, 2011).

To sum up, there are a number of strengths contained in the NSM as outlined in table 3.1. Its strengths incorporate wholism (sic), flexibility and comprehensiveness and it is mooted that it provides an appropriate framework for underpinning nursing studies (Stepans and Knight, 2002; Ume-Nwagbo et al, 2006; Pines et al, 2011; Bademli and Duman, 2017). A major facet is the systems' perception of environmental factors. The concept of the system interacting in a reciprocal manner with the environment provides a creative method with which to explore the relationships between system variables. However a number of weaknesses are noted, one of which refers to the complexity of the concepts (Gigliotti, 1999). This is a key consideration for any researcher intending to use the NSM due to the caveat articulated by Neuman (2011). Neuman (2011) advises that the first step in using the NSM for research purposes is to develop a clear understanding of the content of the model to include the various concepts and relational propositions. As illustrated in the foregoing section, the NSM is quite verbose and intricate and there is an emphasis on the concept of stressors or events that causes stress as opposed to the concept of eustress or stress that comes from positive challenges (Grant and Bean, 1992). As a result, the NSM may be more

appropriate to use in research studies which explore the influences of nurses' stress rather than nurses' experiences. As the intended use of the NSM was to provide a conceptual framework within which to explore one part of the current study ie the findings, the complexity of the NSM, combined with the lack of clarification of terms used within it, resulted in seeking an alternative conceptual framework. To this end, the discussion will now present an overview of the Socio-technical System Theory.

3.5 Socio-technical System Theory (STS)

The socio-technical system theory (STS) was developed as a result of work carried out by researchers with a background in behavioural sciences, Eric Trist and Ken Bamforth, from the British Tavistock Institute of Human Relations. Their research and the subsequent development of the STS related to the introduction of mechanised technology systems in the coal mining industry in Britain during the 1950s (Trist, 1981). The industry was performing badly, following the introduction of mechanised technical systems (Trist, 1981) and technical systems impacted negatively on both the social structure and the physical environment of the organisation (Fox, 1995). This was due to the fact that the process became highly dependent on the technical intervention and less dependent upon the coal miners, thus causing an imbalance between the social and technical systems interacting within the environment (Fox, 1995). The researchers recognised the importance of the inter-relationships and interdependence of the social and technical subsystems interacting within their environment. They conceptualised that optimal work performance and equilibrium requires joint interaction between the technical and social subsystems within the environment of an organisation (Trist, 1981).

3.5.1 Key Concepts of the Socio-technical System Theory

According to Trist (1981) the socio-technical system theory was originally conceived as a set of interacting systems taking cognisance of general system theory. Trist (1981) acknowledges the influence of the work of von Bertalanffy's general system theory, on the development of the STS theory. The STS theory is founded on the premise that an organisation or work place environment is composed of two interdependent social and technical components, or the work force to include knowledge, skills and attitudes of employees and technical aspects such as devices and techniques that support the work system (Trist, 1981). As Trist (1981) comments, the two components are independent of each other with technical systems following the rigid laws of the natural sciences while the social system is immersed in the

more unpredictable human sciences. This independence is misleading as the systems cannot create outcomes separately (Trist, 1981). As specified within the STS theory, the social and technical sub systems have to be considered as Trist (1981) suggests, 'correlatively', or as naturally related, as individually they cannot fulfil the functional tasks or goals of the organisation (Trist, 1981). As Trist (1981) cautions, if their unique characteristics are not appreciated "their contradictions will intrude and their complementarities will remain unrealized" (p.24).

In other words, the social and technical subsystems have to be thought of as co-dependent, since understandings that are appropriate for one may not be appropriate for the other. This understanding necessitates a dual focus and joint optimisation (Fox, 1995). Optimal work performance is the desired outcome and is commensurate with the level of best fit between the two components (Cherns, 1976). As Cherns (1976) states, peak organisational performance is best met by jointly optimising the social and technical subsystems within the organisational environment. Thus, he recommends developing the flexibility and resourcefulness of the workforce in meeting the organisational goals rather than overemphasising technically the ways in which these goals can be accomplished (Cherns, 1976). The interaction of the social and technical components creates the conditions for effective organisational performance. If optimisation of only one aspect occurs, the consequence of this may result in unpredictable organisational performance or dis-equilibrium (Trist, 1981). The focus on workers was the impetus for conceptualising a socio-technical system as two separate but interconnected systems, a social system and a technical system (Whetton and Georgiou, 2010). Thus the principle concept of STS is to bring about an understanding of the interaction between the social requirements of the people carrying out the work with the technical requirements necessary to keep the work systems viable within a particular environment (Whetton and Georgiou, 2010). Table 3.2 provides a summary of the strengths and weaknesses of the STS.

Table 3.2 - **Socio-technical System Theory, Strengths and Weaknesses**

	Strengths	Weaknesses
Socio-technical System Theory	STS can lend more precision in describing the social and technical components. STS thinking proposes a situation relating theory for nursing in that it seeks to explain and predict how the patient's and nurse's situations relate to the sociotechnical work environment. STS has potential as a means of capturing the influence of the environment, including physical design, care delivery system and management model have on both workers and care recipients (Happ, 1993). Wide application of the socio-technical approach is due to its generality and so has the capacity to be adopted with ease to almost any organisational situation (Appelbaum, 1997). Provides the theoretical framework for considering the relationship between people and technology and between the organisation and its environment (Song et al, 1997). STS one of the most widely accepted and extensively used social science paradigms due to its functional reality and conceptual simplicity. It can be used as a heuristic device, a method to explore and discover the hypothesised relationships and in that way move closer to problem solving (Heller, 1997). The open systems approach in which technical as well as social aspects of the organisation are recognised offers a sound starting point for studying productive organisations while meeting the needs of the employees (Brooks and Anderson, 2005). STS stresses the organisations need for flexibility and attention to the processes used to create and deliver care (Ingersoll et al, 2005). STS provides a basis from which to identify methods for studying and measuring aspects of an organisations' social and technical systems (Westbrook et al, 2007). Provides a theory to examine the interplay of the technical and social subsystems across a range of organisations. (Suter et al, 2013).	Social components of STS are defined imprecisely (Ingersoll et al, 2000). Lack of coherence between theoretical concepts, ambiguous definitions of social and technical subsystems, unclear boundaries between organisation and the environment (Brooks and Anderson, 2005).

In summary and relevant to the current study, the strength of the STS lies in its functional reality and conceptual simplicity. It has been widely used in research studies within a number of disciplines as a conceptual framework, due to its generality and it can be adapted easily to various organisational situations. The STS is capable of providing a conceptual framework for exploring the interplay between technical and social subsystems and between

the organisation and its environment across a range of organisations. The STS can be used as a sound starting point or a heuristic device. On the other hand, weaknesses include opaqueness between the theoretical conceptions, a lack of clear definition of the technical and social subsystems and indistinct boundaries between the environment and the organisation (Brooks and Anderson, 2005). However, the weaknesses are not insurmountable and can be dealt with by providing well defined and distinct definitions of the technical and social subsystems and clear cut boundaries between the environment and the organisation (Happ, 1993).

For example, in the current study, the social component refers to the participant nurses and the technical component refers to the resources available to the participant nurses. The environment focuses on the organisational environment and the physical characteristics of the environment of care. As Ingersoll (2000) explains, the central tenet of the STS is the focus on the interaction between the environment and the social and technical components of an organisation. Each of these components overlap and are interactive with one another (Ingersoll, 2000). In other words, as related to the current study, within the hospital environment, the overall organisational structure (technical components) to include, corporate management, hospital policies and procedures (applicable to nursing staff) along with organisational support (such as appropriate nursing staffing levels) interacts and impacts and influences the attitudes (positively or negatively) and behaviours of the nurses (delivery of person-centred care or task based care delivery) (social components) within the individual wards/units (environment of care) and consequently, effects nurses' experiences of dementia care nursing. Optimal work performance is dependent upon equilibrium between the social and technical subsystems.

3.6   STS From a Nursing Perspective

A detailed report and analysis of the application of the STS in nursing research was presented by Happ (1993). Although this report was published in 1993, it remains influential and continues to be referenced widely. Happ (1993), in accord with the STS theorists recognises the organisation as an open and living system in constant interaction with the environment. The work environment within healthcare delivery, according to Happ (1993) is described as having social and technological components within a patient care setting and it is suggested that the social and technological components may in part determine the physical design of that setting. Happ (1993) is of the opinion that STS has potential as a means of capturing the

influence that environment, including physical design, care delivery system and the management model have on the experiences of both workers and care recipients. According to Happ (1993) the technological components of a patient care system include observable biotechnical equipment as well as the written policies, procedures and protocols that guide the work or provision of care. The social components of a patient care system include the unit culture, management model and nursing care delivery model. The STS philosophy is recognised as seeking to optimise the social and technical components of the organisation in a mutual way (Happ, 1993). Happ (1993) maintains that the STS with its emphasis on the interaction between social and technical components within an organisational environment, offers a sound conceptual framework for exploring the influence that these components have on nurses' experiences of care delivery and clinical practice. These points, as outlined by Happ (1993), assimilated fittingly with the purpose of using the STS in the current study and were influential in the rationale for utilising it.

Ingersoll et al's (2000) description of the STS within the health care environment of care is consistent with that of Happ (1993). The focus is described as the interactions between the work environment and the social and technical components of the organisation. Ingersoll et al (2005) in relation to the STS identified that the structural, social and technical components of the acute environment of care contributes to the delivery of care and has the propensity to influence the experiences of both employees and patients. Social components focus on the work group relationships, essential to successful work environments. Technical aspects include amongst other issues, availability of continuous learning and performance improvement/safety assurance practices to promote understanding of ways in which care is monitored, delivered and understood (Ingersoll et al, 2005). The use of the STS as a sound conceptual framework was illustrated in a nursing study conducted by Ingersoll et al (2000) to determine the relationship of organisational culture and readiness for change to employee commitment to the organisation. A further study conducted by Ingersoll et al (2001) was undertaken to determine the perceived impact of organisational redesign on nursing staff at two acute care hospitals. In this study Ingersoll et al (2001) highlighted the need for an organising framework for the collection and interpretation of data within nursing studies. The identified conceptual framework was the STS which was subsequently successfully utilised in a comprehensive evaluation of two acute care hospitals. Questionnaires and focus group interviews were used to measure the social and technical components of the theory. The focus of the Ingersoll et al (2001) report was on the social and technical components of

the system as perceived by staff nurses employed in the hospitals. The staff nurses' perceptions about the social and technical components of the work environment were measured through the use of 12 focus group interviews. The questions posed were described as including the staff nurses' perceptions and responses on nursing roles, work environment, work group relationships and provision of services to patients and families. Ingersoll et al (2001) in concurrence with Happ (1993) recommend the use of the STS as a sound conceptual framework to guide the interpretation of study findings. Happ (1993) and Ingersoll et al's (2001) recommendations further strengthened the decision to use the STS in the current study for the purpose of guiding the interpretation of the study findings.

From a nursing perspective, Brooks and Anderson (2005) also interpreted the STS as being composed of an organisational environment, with social and technical subsystems as well as physical design and work settings which act together to influence and produce the outcome or service. The social component, according to Brooks and Anderson (2005) comprises the people who work in the organisation. Aspects originating from the social component that could possibly concern nurses who work in hospitals may include supervisory-subordinate relationships, skill levels, attitudes and expectations of the work organisation (Brooks and Anderson, 2005). Technical subsystems consist of the tools, techniques, procedures, and devices used by members of the social subsystem to accomplish the organisations tasks. In concurrence with the literature review (chpt 2), Brooks and Anderson (2005) advise that to ensure that the organisational goals are met, the organisational members have to be supported. The surest way to support the organisational members is to identify their needs and incorporate the means to meet these needs through the design of the technology and the work itself. The STS approach in which technical as well as social aspects of the organisation are recognised offers a sound starting point for studying and meeting the needs of employees (Brooks and Anderson, 2005). Another example of the successful use of the STS in nursing studies to develop socially and technically balanced workplaces was described in a study conducted by Casella et al (2014). The STS was used as a theoretical framework in this study, to underpin the exploration of the balance between the social and technical aspects of nurses' work in relation to social media (Casella et al, 2014).

The STS from a nursing perspective, as presented, has demonstrated that it has the potential to provide a framework capable of capturing the interplay between the social and technical elements interacting within the environment of care. In the current study, and consistent with

the work of Ingersoll et al (2001) the STS provided a robust conceptual framework within which to organise and interpret the study findings into social and technical elements. Organising the social and technical elements interacting within the environment of care, as described by the participant nurses clearly illuminated the degree of equilibrium achieved. As Cherns (1976) advises, optimal work performance (as related to the current study, dementia care nursing) is commensurate with the level of best fit between the two components. Appendix three provides an illustration of the social and technical components within the environment of care as applicable to the current study. The participant nurses' experiences of dementia care nursing was explored by using a two phase mixed methods sequential explanatory method as will be described in the following chapter.

3.7   Summary

A summary of the evolving worldview that forms the foundation for general system theory was presented in this chapter. The aim was to gain an understanding of the underpinning philosophies of system theories and outline the rationale for choosing the STS. System theory emphasises the inter-relatedness and interdependence of subsystems interacting within their environments and the notion of systems as integrated wholes with a trend towards equilibrium (von Bertalanffy, 1972). The health care system which is composed of inter-dependent and interrelated subsystems interacting within their environment represents an example of a general system. Following an exploration of two systems which were influenced by general system theory ie Neuman Systems Model (NSM) and the Socio-technical System theory (STS) a decision was reached to use the STS. It provided a conceptual framework within which to categorise and develop an understanding of the complex interactions as perceived by the participant nurses between the social components (participant nurses) and the technical components (overall organisational structure) necessary to keep the work system (dementia care nursing) viable within the environment of care. According to the STS, optimal work performance is dependent upon equilibrium between the social and technical subsystems interacting within their environment. Ultimately, the degree of equilibrium as perceived by the participant nurses between the social and technical systems interacting within the environment of dementia care nursing will influence the nurses' experiences of dementia care nursing. The STS framework provided the lens through which the results of the current study can be viewed. The following chapter will present the methodologies used in the current study.

Chapter Four – Methodologies

4.1 Introduction

This chapter presents the mixed methods research design used in this study. Mixed methods research is an approach to inquiry that mixes both quantitative and qualitative paradigms and involves philosophical assumptions (Creswell, 2009). The chapter explores the philosophical assumptions of the quantitative, qualitative and mixed methods paradigms. It also explores the perceived challenges in mixing quantitative and qualitative paradigms. It then moves on to provide the rationale for choosing the mixed method research design to include purposes and typologies.

4.2 Research Question, Research Aim and Objectives

4.2.1 Research Question

"What are nurses' views and opinions about dementia care nursing based on their experiences of caring for the older person with dementia in non-dementia specific wards/units that include acute, rehabilitation and residential, contained in dedicated health care services for the older person linked to acute general hospital services?"

4.2.2 Research Aim

The aim of this two phase mixed methods sequential explanatory study was to explore nurses' views and opinions about dementia care nursing based on their experiences of caring for the older person with dementia in non-dementia specific wards/units that include acute, rehabilitation and residential, contained in dedicated health care services for the older person linked to acute general hospital services.

4.2.3 Research Objectives

- To explore and describe, nurses' views and opinions about dementia care nursing based on their experiences of caring for the older person with dementia in non-dementia specific wards/units that include acute, rehabilitation and residential, contained in dedicated health care services for the older person linked to acute hospital services.

- To investigate attitudes held by nurses towards dementia and nurses' views and opinions based on their experiences of caring for the older person with dementia in non-dementia specific wards/units that include acute, rehabilitation and residential,

contained in dedicated health care services for the older person linked to acute hospital services.

- To obtain descriptions of nurses' beliefs about the environment of care and its impact on nurses' experiences of caring for the older person with dementia in non-dementia specific wards/units that include acute, rehabilitation and residential, contained in dedicated health care services for the older person linked to acute hospital services.

- To explore the associations between nurses' demographic characteristics and their views and opinions about dementia care nursing based on their experiences of caring for the older person with dementia in non-dementia specific wards/units that include acute, rehabilitation and residential, contained in dedicated health care services for the older person linked to acute hospital services.

4.3   Research Paradigms

It is widely accepted that research is built on particular philosophical beliefs or ways of knowing resulting in the classification of research methods into paradigms (Weaver and Olson, 2006). The word paradigm from the Greek word meaning pattern, describes the world views or philosophical beliefs which guide the actions of a particular scientific community (Guba, 1990; Creswell, 2009; LoBiondo-Wood and Haber, 2014). Paradigms are defined by distinct components namely epistemological (how we know what we know), ontological (the nature of reality), axiology (the place of values in research) and methodological elements (the process of research) (Hanson et al, 2005). Guba (1990) suggests that paradigms are characterised by the manner in which their advocates respond to these basic components. Paradigms clarify assumptions about the way phenomena can be studied, the methods that can be employed and the way in which the resultant data can be analysed and presented (Creswell, 2009; LoBiondo-Wood and Haber, 2014). In short, paradigms are grounded in a group of assumptions that support researchers to determine the shape and goals of an inquiry and assist in elucidating ways in which the results of the exploration are interpreted and viewed (Ford-Gilboe et al, 1995). Creswell (2009) proposes that the researcher's approach to data collection and analysis relates to their epistemological and ontological stance. Historically, within nursing research the pursuit of nursing knowledge has been strongly influenced by two opposing paradigms, namely positivism or the quantitative paradigm and constructivism/interpretivism or the qualitative paradigm (Weaver and Olson, 2006). As Creswell (2009) and Morgan (2014) suggest, gaining an understanding of the strengths and weaknesses of quantitative and qualitative paradigms is an important step for the researcher

considering the use of mixed methods research. The following section will provide a brief overview of these two paradigms to include strengths and weaknesses.

4.3.1   Quantitative and Qualitative Paradigms

The quantitative or positivist paradigm is rooted in logical positivism and the notion of truth based around rigid rules concerning logic, measurement, principles and predictions (Weaver and Olson, 2006). Positivists believe in realist ontology, ie that reality is out there and there is an objective way of understanding it (Guba, 1990; Parahoo, 2006). Epistemology is concerned with seeking truth in a replicable, objective sense and developing knowledge through systematic testing in a rigorous and controlled manner (Ford-Gilboe et al, 1995; Burke Johnson and Onwuegbuzie, 2004). To this end, theory is arrived at deductively, through formal and statistical testing of hypothesis (Morgan, 2014). It is also understood that there must be a separation between the object of research and the researcher to ensure that an objective unbiased stance is maintained (Guba, 1990; Burke Johnson and Onwuegbuzie, 2004). Purposively measuring and analysing casual relationships between variables is the goal (Sale et al, 2002). Research methodologies within the positivist paradigm include survey methods that can be analysed using statistical methods which can be generalised to a wider population (Morgan, 2014). Quantitative methods such as surveys provide a useful objective method for studying relationships between concepts by the use of measurements and statistical tests (Morgan, 2014). For example, and of interest to the current study, the relationship between concepts such as experiences and demographic characteristics can be measured quantitatively by using statistical procedures (Parahoo, 2006). The literature reviewed in chapter two, demonstrated that nurses' experiences of dementia care nursing to include attitudes has previously been researched, although not in the unique setting utilised in the current study, as a result relevant tools have been identified (section 2.8). This suggested that a quantitative approach could be used as a sole paradigm to answer the research question. The strengths of the quantitative paradigm include, that data collection using tools such as questionnaires can be reasonably quick, it provides precise numerical data and data analysis using statistical software is comparatively time efficient (Burke Johnson and Onwuegbuzie, 2004). However, there are a number of limitations associated with using this paradigm and these are considered in the following paragraph.

During the second half of the 20th century, challenges to the dominant positivist paradigm began to emerge as nurse researchers became more aware of the mismatch between the

philosophy of the positivist paradigm and the holistic, interactional philosophies of the nursing discipline (Dootson, 1995; Weaver and Olson, 2006; Larkin et al, 2014). A further denunciation of the positivist paradigm was the dehumanisation of people to scores and percentages for statistical analyses along with the reduction of human beings to parts (Weaver and Olson, 2006). For example, by reducing phenomena such as attitudes to empirical observations, it is not possible to form a meaningful understanding (Morgan, 2014). Consequently, this would suggest that while using a quantitative approach would answer the current study research question, it may not provide a more in-depth meaningful understanding. Since the 1970s, nurse researchers have gradually adapted the constructivist also known as interpretive, naturalistic or qualitative paradigm which has traditionally been recognised and valued by behavioural scientists. As a result, nursing research began to experience a shift from the philosophies of rationalism to the constructivist or qualitative paradigm (Dootson, 1995; Parahoo, 2006).

The philosophical assumptions of the constructivist or qualitative paradigm stem from the ontological perspective that reality is complex, context dependent and holistic (Creswell, 2009). Epistemology is based on the assumption that truth is multi-faceted and is determined by the on-going experiences of the individual or cultural group (Burke Johnson and Onwuegbuzie, 2004). It is a flexible approach underpinned by inductive methods (Morgan, 2014). Within the qualitative gaze, the focus is concerned with subjective experiences, narrative descriptions and understandings, as viewed or constructed through the perspective of the participants in their lived situation (Weaver and Olson, 2006). The researcher is generally an active participant and the research is conducted in a dialogue, such as focus group interviews with the participants, in order to collect data for analysis (Moule and Goodman, 2014). The aim is to establish a deeper understanding of experiences and reality of others within a small sample size (Morgan, 2014). Analysis is undertaken in a rigorous manner which involves searching through the information and presenting data in the form of words which offer a theory or a description of the subject under investigation (Morgan, 2014). Consequently, the foregoing suggested that using a qualitative approach would bring about a deeper understanding of the research question which contained concepts such as nurses' experiences and attitudes, as viewed from the participants' perspectives. The main criticisms levelled at the qualitative research paradigm, include issues relating to reliability, subjectivity, bias and generalisation due to small sample sizes (Burke Johnson and

Onwuegbuzie, 2004; Larkin et al, 2014). The perception can be that qualitative research is less powerful and influential than the quantitative process (Larkin et al, 2014).

Many nurse researchers now believe that using a single method or theoretical perspective in isolation can only provide a partial understanding of the complexities and multi-faceted nature of nursing (Happ, 2009; Halcomb and Hickman, 2015). It is contended within the discipline of nursing that using a mixed method research design incorporating quantitative and qualitative paradigms has the ability to strengthen the reliability and add richness to the research topic (Fleming, 2007; Larkin et al, 2014; Halcomb and Hickman, 2015). This has led to an increasing number of nurse researchers using a variety of data collection methods, or mixed methods research in a single research project and combining both qualitative and quantitative paradigms to address research questions (Parahoo, 2006; Moule and Goodman, 2014; Halcomb and Hickman, 2015).

4.4   Mixed Methods Research

It is suggested by Happ (2009) that nurse researchers practicing in the field of gerontological nursing believe that mixed methods research lends itself well to this area of practice. According to Happ (2009) such research has been invaluable in providing a deeper understanding of such issues as care giving and the complexities of the environment of care. Following on from the foregoing exploration of quantitative and qualitative paradigms and Happ's (2009) contentions regarding the field of gerontological nursing research, it was believed that using a single paradigm would only reflect a partial understanding of the research concepts. Using quantitative measures such as questionnaires, while proficiently providing answers to the research question would not have provided an opportunity to expand or elaborate on participants' responses. Following up with a qualitative approach offered a way of providing insight and a deeper understanding of the concepts contained in the research question, such as nurses' experiences of and attitudes towards dementia care nursing. Mixed methods research, as the title suggests is a synthesis of the ideas included in qualitative and quantitative research (Burke Johnson et al, 2007). While it is acknowledged that mixed methods is not new, it is considered to be a new movement or discourse in research paradigms (Burke Johnson and Onwuegbuzie, 2004). A noted shortcoming in the development of mixed methods research, is that the language has not always been consistent and precise (Tashakkori and Teddlie, 2003; Creswell and Plano Clark, 2007). Terms used throughout the years include, multi-method, blended, methodological triangulation and mixed

methods research (Tashakkori and Teddlie, 2003; Creswell and Plano Clark, 2007). For the sake of consistency, Creswell and Plano Clark (2007) contend that the systematic use of the term mixed methods research should be used to describe research that combines quantitative and qualitative data. This will ensure that mixed methods research is viewed by the research community as a distinct method (Tashakkori and Teddlie, 2003; Creswell, 2009). Indeed, according to Morgan (2014) the term, mixed methods research has become the most common expression to describe this movement. In consideration of the foregoing, the term 'mixed methods research' is the term that will be used for the current study. Burke Johnson et al (2007) offer a general definition of mixed methods research:

> "mixed methods research is the type of research in which a
> researcher or team of researchers combines elements of qualitative
> and quantitative research approaches (eg use of qualitative and
> quantitative viewpoints, data collection, analysis, inference techniques)
> for the broad purpose of breadth and depth of understanding
> and corroboration." (p. 123)

This definition proposes that mixed methods research focuses on a mixture or combination of quantitative and qualitative research techniques within a single study and proponents believe that it offers a way of bridging the gulf between them (Burke Johnson et al, 2007). Although, these authors offer the caveat that definitions will change over time as knowledge continues to grow around mixed methods research (Burke Johnson et al, 2007). However, this definition remains comparatively current as illustrated in and alluded to in the work of Schoonenboom and Burke Johnson (2017). Burke Johnson et al's (2007) definition was adopted for the current study, due to the fact that it was arrived at by a carefully constructed, clearly delineated examination of definitions supplied by 19 acknowledged experts in the field of mixed methods research.

Using a mixed methods research design in the current study permitted a deeper understanding of the research question which focussed on the concepts of nurses' experiences and attitudes towards dementia care nursing and beliefs about the environment of care than would have been obtained by using a single paradigm. As contended by Tashakorri and Teddlie (1998), the use of two or more research paradigms can strengthen the overall design. The combination of quantitative and qualitative paradigms can be used to build on the strengths of both paradigms thus overcoming the weaknesses inherent in both (Burke Johnson and

Onwuegbuzie, 2004). For example, quantitative paradigms which included the use of surveys as in the current study are restrictive, as statistical methods do not permit an holistic picture of the phenomenon under exploration to emerge such as experiences or attitudes. Similarly qualitative methods, such as focus group interviews which were used in the current study, due to small sample sizes restrict generalizability and are considered to be subjective (Burke Johnson and Onwuegbuzie, 2004; Larkin et al, 2014). It is also advocated, that taking this approach should neutralise any bias involved in using a single method approach, as well as increasing the researchers' ability to interpret data and better explain the research phenomenon (Jick, 1979; Begley, 1996; Halcomb and Andrew, 2005; Creswell, 2009).

There are quantitative and qualitative purists who contend that these paradigms and their associated methods cannot be mixed (Ford-Gilboe et al, 1995; Burke Johnson and Onwuegbuzie, 2004). Tashakorri and Teddlie (1998) coined the phrase 'paradigm wars' to describe the relentless focus on the differences between the positivists and the constructionists. Purists assert that the philosophies of the two paradigms are irreconcilable, as they represent bipolar ontological and epistemological beliefs (Burke Johnson and Onwuegbuzie, 2004). The counter argument is that as both paradigms share a cohesive logic and have a shared goal of comprehension of the world, they can be united (Sale et al, 2002; Fleming, 2007). Burke Johnson and Onwuegbuzie (2004) are of the opinion that some of those who engage in the qualitative versus quantitative debate confuse the logic of justification, or understanding of propositions and beliefs which is a vital component of epistemology, within research methods. They comment that epistemology does not determine the particular data collection and the data analytical methods that a researcher should employ (Sandelowski, 2000; Burke Johnson and Onwuegbuzie, 2004). In other words, it is the methods that are mixed not the methodologies (Ford-Gilboe et al, 1995; Giddings and Grant, 2007; Morgan, 2014). As Burke Johnson and Onwuegbuzie (2004) and Creswell (2009) suggest, qualitative and quantitative research paradigms and their associated methods can be conceptualised as two ends of a continuum. As mixed methods research contains elements of both qualitative and quantitative, it can be placed in the middle of the continuum (Burke Johnson and Onwuegbuzie, 2004; Creswell, 2009). This concept is illustrated in table 4.1 which is based on the work of Creswell (2009)

Table 4.1   Quantitative, Mixed and Qualitative Research Methods

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Quantitative Methods   →   **Mixed Methods**   ←   **Quantitative Methods**

It would appear that despite arguments to the contrary, the judicious blending of the mixed methods approach can be successfully implemented. According to Burke Johnson and Onwuegbuzie (2004) the time has come to move beyond debate about the quantitative versus the qualitative divide and instead focus on the potential for using mixed methods research designs.

A further consideration within the mixed methods research approach is that of an underpinning philosophy (Sandelowski, 2000; Burke Johnson et al, 2017). The next section will briefly outline the philosophy of pragmatism which it is suggested, constitutes an ideal underpinning philosophy for mixed methods research (Creswell, 2009; Morgan, 2014; Burke Johnson et al, 2017).

4.4.1   Pragmatism and Mixed Methods Research

Classical pragmatism has its origins in the works of three American philosophers, Charles Sanders Peirce, William James and John Dewey (Ormerod, 2006). Pragmatism was conceived within a problem solving and practical culture following the social and political reverberations of the American Civil War and significantly its approach to philosophy embraced the empirical over speculative metaphysics (Williams, 2016). For these pragmatists truth is 'what works' (Williams, 2016). According to James (1907), an idea is true if it works in practice. There is general agreement that the influence of classical pragmatism went into abeyance during the mid-twentieth century but enjoyed a renaissance during the 1970s under the influence of neo-pragmatists such as Richard Rorty (Warms and Schroder, 1999; Burke Johnson and Onweugbuzie, 2004; Burke Johnson et al, 2017). According to Burke Johnson et al (2017), pragmatism offers a solution to the many, philosophy of science dilemmas, encountered by researchers in the field of social sciences.

Methodological pragmatists such as Creswell (2009), Morgan (2014) and Burke Johnson et al (2017) are of the opinion that pragmatism provides a sound philosophical partner to mixed methods research. Research methods in the spirit of pragmatism as advocated by the classical

pragmatists, Peirce, James and Dewey, should follow the research questions using the approach that gives the best possibility of obtaining worthwhile answers (Burke Johnson and Onwuegbuzie, 2004). Onwuegbuzie et al (2009) hold the position, in line with Peirce, James and Dewey, that the need to answer research questions is based on methodological choice rather than on philosophical alignment. A pragmatic standpoint, offers epistemological justification and logic for combining multiple sources of knowledge with the objective of establishing a comprehensive understanding of people and the world in which we live and practice (Onwuegbuzie et al, 2009). This is consistent with Dewey's objective of directing the philosophy of pragmatism to meet the needs of the people (Ormerod, 2006). It gives practical and effective answers that are acceptable to those who subscribe to the paradigm wars (Burke Johnson et al, 2017). It is also compatible with a Rortyan perspective, as interpreted by Burke Johnson et al (2017) which recommends that researchers should be resourceful in finding and creating the best ways in which to advance human flourishing in the widest sense. Clearly then, pragmatism is not committed to any one system of philosophy and reality, it does not ask questions about the laws of nature and reality (ontology) and theory of knowledge (epistemology) (Creswell, 2009; Morgan, 2014). This is consistent with mixed methods research where researchers pursue both qualitative and quantitative paradigms within one study (Creswell, 2009). Thus, within the current study, the mixed methods research design allowed the researcher the freedom to choose the most appropriate procedures to answer the study question. This was also consistent with the following caveat - this is not to suggest that the researcher discarded all logic and rigor, instead it proposed that the researcher moved away from rigid beliefs and from absolutes and dealt only with the emerging facts concerning the problem at hand (Florczak, 2014).

The pragmatic approach to mixed methods research recognises the epistemological differences between qualitative and quantitative paradigms but these forms of inquiry are not viewed as incompatible, instead a shared aim for all research is advocated (Burke Johnson and Onwuegbuzie, 2004). The rejection of incompatibility between the quantitative and qualitative paradigms and the combination of the two paradigms as put forward by Burke Johnson and Onwuegbuzie (2004) allowed the aim of the current study to be realised in a way that promoted understanding of the reasons behind the quantitative answers which could not have been realised by using a single paradigm. Consistent with the work of Doane and Varcoe (2005) the inseparability of knowledge and practice was acknowledged by the researcher and, the integral role practice experience played in on-going knowledge creation

was recognised. This was a particularly cogent point as the aim of the current study was to explore the nurses' views and opinions about dementia care nursing, in acute care settings, based on their practice experiences. Pragmatism is determining the value of an idea by its outcome in practice (James, 1907). The pragmatic approach offered a foundation for weaving together quantitative and qualitative methods in the current study and as Morgan (2007) states, a move away from troubling metaphysical or abstract matters.

Within mixed methods research, pragmatists focus on abduction which involves moving back and forth or iteratively between a deductive (testing of theories and hypotheses) and inductive (discovery of patterns) process of reasoning (Morgan, 2007). Pragmatism, therefore, offers a multiplicity of methods, worldviews and assumptions including various forms of data collection and data analysis (Denscombe, 2008; Creswell, 2009; Burke Johnson et al, 2017). This is consistent with the mixed methods research approach to inquiry (Creswell, 2009). Pragmatists are focused on the exploration of socially shared beliefs rather than the nature of truth and individual isolated sources of belief (Morgan, 2014). There is an endorsement of fallibilism, a notion proposed by Peirce as referred to by Mounce (2000). This is to say that current beliefs or conclusions can very rarely be construed as certainties or absolutes, truth is what works at the time (Burke Johnson and Onwuegbuzie, 2004). This is in line with the maxim of the pragmatic philosophers, Peirce, James, Dewey, who believed that the present is always a new starting point (Burke Johnson et al, 2007).

Throughout the current research journey, cognisance was taken of the potential weaknesses of the pragmatic approach which are now highlighted. Although Burke Johnson and Onwuegbuzie (2004) propose that pragmatism provides a sound philosophical partner to mixed methods research, shortcomings include the fact that many researchers look to pragmatism as a means of overlooking various traditional philosophical and ethical dilemmas. Burke Johnson and Onwuegbuzie (2004) also comment, that overall while pragmatism holds up well to scrutiny, it has been rejected by a number of philosophers precisely because of a lack of engagement with metaphysical concerns. Within the current study, while pragmatism was acknowledged as the philosophical partner to mixed methods research as advocated by Creswell (2009), Morgan (2014) and Burke Johnson et al (2017) the philosophical assumptions pertinent to both quantitative and qualitative paradigms have been explored in the foregoing discussions and the choice of a mixed methods research approach was taken based on these explorations. A further shortcoming is that the philosophical

meaning of pragmatism has the potential to be associated with the common use of the word pragmatic that implies a certain lack of principles underlying a course of action or the notion that anything goes (Denscombe, 2008). As Denscombe (2008) cautions, this is different from the philosophical meaning of pragmatism and should not be linked with the mixed methods research approach. The purpose for choosing the mixed methods research approach and evidence of how it can contribute to the current study will follow.

4.5   Mixed Methods Research Design

As outlined throughout this chapter, the goal of using a mixed methods research approach is fundamentally to answer the research question. However, it is acknowledged that there are a number of difficulties to be overcome by researchers contemplating the use of this design (Larkin et al, 2014). A major challenge is that mixed methods research requires a heavy investment of time and investigator skills and knowledge (Creswell, 2009; Morgan, 2014). As Creswell (2009) suggests, mixed methods research design encompasses more than the collection and analysing of differing data sets, it involves philosophical assumptions which have to be considered and understood. A clear understanding of the complexities of the mixed methods research process has to be reached if one is to avoid methodological eclecticism (Morgan, 2014). However, considerable obstacles can be encountered in reaching a clear understanding of the mixed methods research process (Larkin et al, 2014; Doyle et al, 2016). These difficulties are due in part to the ever increasing number of purposes debated in the literature for using a mixed methods research design in a single study (Schoonenboom and Burke Johnson, 2017). Many of the purposes outlined in the relevant literature are generated from the five purposes originally identified by Greene et al (1989) for undertaking a mixed methods research approach which include triangulation, complementarity, development, initiation and expansion. Although developed in 1989, as noted by Schoonenboom and Burke Johnson (2017) this system of classification is still currently relevant. Greene et al (1989) arrived at these five purposes following an analytic review of first the theoretical literature and then an analysis of 57 empirical evaluations on mixed methods research. These five purposes are outlined in Table 4.2.

Table 4.2   Purposes of Mixing Data

Purposes of Mixing Data in Mixed Methods Research Design

Triangulation – Purpose: To achieve or ensure corroboration and convergence of data from different methods (Greene et al, 1989). Triangulation involves the measure of a single concept in a variety of different approaches so that the extent to which differences converge or agree can be established. The rationale for using triangulation is that the higher the convergence, the more the confidence that the measure was capturing the concept of interest (Greene et al, 1989)

Complementarity – Purpose: To more fully elaborate, enhance and clarify the results from one method with results from the other method. The rationale for using the complementarity design is that it enhances interpretability, meaningfulness and validity of the concepts and inquiry findings by taking advantage of the strengths of and counteracting the weaknesses of both methods (Greene et al, 1989)

Developmental – Purpose: Uses the findings from one method to assist in informing the other method. The rationale for using development design is to increase confidence in the validity of the study concepts and findings (Greene et al, 1989)

Initiation – Purpose**:** Uncovering contradictions and inconsistencies that lead to restructuring of the research questions or results from one method with questions or results from the other method. The rationale for using initiation is that it is believed by analysing the findings and interpretations from different perspectives of different paradigms and methods increases the breadth and depth of the findings (Greene et al, 1989).

Expansion – Purpose: Seeks to expand the scope and breadth of inquiry by employing different methods for different inquiry elements. The rationale for using the expansion design is that it is believed that by choosing the methods most suitable for multiple inquiry elements, this will increase the scope of inquiry beyond the scope of a single method (Greene et al, 1989).

According to Burke Johnson et al (2007) any or all of the above reasons for selecting a mixed methods design can be relevant to the study at hand. The most important point is that the data collected should provide all of the information that is potentially relevant to the purpose of the study (Burke Johnson et al, 2007). While the current study reflected elements of triangulation, developmental and expansion, the principal aim was to 'more fully elaborate, enhance and clarify the results from one method with results from the other method' which corresponds with using a complementarity approach. Consistent with the work of Burke

Johnson and Onwuegbuzie (2004) the aim of mixing paradigms in the current study was not to specifically seek corroboration of results, but rather to expand understanding of the research question. As these authors suggest, if findings either corroborate or conflict, it leads to an increased understanding and interpretations and conclusions can be modified accordingly (Burke Johnson and Onwuegbuzie, 2004). Mixing quantitative and qualitative methods in the current study illustrated that while the findings relating to the nurses' experiences of dementia care nursing in non-dementia specific wards/units, were corroborated to a certain extent, conflicting findings were also evident and, the findings from the survey led to the development of the focus group interview schedule which resulted in examining the research question in different ways. Thus, elements of triangulation, developmental and expansion were evident.

The purpose of the current study was not to intentionally seek to uncover paradoxes and contradictions or to recast the research question which is consistent with initiation, although inconsistencies, as noted above, were uncovered. According to Greene et al (1989) and in congruence with the current study, the reasons for using a complementarity mixed methods research design, where both qualitative and quantitative methods are employed, was to bring about a greater understanding of the significance of the results from one method to another. Within the current study, using a complementarity mixed method research design enabled the quantitative responses from phase one to be more fully explored from the participants' perspective by using qualitative focus group interviews in phase two. The mixing of methods resulted in an increased understanding of the nurses' experiences of dementia care nursing in acute care settings. The qualitative elements of the experiences of dementia care nursing enabled important differences to be elaborated in a way that could not have been achieved by using a quantitative method alone. According to Morgan (2014) complementarity results are realised by using the strengths of one method to augment the other. The complementarity mixed method research design underpinned the reason for mixing methods in the current study and consequently brought about further explanation, elaboration and enhancement of the data collected quantitatively using questionnaires and then following up with qualitative focus group interviews.

4.5.1   Typologies of Mixed Methods Research

The researcher considering the use of mixed methods research designs has to explore the various design typologies. Over the years a large number of typologies have been developed

and used in mixed methods research designs (Hanson et al, 2005; Ivankova et al, 2006; Creswell, 2009). According to Ivankova et al (2006), as many as 40 typologies have been identified in the literature. As noted by Teddlie and Tashakorri (2006), the range of mixed methods research designs far outstrips the adequacy that any typology classification can encompass. This comment is supported somewhat by Schoonenboom and Burke Johnson (2017), who note that none of the current typology classifications are fully exhaustive. Notwithstanding, the mixed methods research design or typology offers an organisational plan for various research processes (Teddlie and Tashakkori, 2006). Typologies also serve the purpose of creating a generic language. Morse's notations and abbreviations which were developed as far back as 1991 are still commonly used to indicate the nature of the mixed method research design, for example, QUAN → qual design, indicates that the primary element is presented in capitals and the supplemental element is presented in lowercase letters (Schoonenboom and Burke Johnson, 2017). It is acknowledged that a considerable amount of overlap occurs within typologies which can be confusing (Creswell, 2009; Doyle et al, 2009; Larkin et al, 2014). However, the six most frequently used designs as identified by Creswell (2009) are categorised as, sequential (explanatory, exploratory and transformative) and concurrent (triangulation, embedded and transformative). Each typology provides varying details relative to its use to include approaches to implementation, either sequential or concurrent data procedures, details of priority of the quantitative and qualitative data, these can be equal or unequal and, stages at which the data are analysed and integrated (Creswell, 2009).   Table 4.3 briefly outlines the specific features of the six mixed methods research designs:

Table 4.3   Typologies

Mixed Methods Research Design Typologies

Sequential Designs: According to Creswell (2009) sequential mixed methods, refer to procedures in which the researcher is looking to expand on or elaborate on the findings of one method with another method. The three categories include:

- **Explanatory -** is characterised by firstly collecting and analysing quantitative data, followed by collecting and analysing qualitative data in the second phase. Priority is given to the quantitative data (Creswell, 2009). According to Morse (1991) this design is especially useful for bringing about a fuller understanding of quantitative results by following up with qualitative interviews.
- **Exploratory –** is characterised by firstly collecting and analysing qualitative data, followed by collecting and analysing quantitative data that builds on the results of the first qualitative phase. Priority is given to the qualitative data (Creswell, 2009). According to Morse (1991) this design is useful for determining distribution of phenomenon in a population.
- **Transformative –** this is a two phase design underpinned by a theoretical lens specially undertaken to collect data from under-represented or marginalised groups (Creswell (2009)

Concurrent Designs: Concurrent mixed methods according to Creswell (2009) refer to procedures in which the researcher merges or converges, qualitative and quantitative data to gain a comprehensive analysis of the research problem. Both forms of data are collected simultaneously and the information is integrated during the interpretation of the overall results. The three categories include:

- **Triangulation –** Qualitative and quantitative data are collected at the same time to obtain different but complementary data on the same topic (Creswell, 2009).
- **Embedded -** Qualitative and quantitative data are collected simultaneously. The secondary method is embedded within the primary method (Creswell, 2009).
- **Transformative -** Qualitative and quantitative data are collected concurrently. This approach is guided by a specific theoretical perspective similar to the sequential transformative approach (Creswell, 2009).

4.6   Sequential Explanatory Mixed Methods Research Design

The research paradigm, approach and design are determined by the research question (Creswell, 2009). Research methods should follow the research question in a way that offers the best choice to obtain useful answers (Burke Johnson and Onwuegbuzie, 2004). The study question in the current study was designed to explore nurses' views and opinions about

dementia care nursing based on their experiences. The literature review revealed that dementia care nursing covers a broad and complex range of care which encompasses theoretical and philosophical aspects of care and concepts include person-centred care and advocacy. The environment of care includes both physical and organisational aspects. To bring about contextual understandings of these multiple perspectives required a creative, pluralistic and inclusive approach. There is a paucity of dementia care nursing research studies conducted in the unique setting outlined in the research question, this fact gave the impetus for conducting the current study. Following careful consideration of the foregoing literature and the purposes and typologies explored in this chapter a decision was reached to utilise the two phase sequential explanatory mixed methods research design, as outlined in table 4.3. The strengths of this design include its comparative straightforwardness and the opportunity to explore quantitative data in more depth. The weaknesses include the amount of time needed to collect data in two separate phases (Ivankova et al, 2006; Creswell, 2009).

As the intention of the current study was to conduct a sequential study, the concurrent mixed methods design where data is merged or converged was not considered to be appropriate. Similarly the transformative mixed methods research design was considered to be incongruous, as the current study did not involve gathering data from under-represented or marginalised groups. The sequential mixed methods research design is characterised by exploratory and explanatory approaches as referred to in table 4.3. According to Morse (1991) and Creswell (2009) the exploratory design is applicable when the research concept has not been previously researched and consequently there is a lack of theory and the concept is immature. This was not the case for the current study thus, the exploratory design was considered to be inapplicable. On the other hand, the explanatory approach is appropriate when the research topic has been previously researched and measurement tools can be located (Morse, 1991). As alluded to earlier in this chapter (section 4.3.1) empirical literature on the topic of nurses' experiences of dementia care nursing was available (but not in the unique environment of the current study). The literature identified the availability of appropriate measurement tools (section 2.8). According to Morse (1991) when substantial and relevant literature is available on the research topic, it is appropriate for the study to be driven by the quantitative method and complemented by a qualitative component. As noted earlier in the chapter, the objective approach in quantitative methods may make it difficult to understand the research problem from the participants' perspectives (Morgan, 2014). It can be difficult to reach a meaningful understanding of phenomena such as nurses' experiences

from statistical data. This problem is offset, as suggested by Morgan (2014) by conducting a sequential qualitative element to examine aspects of the participants' subjective interpretations. As recommended by Morse (1991) and Creswell (2009) the explanatory design is executed by following the quantitative paradigm in the first phase of the study with a qualitative approach in the second phase for the purpose of explaining and interpreting the quantitative results from the first phase. As noted earlier, the two phase sequential explanatory mixed methods research design was utilised in the current study. As well as making a decision about the mixed methods research design, procedural issues to include, timing, data priority and integration of the data have to be determined (Ivankova et al, 2006; Creswell. 2009) these issues will now be addressed.

4.6.1 Timing

Timing refers to the sequence of data collection and analysis. In a sequential design, the quantitative element comes before the qualitative element in an explanatory design (Creswell, 2009). In a mixed methods sequential explanatory study, the first phase is characterised by the collection and analysis of the quantitative data (Morse, 1991; Burke Johnson and Onwueghbuzie, 2004; Creswell, 2009). This is followed by the collection and analysis of the qualitative data in the second phase (Morse, 1991; Burke Johnson and Onwueghbuzie, 2004; Creswell, 2009). The two phases remain separate but are connected in the intermediate stage as the analysed data from the first quantitative phase leads to the development of the second qualitative phase and guides the development of the interview schedule. The quantitative analysed data provides a general understanding of the research problem, the qualitative phase builds on and elaborates on the quantitative data collected in the first phase by exploring the participants' views and opinions in more depth (Ivankova et al, 2006; Creswell, 2009).

In the current study, phase one involved using a survey design with a convenience sample of 129 registered general nurses. Four questionnaires were used to collect quantitative data related to:

(1) Nurses' demographics, measured by a demographic questionnaire.
(2) Nurses' views and opinions about caring for the older person with dementia based on their experiences, measured by the Satisfaction with Nursing Care and Work Assessment Scale (SNCW) (Hallberg et al, 1994).

(3) Attitudes held by nurses towards dementia, measured by the Approaches to Dementia Questionnaire (ADQ) (Lintern et al, 2000).

(4) Nurses' beliefs about the environment of care and its impact on nurses' experiences of dementia care nursing, measured by the Ward Organisational Features Scale (WOFS) (Adams et al, 1995).

The context was non-dementia specific wards/units that included acute, rehabilitation and residential, contained in dedicated health care services for the older person, linked to acute general hospital services. The quantitative data and statistical results from phase one provided a general understanding of the experiences of nurses caring for the older person with dementia. Phase two involved running five focus group interviews with a purposive sample of 25 registered general nurses working within non-dementia specific wards/units within the same dedicated health care services for the older person as in phase one. The analysed data from phase one led to the development of the interview schedules used in phase two. The data from phase two was collected and analysed separately from phase one. The addition of qualitative interviews to directly discuss the issues under investigation tapped into the participants' perspectives and the qualitative data fulfilled the important role of interpreting, clarifying and describing the quantitative results.

4.6.2   Data Priority

Priority refers to which approach, quantitative or qualitative or both that researchers give the most attention to throughout the data collection and analytic process of the study (Creswell, 2009; Morgan, 2014). Within a mixed methods sequential explanatory study, the priority is generally given to the quantitative approach due to the fact that the quantitative data collection is first in the sequence and generally represents the most substantial element of the mixed methods research data collection process (Creswell, 2009; Morgan, 2014). The smaller qualitative element is conducted in the second phase of the research (Creswell, 2009; Morgan, 2014).

Priority in the current study was given to the quantitative data collection and analysis phase. This decision was taken at the outset of the study and was influenced by the study question. As referred to earlier in the chapter (section 4.3.1) while it was acknowledged that data collected and analysed from the survey would answer the research question, it would not provide a meaningful understanding of the concepts. Analysis of the quantitative data revealed significant differences between nursing groups in relation to the concepts under

investigation. Although differences were apparent from the survey data, the reasons behind those differences could not have been determined from the survey responses alone. The follow up qualitative focus groups interview explored issues where, for example, significant statistical differences were found. In other words, the qualitative data expanded the original quantitative data but the quantitative paradigm drove the study.

4.6.3 Integration

Integration or mixing of the quantitative and qualitative components is perhaps the most difficult and least understood characteristic of mixed methods research design when one considers the philosophical differences inherent in qualitative research which consists of text and images and quantitative research which is concerned with numbers (Creswell, 2009). Certainly, within a mixed methods research study, findings must be mixed or integrated at some point (Burke Johnson and Onwueghbuzie, 2004). However, despite the growing popularity of mixed methods research design, and the increasing discussions in the methodology literature, some methodological aspects of this design such as integration of the results of both phases of the study still require further clarification (Ivankova et al, 2006; Morgan, 2014; Halcomb and Hickman, 2015). A point of agreement has been reached in the relevant literature that the data collected from phase one, the quantitative phase may be collected and analysed before moving on to the second qualitative phase (Hanson et al, 2005; Ivankova et al, 2006). The qualitative data are then collected and analysed in the second phase of the study. The findings from the quantitative and qualitative phases of the study are presented and analysed separately and then presented and integrated during the discussion chapter of the study (Hanson et al, 2005; Ivankova et al, 2006).

Within the current study, data analysis was executed by collecting and analysing the quantitative data from phase one independently of the data from the second qualitative phase which was analysed independently of the data from the first phase. Connecting, was effected at the intermediate stage when the analysed quantitative findings from phase one, informed the data collected in phase two the qualitative phase. This was achieved by developing the focus group interview schedule to reflect both the analysed data findings from phase one and the themes identified in the literature review. Integrating the data took place in the discussion chapter of the dissertation. This was accomplished by way of providing explanations as to how the qualitative findings assisted in bringing about a richness and depth of understanding to the quantitative findings. However, the data sets remained separate from the other. As

outlined in chapter three, the discussion chapter was underpinned by the Socio-technical System theory (Trist, 1981). The STS provided a meaningful conceptual framework within which to categorise the integrated findings and demonstrated the degree of equilibrium present between the social and technical components interacting within the organisational environment. Optimal work performance is dependent upon equilibrium (Trist, 1981).

The mixed methods notation table 4.4 adapted from Creswell (2009) based on (Morse, 1991) outlines the main procedures and steps undertaken in this study. The arrows indicate the sequential form of data collection. Capitalisation illustrates the priority given to the data.

Table 4.4   Research Design

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┌────────────────────────────────────────────────────────────────────────────┐
│                                                                            │
│  ┌──────────────────────────────┐        ┌────────────────────────────┐    │
│  │ Phase One                    │        │ QUANTITATIVE               │    │
│  │                              │        │ Data Analysis              │    │
│  │ QUANTITATIVE                 │        │                            │    │
│  │ Data Collection              │───────▶│ SPSS Quant –software       │    │
│  │ Survey Design                │        │ version 20                 │    │
│  │ Self-Completion Questionnaires│       │ Basic Frequencies,         │    │
│  │ (n=129)                      │        │ Descriptive Statistics     │    │
│  │                              │        │ Parametric and Non-Parametric│  │
│  │                              │        │ Methods                    │    │
│  └──────────────────────────────┘        └────────────────────────────┘    │
│                                                                            │
│                    ╭──────────────────────────────────╮                    │
│                   ╱   Connecting QUAL and Quant Phases  ╲                   │
│                  │                                       │                  │
│                  │  Developing Focus Group Interview     │                  │
│                  │  Schedule Based on Literature Review  │                  │
│                  │  and QUANT Findings.                  │                  │
│                   ╲                                     ╱                   │
│                    ╰──────────────────────────────────╯                    │
│                                                                            │
│  ┌──────────────────────────────┐        ┌────────────────────────────┐    │
│  │ Phase Two                    │        │                            │    │
│  │                              │        │ Qualitative                │    │
│  │ Qualitative                  │        │ Data Analysis              │    │
│  │ Data Collection              │───────▶│                            │    │
│  │ 5 Focus Group Interviews (25 │        │ Coding and Thematic Analysis│   │
│  │ Participants)                │        │                            │    │
│  └──────────────────────────────┘        └────────────────────────────┘    │
│                                                                            │
│            ╭──────────────────────────────────────────╮                    │
│           ╱     Integration of the QUANT and Qual Results ╲                 │
│          │                                                │                 │
│          │   Interpretation and Exploration of the QUANT  │                 │
│          │   and Qual Results                             │                 │
│           ╲                                              ╱                  │
│            ╰──────────────────────────────────────────╯                    │
│                                                                            │
└────────────────────────────────────────────────────────────────────────────┘
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4.7   Conclusion

The purpose of using a mixed methods research design is to expand the scope of and increase understandings of research problems and the research question occupies a central position

(Creswell, 2009). As Burke Johnson and Onwuegbuzie (2004) suggest, researchers should take a wide ranging approach to method selection as they believe that the use of a mixed methods research design allows researchers to develop a creative approach to research which is pluralistic and inclusive. Using a complementary sequential explanatory mixed methods research design proved to be advantageous and resulted in capturing, more fully, the complexities of dementia care nursing in the unique setting of the current study and a fuller understanding was gained of the nurses' experiences. The design also allowed the participants' voices to be heard directly in relation to their nursing experiences. The results from the overall project were strengthened because the results from one method allowed another method to do more than it could by itself (Morgan, 2014). The use of qualitative and quantitative viewpoints, data collection, analysis and inference techniques were used in the current study for the broad purpose of breadth and depth of understanding. This is consistent with the definition of mixed methods research as outlined by Burke Johnson et al (2007). The relevant philosophical assumptions have been briefly outlined along with the rationale for choosing a complementary mixed methods design. The following chapter will discuss and present the specific procedures that, translated this design into practice in the current study.

Chapter Five - Methods

5.1   Introduction

This chapter presents the procedures that translated the mixed methods design into practice, to include, the settings and access to the study sites along with decisions regarding the study population and sampling strategies. This is followed by descriptions of the data collection methods, pilot studies and the process of data analysis in both phases of the study. Lastly, issues related to rigour and trustworthiness relative to the current study along with ethical considerations are explored.

5.2   Setting and Process of Gaining Entry to the Research Sites

Two acute general hospitals and one affiliated hospital site with non-dementia specific wards/units to include acute, rehabilitation and residential contained in dedicated health care services for the older person provided the setting for the current study. A full description of the research sites is provided in Appendix Four. Following ethical approval, the researcher wrote to the three Directors of Nursing (Appendix Five) seeking permission to conduct the study and access staff in their respective hospitals which was subsequently granted.

5.2.1   Gatekeepers

In health care research, access to a research site is an important ethical issue (Punch and Oancea, 2014). Access to a research setting is normally negotiated with a relevant gatekeeper, such as a Director of Nursing (Lee, 2005). From an ethical standpoint, the primary role of a gatekeeper is to ensure that all participants are protected and also to maintain the objectivity of the research (Lee, 2005; Punch and Oancea, 2014). The role of a gatekeeper is to act as an agent for recruitment of the study population. This ensures that the identity of the study population is protected and that personal contact data is not released to a study without the participants' consent (Lee, 2005; Punch and Oancea, 2014). To be an appointed gatekeeper, the person should not have a power relationship with the potential participants. Gatekeepers, in nursing research, are usually selected from the hospital administration staff.   The gatekeeper should not know who has agreed to participate in the study and cannot be involved or be part of the study. Details of the appointed gatekeepers are as follows:

Hospital A - The Director of Nursing appointed a member of the office staff from the human resources unit in the hospital to act as gatekeeper.

Hospital B - The Director of Nursing appointed a member of the administration staff (ward clerk) from the dedicated health care services for the older person units to act as gatekeeper for phase one. For the follow up focus group interviews, the Director of Nursing appointed two candidate Advanced Nurse Practitioners from the dedicated health care services for the older person units as gatekeepers. The two gatekeepers did not take part in the study.

Hospital C - The Nurse Research Access Committee (NRAC) appointed three members of administration staff (ward clerks) from the ten units contained in the health care services for the older person units to act as gatekeepers.

The researcher gave the invitational posters and the participant information packs to the appointed gatekeepers. The role of the gatekeepers was to place the invitational posters on the relevant notice boards (nurses' stations, staff rooms) within the non-dementia specific wards/units contained in the dedicated health care services for the older person within the two acute general hospitals and one affiliated hospital site. The gatekeepers also distributed the information packs (phase one and phase two) to potential respondents. The researcher's contact details were contained in the information packs.

5.3   Population and Sampling

5.3.1   Phase One

In a research study, sampling refers to the procedures undertaken in the selection of representative units of a population (Moule and Goodman, 2014). A population may be described as all of the people from whom data can possibly be collected (Parahoo, 2006; Moule and Goodman, 2014). Once specific inclusion and exclusion criteria are established, they become the target population, or the group from whom the researcher aims to draw a sample from (Parahoo, 2006). The target population identified within the current study included all registered general nurses (RGNs) who provide nursing care for older adults with dementia in non-dementia specific units/wards that include acute, rehabilitation and residential contained in dedicated health care services for the older person which are linked to two acute general hospitals and one affiliated hospital site. The accessible population comprised all RGNs who met the inclusion criteria. The accessible population appropriate to the three hospitals was obtained from the respective gatekeepers. The accessible population once defined became the population of interest from whom the data was collected. The

eligibility inclusion for both phases were supported by the aim to capture registered general nurses who had experience of dementia care nursing within the identified context and who could offer their experiences about dementia care nursing. A further aim was to promote the validity and representativeness of the sample by using criteria that reflected the target population.

Inclusion Criteria:
- Registered general nurses employed in a full or part-time capacity within non-dementia specific wards/units contained in dedicated health care services for the older person which are linked to acute hospital services with experience of care for the older person with dementia

Exclusion Criteria:
- Registered general nurses employed in a full or part-time capacity within non-dementia specific wards/units contained in dedicated health care services for the older person which are linked to acute hospital services with experience of care for the older person with dementia employed on an agency or bank contract

It is important in quantitative designs to use as large a sample as possible and to take steps to build representativeness into the design. This means ensuring that the crucial qualities of the representative sample match as closely as possible those of the target population. In quantitative research the principal consideration is the representativeness (Robson, 2011). Sampling is grouped into two categories, probability and non-probability. Probability sampling involves some form of random selection from the target sample according to a pre-determined method (Parahoo, 2006; Moule and Goodman, 2014). As all participants have an equal chance to be involved in the study, probability sampling assists in removing the bias in selection (Krueger and Casey, 2009). Non-probability, on the other hand is where the elements are selected by using a sample that are considered to be best able to provide the data needed. Probability sampling is the more respected of the two, as greater confidence can be placed in the representativeness and it increases the validity of the findings (Haber, 2002; Parahoo, 2006; Robson, 2011).

Another view is that it is common practice to use non-probability samples within small scale surveys (Robson, 2011) and nurse researchers often turn to the local population of staff to form a sample of convenience which is a type of non-probability sampling (Moule and Goodman, 2014). In the current study, phase one used a non-probability, convenience sample. It was purposeful at two levels, (i) choice of setting, i.e., non-dementia specific wards/units within dedicated health care services for the older person linked to two acute

general hospitals and one affiliated hospital site and (ii) participants who met the inclusion criteria. Within nursing research most research samples are non-probability with convenience sampling being the most frequently used (Haber 2002; Parahoo, 2006). A recognised shortcoming of convenience sampling is the inability to generalise results. A further disadvantage is the risk of bias which stems from the fact that convenience samples are self-selecting, or comprised of people who volunteer to participate (Haber, 2002). This fact may lead to questioning the representativeness of the people who did participate in relation to the population and caution must be exercised in analysing and interpreting the results (Haber, 2002). However, as recommended by Haber (2002) and Parahoo (2006) within the current study, careful selection was undertaken to reflect the target population and thorough inclusion and exclusion criteria were put in place, therefore, confidence in the representativeness and validity of the findings was achieved, as far as was possible.

5.4   Phase Two

Purposive sampling was used for phase two, where focus group interviews were used to collect qualitative data. According to Parahoo (2006) and Moule and Goodman (2014) purposive sampling is fitting when the aim is to obtain information from a group of participants who are knowledgeable about the subject to be explored and who are thought to be typical of the population. This is congruent with the current study and this fact led to using purposive sampling to identify those participants who were well placed to discuss their views and opinions about dementia care nursing based on their experiences and who met the inclusion criteria. The participants were drawn from the same setting as phase one of the study, thus it was relevant to use the same inclusion criteria. Focus groups are not intended to infer, generalise or make statements about the population rendering randomisation inappropriate (Krueger and Casey, 2009). Within qualitative research, purposive sampling is frequently used (Moule and Goodman, 2014). This was achieved by recruiting nurses who met the inclusion criteria through an invitational poster placed on specific notice boards within non-dementia specific wards/units contained in dedicated health care services for the older person linked to two acute general hospitals and one affiliated hospital site and liaising with the relevant appointed gatekeepers. According to Parahoo (2006) and Moule and Goodman (2014), the disadvantages of purposive sampling share the same shortcomings as those of convenience sampling i.e., the ability to generalise the findings is limited and as participation is voluntary there is a greater chance of bias being introduced.

5.5   Data Collection

5.5.1 Phase One

The research question was as follows: "What are nurses' views and opinions about dementia care nursing based on their experiences of caring for the older person with dementia in non-dementia specific wards/ units that include acute, rehabilitation and residential, contained in dedicated health care services for the older person linked to acute general hospital services?" To answer this question, the quantitative phase involved collecting data by way of four self-completing questionnaires from 129 respondents. This was followed sequentially in phase two, the qualitative phase, by conducting five focus group interviews (25 participants overall) with the purpose of building and elaborating on the quantitative data collected in the first phase. The study was driven by the quantitative method used in phase one and complemented by the qualitative component used in phase two. This was consistent with the complementary sequential explanatory mixed methods research design which guided the study.

5.5.2 Data Collection Tools

The goals of phase one, the quantitative deductive phase was to identify the respondents' demographic characteristics and explore and describe the respondents' views and opinions based on their experiences of dementia care nursing. Two further goals were to investigate the respondents' attitudes towards dementia and obtain descriptions of the respondents' beliefs about the environment of care and its impact on dementia care nursing. To achieve the aforementioned goals, quantitative data was collected using four self-completion questionnaires. Questionnaires provide a useful method of collecting valid, reliable and unbiased data from a representative sample of respondents (Moule and Goodman, 2014) particularly in relation to obtaining facts about beliefs, opinions, knowledge and experiences (Parahoo, 2006; Moule and Goodman, 2014). Questionnaire surveys are a commonly used effective method used within nursing research (Parahoo, 2006; Moule and Goodman, 2014).

5.5.3 Demographic Questionnaire

The most common factual data collected by questionnaires are demographic details, such as age, gender and qualifications (Parahoo, 2006; Moule and Goodman, 2014). In the current study demographic questions were constructed by the researcher, in order to explore the associations between nurses' demographic characteristics and their experiences of caring for the older person with dementia in the context of non-dementia specific wards/units that include acute, rehabilitation and residential, contained in dedicated health care services for

the older person linked to acute general hospital services. The ten demographic questions (Appendix Six) were developed to take cognisance both of the literature review findings and the research question.

The literature reviewed demonstrated that being younger and the work experience of participant nurses influenced dementia care nursing, with the former having a negative influence and the latter having a positive influence. It was therefore considered relevant to explore these issues in the current study (Questions 1, 4, 9 and 10). No literature on the influence of nursing staff gender on dementia care nursing was found which led to the inclusion of this subject (Question, 2). In relation to cultural diversity, the literature illustrated that the Irish nursing workforce is currently culturally quite diverse, to include nurses practicing within age related services. To provide a contextual backdrop to the current study it was considered relevant to include the respondents' country of nurse education (Question 3). Other major components illustrated in the literature reviewed, were those of nurses' specialist knowledge and education in relation to dementia. It was therefore thought to be appropriate to consider these factors within the context of the current study (Questions 5 and 6). It was also noted that nurse mangers can hold differing views from clinical nursing staff. Exploring the views of different grades of nursing staff permitted exploration of this phenomenon within the present study (Question 7). There was a suggestion in the literature reviewed that respondents who practice within rehabilitation settings for the older person are more positive in their attitudes towards persons with dementia than those respondents who practice within acute care units for the older person. Question 8, measured these factors within this study.

The questions were answered by ticking the appropriate box on the questionnaire, for example:

How long have you been a registered general nurse?

1- 2years	3-5years	6-10years	11-15years	16-20years	21-25years	26-30 years	other

5.5.4   Satisfaction with Nursing Care and Work Assessment Scale (SNCW) (Hallberg et   al, 1994)

The function of the SNCW (Hallberg et al, 1994) in the current study was to explore nurses' views and opinions about dementia care nursing, based on their experiences of caring for the

older person with dementia within non-dementia specific wards/units that include acute, rehabilitation and residential, contained in health care services for the older person linked to acute hospital services.

The SNCW (Hallberg et al, 1994) was developed in Sweden to form part of a study to investigate various aspects of nursing care provided for persons with dementia (Appendix Seven). It was the only identified tool with which to explore the various aspects of dementia care nursing that emerged as pertinent from the literature review. The tool contains 32 Likert items divided into five Likert sub scales. A Likert scale consists of a number of purposeful items constructed to be either positive or negative expressions that connect the specific concept to be measured, usually six to eight balanced items (Likert, 1932). The response format is constructed using a five point response scale with varying ranges of intensity between two extremes. The extremes are generally anchored by responses ranging from strongly agree to strongly disagree with agree, undecided to disagree in between. Respondents are requested to rate each individual item within the scale according to the response that they agree with (Likert, 1932). The five Likert sub scales contained in the SNCW (Hallberg et al, 1994) are:

(1) Work Co-operation (social integration) (8 items, range 8-40)

(2) Personal and Professional Development (self-concept) (6 items, range 6-30)

(3) Quality of Care (participation) (9 items, range 9-45)

(4) Workload and Work Satisfaction (achievement) (4 items, range 4-20)

(5) Knowledge of Patients (communication) (5 items, range 5-25)

The factors are consistent with the emergent themes from the literature reviewed and presented earlier. For example, it was shown in the reviewed literature that nurses' specialist knowledge and professional competence along with organisational support have a direct bearing on the quality of dementia care nursing that can be delivered. Questions within the sub-domains (5) Knowledge of Patients (2) Personal and Professional Development (3) Quality of Care and (1) Work Co-operation enabled exploration of these issues. It was also revealed that specialist dementia education or professional development programmes are either not available or when they are, organisational support in terms of sufficient staffing levels needed to support attendance are not provided. Thus workload issues inhibit

attendance. Questions within the sub-domain (4) Workload and Work Satisfaction permitted an exploration of these points.

Hallberg et al (1994) reported Cronbach's alpha as 0.71, for overall reliability of the SNCW. This indicates a moderately high internal reliability, as a level of 0.70 or higher is considered to be an acceptable level of reliability (Field, 2013). The tool has been used in a number of other Swedish nursing studies including Welander-Hansson et al (1995). The aim of the Welander-Hansson et al (1995) study was to explore nursing care and work with patients with dementia. Cronbach's alpha was reported as 0.78, for overall reliability (Welander-Hansson et al, 1995). The most recent Swedish study which reported use of the tool was undertaken by Nilsson et al (2012). The study was conducted within 12 medically orientated wards within one university hospital. The tool was used to measure staff experiences of care and work in relation to older persons with cognitive impairment (n=391). Cronbach's alpha was reported as 0.77 for overall reliability. An English version of the instrument was used in an Australian study (Brodarty et al, 2003). This study was conducted to explore different aspects of dementia care nursing (n=253). Cronbach's alpha was reported as 0.85, for overall reliability.

The SNCW (Hallberg et al, 1994) as noted above, uses a five point Likert scale of measurement ranging from "strongly agree" to "strongly disagree". Positive statements are scored high, negative items are scored low. For example, SNCW question 4:

4.   I often feel that I do not complete everything that I should in my job?

Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
1	2	3	4	5

 Eight of the statements are negative (4,6,12,13,21,22, 23, 24) and are reverse coded. In the current study, the sum of all of the items was examined along with the individual total scores of the five sub domains. The English version of the instrument was used. The tool contains items relating to dementia care nursing as identified in the literature review and it has been used successfully in a number of previous studies and has proven reliability. Therefore it would appear that the SNCW (Hallberg et al, 1994) was well placed to measure the nurses' views and opinions based on their experiences of dementia care nursing.

5.5.5 Approaches to Dementia Questionnaire (ADQ) (Lintern et al, 2000)

The function of the ADQ (Lintern et al, 2000) (Appendix Eight) in the current study was to investigate attitudes held by nurses towards dementia and nurses' experiences of caring for the older person with dementia within non-dementia specific wards/units that include acute, rehabilitation and residential, contained in health care services for the older person linked to acute hospital services. A review of the literature related to dementia revealed a number of tools that explored attitudes towards dementia including Hallberg and Norberg (1995), Lintern et al (2000), Norbergh et al (2006) and O'Connor and McFadden (2010). A table to describe the strengths and weakness of these tools along with other details is presented in Appendix Nine. Following a review of these tools it was identified that the most appropriate instrument for the current study was the English self-reporting Approaches to Dementia Questionnaire (ADQ) (Lintern et al, 2000). The ADQ contained the most relevant statements in relation to the current study and provided details regarding both validity and reliability.

Since its conception, the ADQ has been used in a number of international studies to measure care staff attitudes towards persons with dementia. Countries include England, Ireland, America, Norway, Australia and Korea. The ADQ consists of 19 Likert items divided into two Likert sub scales, eight items measure the participants' degree of hopefulness for the person with dementia and the remaining 11 items measure the participants' degree of person-centred care approach. From the reviewed literature, it was found that nurses' attitudes influence the quality of care that a person with dementia receives (Kang et al, 2011; Pinkert et al, 2017). Positive attitudes' towards persons with dementia result in a positive effect on the delivery of nursing care to include attentiveness, connectedness and respectfulness (Eriksson and Saveman, 2002; Nilsson et al, 2016). On the other hand, negative attitudes can lead to believing that the person with dementia is demanding and disruptive to ward routines and threatening to other patients (Cowdell, 2010a; Nilsson et al, 2016). The ADQ results generally indicate the type of dementia care nursing that staff deliver (Lintern et al, 2000). Scores are measured on a five point Likert response scale with, responses ranging from strongly agree to strongly disagree. Positive attitudes are scored high, negative attitudes are scored low. For example, ADQ, Question 2.

2.   People with dementia are very much like children

Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
1	2	3	4	5

There are 3 scores that can be calculated:

(1) total score – the sum of all items. Range 19-95

(2) hope – sum of items 1, 2, 3, 4, 6, 8, 10 and 13 (8 items, range 8-40)

(3) person centred – sum of items 5, 7, 9, 11, 12, 14 15, 16, 17, 18 and 19 (11 items, range 11-55)

In the current study, the sum of all of the items was examined along with the total scores of the two individual Likert sub scales. The total and the two subscales have good reliability and validity and Lintern and Woods (2010) report reliability as shown in table 5.1:

Table 5.1   Reliability of the ADQ

	Total Score	Hope	Person Centred
Cronbach's Alpha	0.83	0.76	0.85
Re-Test Reliability	0.76	0.70	0.69

The scores obtained by using Cronbach's alpha indicate a moderately high internal reliability. Lintern et al (2000) do not report the time interval in the test-retest reliability scores but the scores on face value appear to be reliable, as they achieve a total score of 0.76. Validity was established by direct observation of staff behaviour and responses to video vignettes. Concurrent validity was established by using observation but no specific details have been supplied (Lintern and Woods, 2010). According to Lintern and Woods (2010) the scale is simple to use, there is no need for special instructions and all grades of staff should be able to complete it. Permission was granted to use the questionnaire by Professor Bob Woods, University of Wales, Bangor (Appendix Ten). As the tool has proven validity and reliability and relevant content, it was considered appropriate to use in the current study.

5.5.6   Ward Organisational Features Scale (WOFS) (Adams et al 1995)

The function of the WOFS (Physical Environment of the Ward sub scale) (Adams et al, 1995) in the current study was to obtain descriptions of nurses' beliefs about the physical environment of care and its impact on nurses' experiences of caring for the older person with dementia within non-dementia specific wards/units that include acute, rehabilitation and residential, contained in health care services for the older person linked to acute hospital services.

According to the literature review, the practice environment includes the professional, organisational, social and physical characteristics of the ward/unit where nursing takes place (Adams et al, 1995; McCance and McCormack, 2017). For persons with dementia, the care environment should include such elements as patient safety and good facilities for the person with dementia, relatives and staff members (Grey et al, 2017). Organisational support to include adequate staffing levels was also noted to strongly influence dementia care nursing (Brooke and Semlyen, 2017).

A review of the literature relevant to the care environment revealed two possible tools, namely, Adams et al (1995) and Parker et al (2004) with which to potentially explore the respondents' beliefs about the care environment. A table illustrating the strengths and the weaknesses of the two tools is presented in Appendix 11. Following the review, a decision was made to use the Adams et al (1995) scale as it contained items more consistent with the aims of the current study (Appendix 12). The WOFS was constructed in order to explore the influence of the ward environment on nursing care and to provide evidence with which to support recommendations for effective nursing care. Donabedian's 1980s framework of structure, process and outcome was used to underpin the study. The WOFS (Adams et al, 1995) contains items within the Physical Environment of the Ward (PEW) sub scale related to the physical environment of the ward which refer to patient safety along with items related to staffing levels. The WOFS has been used in a number of studies in England and it has been translated into Norwegian and used in a study to measure the nursing practice environment and patient outcomes in Norway (Sjetne and Stavem, 2006). The tool includes 6 scales:

(1)   Physical Environment of the Ward (20 items)

(2)   Professional Nursing Practice (19 items)

(3)   Ward Leadership (9 items)

(4)   Professional Working Relationship (26 items)

(5)   Nurses' Influence Over Ward Organisation, Financial and Human Resources
        (24) items

(6)   Job Satisfaction (7 items)

Factor analysis and psychometric testing was undertaken by the authors to refine the tool. The developers state that due to the careful construction of the individual scales within the WOFS, the scales can be used independently or in combination with other tools. Within this

study, the PEW sub scale was used. Statistical analysis relative to the items within the sub scale items is presented in table 5.2:

Table 5.2   Summary of the PEW Scale with Statistical Properties

Physical Environment of the Ward	No of Items	Cronbach's Alpha	Test-retest Pearson correlation coefficient
(a) Ward Facilities	5	0.79	0.80
(b) Staff Organisation	5	0.80	0.71
(c) Ward Layout	6	0.81	0.75
(d) Quality of Ward Services	4	0.68	0.74

All items achieved Cronbach's Alpha score of ≥ 0.7, apart from item (d) which scored slightly below ≤ 0.7 at 0.68 which is still considered acceptable (Field, 2013). Test re-test reliability of the scales was examined by Adams et al (1995) following an interval of 2-4 weeks after the first administration. Each scale achieved a correlation coefficient of 0.7 or above. Criterion validity of the scale was established by two pairs of independent assessors. This involved both observations and interviews carried out to reflect the scale constructs. The authors reported similar trends within the questionnaire scale scores and the observers' ratings (Adams et al, 1995).

Scores are measured on a dichotomous response scale with lower scores indicating greater satisfaction. The PEW sub scale items were believed to be appropriate in measuring the areas of interest, for example:

Ward Layout	How easy is it to achieve the following	
	Very Easy	Very Difficult
Patient safety		

Staff Organisation	Strongly Agree	Strongly Disagree
There are enough permanent nurses on this ward to give a good standard of care to all of our patients		

As the tool has proven validity and reliability and relevant content, it was considered appropriate to use in the current study. Permission was granted by Dr Ann Adams to use this tool in the current study (Appendix 13).

5.5.7 Questionnaire Booklet

The four questionnaires were presented to respondents within the current study within one A4 booklet. In order to ensure that the questionnaires were presented clearly and in a comprehensive manner, they were printed professionally, using black type and white paper, as recommended by Bowling (2006). According to Bowling (2006), attention must be given to provision of clear instructions on how to complete the questionnaires. Clear instructions were given at the beginning of the questionnaires along with instructions on how to complete the questionnaires ie tick the appropriate box. Attention was also drawn to the inclusion criteria which specified that the respondent had been selected to be part of the study because of their experience of dementia care nursing and the questionnaire was to be completed only in relation to dementia care nursing. It was also outlined that the questionnaires were anonymous. The questionnaires were presented chronologically and numbered accordingly. The participants were thanked for their contribution at the end of the questionnaire booklet.

The questionnaire booklet was examined for face validity by a small number of experienced registered general nurses (4) within one non-dementia specific ward contained in a dedicated health care service for the older person linked to one acute hospital. The nurses represented different staff grades ie two clinical nurse managers and two staff nurses and they were experienced in dementia care nursing. They also reflected the cultural diversity of the nursing work force practicing in the aforementioned context. The questionnaire booklet was also reviewed by a doctoral Assistant Professor of Nursing within the university associated with the hospital who leads on dementia care. There was a consensus of opinion from all of the reviewers that the questions were clear and unambiguous and easy to complete and they reflected the phenomenon being studied ie nurses' experiences of dementia care nursing.

5.5.8 Pilot Study - Phase One

The reliability and validity of the questionnaires was tested during the pilot study, to ensure that the questionnaires were clear, understandable and relevant to the topic under investigation. All participants were given the same information and the same time period in which to complete the questionnaires. This is consistent with the work of Moule and Goodman (2014). The pilot study was carried out with as much care as the main study including adherence to the ethical principles outlined (section 5.8). The respondents met the same inclusion criteria as for the main study and were not reselected for the main study. A

short letter was contained at the back of the pilot study questionnaire (Appendix 14). The letter thanked the respondent for completing the questionnaire and outlined that participation in the pilot study prohibited taking part in the main study.

The researcher contacted the Director of Nursing from hospital (A) by letter, and permission was granted to both advertise the study and discuss the aims of the pilot study with the appointed gatekeeper. The accessible number of participants for the current study was estimated to be approximately 200 overall, therefore a total of 20 questionnaire packs, representing 10% of the population were left with the gatekeeper for the pilot study. The procedures outlined (later in this chapter) regarding implementation of phase one and ethical procedures were followed for the pilot study. Eleven questionnaires out of a total of 20 were returned, following a two week period, giving a response rate of 55%. If problems are detected during a pilot study, revisions and refinement are carried out to eliminate or reduce the problems occurring in the main study (Polit and Hungler, 2008). The three questionnaires, the SNCW, the ADQ and the WOFS proved to be valid and reliable. They successfully, answered the research question and adequately represented the different attributes of the concepts and the respondents interpreted the questions in the same way. Following scrutiny of the collected data, minor revisions were made to the demographic questionnaire. For example, within the nurse qualification question, the pre-registration and post registration diploma for both the nurse qualification and dementia specific qualifications were recorded thus (pre/post registration). When the participants ticked the box, they did not specify if it was the pre or post diploma which was pertinent to them. These questions were altered to pre-registration and post registration printed separately in the box under the specific question.

5.5.9 Phase One, Data Collection

The researcher contacted the Directors of Nursing from the three identified hospital sites by letter and following permission, 199 packs were delivered concurrently via the appointed gatekeepers to non-dementia specific wards/units that included acute, rehabilitation and residential contained in dedicated health care services for the older person within the three acute general hospital sites. The appointed gatekeepers placed information posters regarding the study to include the respondent inclusion criteria on relevant notice boards in nursing stations and staff rooms to advertise the study and encourage participation. Information posters were also placed on the boxes containing the packs. The packs contained (1) the questionnaire booklet (2) a covering letter with all the information needed in a consent form

(Appendix 15) (3) respondent information leaflet (Appendix 16) and (4) a self- sealing envelope for return of the completed questionnaire booklet. Individual boxes containing the relevant number of packs (ie appropriate to the number of nurses on the ward/unit) was delivered by the gatekeepers to the relevant wards/units along with a sealed box for return of the envelopes and a two week period was arranged for uplift by the respective gatekeepers. A total of 30 packs were delivered to hospital A, 30 packs were delivered to hospital B and 139 packs were delivered to hospital C. The accessible population appropriate to the three hospitals had been obtained previously from the respective gatekeepers. A small number of questionnaires were returned after the initial two week period and thereafter a reminder letter (Appendix 17) was distributed via the gatekeepers and a further one week period was arranged for uplift. Finally a total number of 129 questionnaires were returned giving an overall response rate of 65%.

5.5.10 Phase Two, Data Collection

Following the completion of the survey, the second sequential phase of the study was conducted. According to Morgan (2014), it is desirable, if possible, to re-interview a number of participants from the original survey phase of the study. The participants in the focus groups were derived from the same wards/units within the hospitals as the respondents in the first phase. However, as the survey respondents in phase one were anonymous it is impossible to know if the focus group participants had taken part in phase one.

5.5.11 Focus Groups

Focus groups are recommended when the purpose is to reveal issues that have an effect on behaviours, opinions, attitudes and experiences (Kitzinger, 1995; Krueger and Casey, 2009). Focus groups are defined by Kitzinger (1995) as

> "a form of group interview that capitalises on communication between research participants in order to generate data" (p. 311).

They create an environment in which relationships are formed and the level of discussion which takes place is comparable to those experienced in everyday situations *(*Owen, 2001*).* It is argued that a group of participants who share mutual experiences leads to feelings of security in confiding and elaborating on experiences of sensitive issues as opposed to one-to-one interviews (Kitzinger, 1995; Krueger and Casey, 2009). It is maintained that focus groups

are capable of promoting an egalitarian form of discussion as the controlling role of the group moderator is diluted (Owen, 2001). This is due to the fact that rather than the moderator asking individuals to respond to a question in rotation, the participants are urged to speak to each other and to share anecdotes and reflect on each other's experiences and perspectives (Krueger and Casey, 2009). Focus group interviews can effectively provide a level of understanding of ways in which participants generally reflect and discuss sensitive issues in a group context (Jordan et al, 2007). The knowledge gained from focus group interviews is the product of the participants' discussions and exchange of ideas (Parahoo, 2006). As Kitzinger (1995) explains, conducting focus groups to follow up on a survey can provide a robust method of exploring how the views in the survey were formed.

Critically, Owen (2001) calls to attention the importance of providing support and follow up for participants in the event that they may wish to discuss issues again or in more depth. She also recommends having a supportive and experienced colleague with whom to share thoughts and feelings about the groups afterwards (Owen, 2001). These recommendations were followed in the current study as outlined (section 5.8.2 and Appendix 18). I also had to take into consideration the fact that the findings from the literature review established that dementia care nursing is a sensitive issue. This is due to a variety of reasons such as, poor organisational support which results in nurses frequently perceiving that they are unable to provide either the physical or psychological care that they know the person with dementia requires, far less the person-centred care that is advocated by both professional and governmental bodies. There is also evidence that as a result of not being able to meet the patients' needs, nurses experience feelings of failure, powerlessness and inadequacy. Thus recounting experiences of dementia care nursing to include behaviours and attitudes, could potentially lead to discomfort or distress for the participants. According to Wellings et al (2000) focus groups provide a forum that is particularly well suited to discussing sensitive issues.

One of the most common uses of focus groups is to interpret survey results (Morgan, 1996). A major advantage of conducting focus group interviews is that data can be obtained quickly and efficiently (Parahoo, 2006). On the other hand, the data that they produce can be cumbersome and complex (Kitzinger, 1995). Notwithstanding, following reflection on all of the above, it was decided that conducting focus groups interviews was the most appropriate method for data collection in phase two for the purpose of providing explanations and

clarification of the quantitative data collected in phase one in the current study and in consideration of the sensitivity of the topic. Focus groups are compatible with the philosophical assumptions of the qualitative research approach, and the sequential explanatory mixed methods research design (Kitzinger, 1995).

5.5.12 Development of the Focus Group Interview Schedule

The focus group interview schedule was developed from the themes that emerged both from the literature review and data analysis of the quantitative data which was collected during phase one of the current study. The schedule was developed in collaboration with two members of the specifically formed research team, chiefly with team member A. In relation to focus group analysis and moderation, according to Krueger and Casey (2009) one has to consider the notion of personal bias. Due to my lengthy engagement in gerontological nursing, and my knowledge of the dementia care nursing literature, I was aware that I may have certain biases. In order to safeguard against the possibilities of personal bias, I followed Krueger and Casey's (2009) recommendations which involved the formation of a research team. The research team consisted of myself and two other members. The other members of the team were doctoral nurses who worked within the university setting and had broad experience of conducting research studies and facilitating focus group discussions. Thus, the research team was developed for the purposes of upholding credibility, constructing the focus group interview schedules and to assist and collaborate with the running and moderation of the focus groups. As Krueger and Casey (2009) comment much of the success of focus group interviews depends on skilful moderation. A full outline of the development of the Focus Group Interview Schedule is presented in Appendix 18. The Focus Group Interview Schedule along with the rationale is outlined in table 5.3.

Table 5.3   Focus Group Interview Schedule

Statement/or Question	Rationale
1. Introductions	To welcome the group and introduce ground rules such as one person talking at a time
2. How do you think nurses' attitudes towards dementia, influences nursing care of the older person with dementia?	Significant statistical differences noted in relation to (i) hopefulness for the person with dementia (ADQ) and (ii) person-centred approach to care in the findings from the ADQ questionnaire.
3. In your opinion, how do you think dementia affects the older person?	Significant statistical differences noted in relation to (i) hopefulness for the person with dementia (ADQ). For example, 47.6% of respondents disagree that people with dementia are unable to make decisions for themselves
4. In your opinion how possible is it to get to know and engage with the person with dementia in your ward/unit?	From the SNCW, subscale Quality of Care it was noted that (92%) of respondents were in agreement that the patients always receive good care. This contrasted with the findings from the literature review, where nurses generally agreed that they could not provide good quality care for the person with dementia
5. From your experience, how does nurses' knowledge impact on nursing care of the older person with dementia?	From the SNCW, subscale Knowledge of Patients, it was noted that while the majority of the total score of the respondents skewed towards the more negative end of the scale, it was evident that the 'neither agree or disagree' responses caused the overall mean to reflect a less positive picture. The findings from the literature review reflected that many nurses did not believe that they were sufficiently knowledgeable about dementia, resulting in a task orientated approach to care
6. Reflecting on your experiences, what are your views from a nursing and patient perspective on the quality of nursing care that can be provided within a unit catering for the older person with and without dementia?	There is a dearth of empirical literature in relation to dementia care nursing in non-dementia specific wards/units that include acute, rehabilitation and residential contained in dedicated health care services for the older person which are linked to acute hospital services
7. In your opinion, how does the physical environment of care impact on the provision of nursing care of older persons with dementia?	From the WOFS, PEW subscale, it was noted that the majority of respondents held generally positive beliefs about the environment of care within which they provide dementia care nursing. This contrasts with the findings from the literature review, where nurses generally agree that the environment of care is unsuitable for the older person with dementia
8. How supported do you feel in your current role?	From the SNCW, Work Co-operation subscale, it was noted that only 27% of respondents agreed that there are enough opportunities at work to discuss the psychological stress of the job. From the literature review, it was noted that the majority of nurses do not feel that the work organisation provides sufficient opportunities to discuss the psychological stress of the job
9. In your opinion, how do you think nursing care in a unit such as yours can be improved for older persons with dementia?	General statement to gather the participants views and opinions in relation to dementia care nursing in non-dementia specific wards/units that include acute, rehabilitation and residential contained in dedicated health care services for the older person which are linked to acute hospital services
10. Are there any issues we have not covered or anything that you would like to elaborate on?	To enable the participants to clarify points of views or add a comment of importance that they may have reflected on
11. Concluding remarks and summary	The moderator's summary was given to ensure that the participants agreed that the summary was adequate and correct

The interview schedule was developed in line with Krueger (2002) and Krueger and Casey (2009) recommendations. The schedule moved from general warm up questions such as asking the participants to introduce themselves. It then transitioned to key questions such as asking the participants to share their views and opinions about their experiences of dementia care nursing care. Ending the interview included providing a summary and ensuring with the participants that nothing of importance had been missed.

5.5.13 Phase Two – Pilot Study

The researcher contacted the Director of Nursing from hospital (A) by letter and permission was granted to both advertise the study and to discuss the aims of the pilot study with the identified gatekeeper and to recruit participants (six participants) for a staff nurse focus group interview, the response rate was three. The participants met the same inclusion criteria as for the main study and were not reselected for the main study. The procedures regarding the format of a focus group, and ethical procedures were followed for the pilot study. If problems are detected during a pilot study, revisions and refinement are carried out to eliminate or reduce the problems occurring in the main study (Polit and Hungler, 2008). Following the pilot study and discussions with the moderator and my supervisors, it emerged that participants when invited to discuss issues relevant to nurses' attitudes towards dementia, tended to focus on personality traits rather than attitudes. Consequently, during focus group interviews when discussions took place about nurses' attitudes, the moderator clarified that the discussion was specific to attitudes and not personality traits.

5.5.14 Focus Group Procedures

Three focus groups were initially undertaken but following initial analysis, two additional focus groups were convened to reflect a need for the acute care environment perspective to be included. The five focus groups were made up of homogenous groups of nurses. When an existing hierarchical structure exists within groups taking part in focus group discussions, it is recommended that the groups are stratified so as to ensure open discussion (Kitzinger, 1995; Krueger and Casey, 2009). With this caveat in mind, the staff nurses and the clinical nurse managers were divided into separate groups:

Focus Group One	=	Five Staff Nurses
Focus Group Two	=	Eight Clinical Nurse Managers
Focus Group Three	=	Four Staff Nurses
Focus Group Four	=	Five Clinical Nurse Managers
Focus Group Five	=	Three Staff Nurses

All of the participants were experienced in provision of dementia care nursing and they were able to elaborate on the issues that were important to them, facilitated by the moderator and guided by the relevant interview schedule. Focus groups typically consist of numbers ranging from four to twelve participants in each focus group (Dilorio et al, 1994; Kitzinger, 1995; Onwuegbuzie et al, 2009). If the group is too large, for example, more than twelve participants, it can lead to discomfort in sharing opinions and views. Ideally the group should include enough members to discuss the multiplicity of the topics under discussion (Onwuegbuzie et al, 2009).

The focus groups took place within pre-arranged seminar rooms away from the specified wards within the respective hospital sites. It was understood that attendance at the focus group interviews was commensurate with adequate staffing levels at the appointed time of interview. The interviews lasted approximately two hours in total which the literature recommends as the optimum time period (Dilorio et al, 1994; Parahoo, 2006; Onwuegbuzie et al, 2009). Prior to the commencement of the focus group discussions, the participants completed and signed a consent form (Appendix 19). It is recognised throughout the literature that recording data from focus groups can be daunting, for a number of reasons, such as the volume of data and also the potential problem of several people talking at the same time (Krueger and Casey, 2009). To overcome these problems, the focus group discussions were tape recorded with permission from the participants. The use of the tape recordings, along with written notes, ensured an accurate record of the group discussions and provided a trail of evidence to ensure dependability. The moderator highlighted the presence of the tape recorder and issues of confidentiality were stressed. This was followed by an overview of the study, the planned length of the session and the availability of refreshments. Ground rules such as one person talking at any given time were discussed which led into the participants' opening statements. The focus groups were brought to a conclusion by an ending question that requested the participants to reflect on their discussions and offer their opinions on what they considered to be the most important aspects to them in provision of dementia care nursing in the study context. The moderator then summarised the focus group discussions and asked the participants if the summary reflected accuracy. Finally, the moderator reviewed the purpose of the study and asked the participants, if in their opinion she had missed anything of importance to the topic discussed. The moderator thanked the participants for attending and generously giving their time. According to Krueger and Casey (2009) offering a summary of the interview forms part of the systematic procedure of focus group

research. An outline of the role of the moderator and assistant moderator in conducting the focus group interviews is presented in Appendix 20. The chapter will now turn to and present the process of data analysis which was undertaken for phase one and phase two of the current study.

5.6   Data Analysis

5.6.1   Quantitative Phase - Phase One

The purpose of undertaking data analysis is to allow the research questions to be answered (Parahoo, 2006). The Statistical Package for the Social Sciences (SPSS) version 20 was used to analyse the quantitative data (IBM, 2011). In order to reduce, summarise and bring order to the raw data, it is necessary to apply appropriate statistical methods (Bello, 2002; Polit and Hungler, 2008). All quantitative data were coded and entered for analysis into SPSS and a system file was created and all variables and response choices were labelled. Before analysis took place, basic frequencies were run to screen for missing values and outliers and to establish data entry accuracy. Missing data can be problematic in survey research and it is necessary to minimise the amount (Pallant, 2010). Consistent with Pallant (2010) missing data were dealt with by assigning the average value of the completed item or by excluding cases from the analysis. Total scores and sub-scores were computed for the SNCW, the ADQ and the WOFS (PEW) questionnaires, with reverse scoring being undertaken where applicable. Internal consistency of the three instruments and their subscales was verified through the computation of Cronbach's co-efficient alpha.

In the current study, categorical data and interval data was collected. Categorical data also referred to as ordinal data, demonstrates relative rankings of objects such as age groups (Field, 2013) while, Likert scales are considered to be interval in nature as opinions usually involve five values to which numerical scores can be assigned (Carifio and Perla, 2007; 2008; Norman, 2010). Characteristics, such as age groups were generated from the demographic questionnaire while Likert scales were used to gauge the respondents' opinions within the SNCW, ADQ and WOFS (PEW).

In relation to the demographic data, descriptive statistics such as reporting the central tendency and constructing cross tabulation tables were used for summarising and communicating the demographic data. Associations and the strength of the relationships were run using Mantel-Haenszel, Spearman's rho and a Monte-Carlo Method of Simulation.

Spearman's rho is intended for correlation analysis specific to categorical data while Mantel-Haenszel and the Monte-Carlo Method of Simulation measure the same sample of respondents at many points to test for associations (Pallant, 2010; Field 2013). Characteristics of the sample to include information such as, age and educational status was successfully established using the above methods.

5.6.2 Parametric and Non-Parametric Methods

Analysis of quantitative data can be conducted in a number of ways. The researcher must decide which tests (parametric or non-parametric) are the most appropriate for the data in question. Parametric tests which are considered to be the most powerful make the assumption that there is a large sample size, using probability sampling and that the data is normally distributed and is measured at interval or ratio scale level. In contrast, non-parametric testing often involves non probability sampling, it does not assume a normal distribution, and is described as distribution free and is measured at ordinal and nominal level (Parahoo, 2006; Corty, 2007; Pallant, 2010). In the current study, the convenience sample was 129, categorical and interval data were collected and the data was non-normally distributed.

According to Carifio and Perla (2007, 2008) and Norman (2010), numerous statistical research studies have generally failed to show that violation of the rules for parametric tests, such as a large sample size and non-normal distribution, show any great significance with either statistical decision making or the extent of errors made. As Norman (2010), Professor of Biostatistics suggests, parametric statistics can be utilised with Likert data, non-normal distributions, unequal variances and small sample sizes with impunity. Norman (2010) further proposes that empirical literature extending back to the 1930s, show that parametric procedures such as, ANOVA and t-tests, are highly robust when it comes to issues like skewness and non-normality. When it comes to small samples, he states that the demarcation is considered to be approximately five per group. Furthermore Pallant (2010) elaborates that within social sciences research where samples may not be normally distributed and with sample sizes of above thirty, parametric techniques can be employed. However, Pallant (2010) also cautions that researchers are becoming more aware of the potential problems of assuming that Likert scales constitute interval level scaling and consequently there is an increased usage of non-parametric techniques within social sciences research. So, following the review of the statistical literature, along with statistical advice from a Professor of Statistics and with consideration of Pallant's (2010) caveat, a pragmatic decision was reached

and both parametric to include ANOVA and t-tests and non-parametric techniques to include Kruskal-Wallis H and Mann Whitney U were used to analyse the data generated from the questionnaires. As referred to earlier in this section, Carifio and Perla (2007; 2008) and Norman (2010) consider that Likert scales are interval in nature as they generally comprise six to ten carefully constructed items with an underlying conceptual structure. The summation of which indicates the respondents' views and opinions and as noted can be treated as interval data and parametric tests such as Analysis of Variance (ANOVA) and independent sample t tests can be calculated.

5.6.3   Quantitative Data Analysis

Analysis of variance (ANOVA) is used to compare the variability in scores among the various groups with the variability within each of the groups (Pallant, 2010). According to Pallant (2010), what are required are two variables, one categorical independent variable with three or more distinct categories and one continuous dependent variable. In the current study there were 10 categorical independent variables as measured by the demographic questionnaire and a number of continuous dependent variables. The continuous dependent variables included the total score for the SNCW and the total scores of its five subscales, the total score for the ADQ and the total scores of its two subscales and the total score for the WOFS (PEW) and the total scores of its four subscales. So, for example, in the current study ANOVA was used to find out if there were differences between the total ADQ scores for the respondents' age groups. If significant differences are discovered, post-hoc comparisons such as Tukey's Honestly Significant Differences (HSD) are used to find out where the significant differences in the groups lie. Post-hoc tests are used as a safe-guard against the likelihood of a Type 1 error as a consequence of the large number of different comparisons being made (Pallant, 2010). Where appropriate, in the study, independent t-tests, were used to explore comparisons between two demographic groups, as Pallant (2010) explains t-tests are useful for comparing the means of two groups. In the current study t-tests were used, for example, to compare the means of the Indian and Philippine educated nurses (group one) with the Irish and UK educated nurses (group two) in relation to the total ADQ score where statistically significant differences were found. Post hoc tests to include Levene's test were employed as part of ANOVA and the independent t-tests to ensure equality of variance which is an assumption associated with these parametric tests (Pallant, 2010). Where more refined testing for homogeneity was required, Gabriel's test which is utilised with small sample sizes was

used as further corroboration along with the powerful Games-Howell post hoc test which is employed if there are doubts about the population variance (Field, 2013).

Where the assumptions of the parametric tests were violated, as measured by the Shapiro-Wilk statistic, appropriate non-parametric analyses were used to include Kruskal-Wallis H which is the non-parametric alternative to ANOVA and Mann Whitney U test, the non-parametric alternative to the independent t-test (Pallant, 2010). The Shapiro-Wilk statistic is appropriate for testing normality within small samples (< 50). If the sig value of the Shapiro-Wilk is greater than 0.05 the data is normally distributed, conversely if it is below 0.05 then the data deviates significantly from a normal distribution (Field, 2013). However, caution was exerted when interpreting marginally significant results bearing in mind the possibility of reaching the wrong conclusion due to the possibility of a Type 1 error by rejecting the null hypothesis when it was actually true. Conversely, a Type II error can occur when no relationship is found in the sample but such a relationship does exist in the population (Parahoo, 2006; Corty, 2007). This possibility was minimised by setting the level of significance by alpha level $<.05$ which is the usual significance level adapted in the social sciences (Pallant 2010). It is important to consider the sample size used in a study as it influences the power of a test. However, with sample sizes greater than 100 or more participants, as is the case in the current study, power is not a concern (Pallant, 2010). Cross tabulation tables were also prepared in order to organise the data and to enable exploration of relationships between the variables. This is consistent with the work of Pallant (2010). Further testing involved correlation analysis which is useful for testing relationships between two or more variables (Pallant, 2010). Correlation analysis using Pearson r was undertaken to explore for relationships amongst the three questionnaires and a relevant table was presented. Additional testing to explore for predictions between dependent variables such as attitude and independent variables such as age, education were conducted. According to Pallant (2010) multiple regression is used to predict which independent variables are of the most and least significance in accounting for variance in the dependent variable (Pallant, 2010). Multiple regression is based on correlation but permits a more complex examination of the inter-relationships among a set of variables. It is useful for revealing how well a set of variables is capable of predicting a particular outcome (Pallant, 2010). So for example, in the current study, stepwise linear regression which is part of the family of multiple regression techniques, was conducted to explore the predictive power of the independent variables, the demographic characteristics of the nurses surveyed for the dependent variables, the ADQ,

SNCW and the WOFS. Finally, as the findings from the survey are presented as aggregates from all three sites, analysis using ANOVAs and Kruskil-Wallis H was conducted to examine the individual total scores and total sub-scores of the three questionnaires as generated by the three separate hospitals. Parametric ANOVAs were used for normally distributed data and non-parametric techniques namely Kruskal-Wallis H tests was used where the data was not normally distributed was conducted

5.7   Phase Two – Qualitative Data Analysis

The purpose of qualitative data analysis is to bring about order to a large body of information in order to reach general conclusions (Burnard et al, 2008). Analysis can be conducted for either theory building or for description (Burnard et al, 2008). The purpose of my qualitative data analysis was for description. A considerable amount of data was generated from the five focus group interviews but my key consideration, according to the writings of Krueger and Casey (2009) was during the analysis process to constantly keep the purpose of the study in mind. A recognised challenge in undertaking focus group data analysis is that despite, the extensive amount of literature written in relation to the planning and management of focus groups, there is a dearth of available information on conducting analysis (Onwuegbuzie et al, 2009).

Notwithstanding, according to Kitzinger (1995) focus group data analysis is similar to undertaking analysis of other qualitative self-reporting data. It involves identifying themes and exploring how these relate to the variables within the study population (Kitzinger, 1995). It is suggested that there are a number of different methods for undertaking analysis of qualitative data with similar approaches (Burnard et al, 2008). The method that I drew upon in the current study was thematic analysis which is described as the process of identifying themes or patterns within qualitative data (Braun and Clarke, 2006). Using thematic analysis as advocated by Braun and Clarke (2006) allowed me to both organise and describe the data generated from the focus group interviews. The Braun and Clark (2006) model of thematic analysis was appealing as it constitutes a foundational method for analysing qualitative data and it provides researchers with the core components for undertaking qualitative analysis. A further benefit from the perspective of the current study was that thematic analysis as proposed by Braun and Clarke (2006) does not form part of a particular philosophical approach, for example, grounded theory or discourse analysis. As such it is not united to any pre-existing theoretical framework, it can be applied pragmatically across a range of

epistemological and theoretical approaches resulting in theoretical freedom (Braun and Clarke, 2006). This meant that it was compatible with the flexibility of the mixed methods research design, as used in the current study. Indeed Braun and Clarke (2006) argue that due to its theoretical freedom, thematic analysis offers a flexible and effective method which has the potential to yield a detailed, rich account of the data (Braun and Clarke, 2006). Braun and Clarke (2006) developed a six step guide outlining the different phases of thematic analysis (table 5.4). A cautionary note is that the guidelines are precisely that and as such they should be applied in a flexible manner to fit the particular research purpose (Braun and Clarke, 2006).

Table 5.4   Six Step Guide to Thematic Analysis

Six Step Guide to Thematic Analysis	
(1) Familiarisation with the Data	(2) Generating Initial Codes
(3) Searching for Themes	(4) Review Themes
(5) Define and Name the Themes	(6) Present the Findings

Adapted from Braun and Clark (2006)

I analysed the entire data set to look for repeated patterns of meaning, so that I could produce thematic descriptions to accurately reflect what the nurses had to say about dementia care nursing during the focus group discussions. I used an inductive approach which is the most common method employed to analyse qualitative data (Burnard et al, 2008). An inductive approach is data driven and means using the actual data itself to identify themes and structure analysis. It involves a process of coding that is not tied to a pre-determined coding frame or framework (Braun and Clarke, 2006; Burnard et al, 2008). Although thematic analysis represents a comparatively comprehensive method of qualitative analysis, there are a number of possible pitfalls to avoid (Braun and Clarke, 2006). For example, Braun and Clarke (2006) caution against the collection of a number of extracts with little or no narrative analysis, in other words where there is no evidence of analysis taking place. A further pitfall is that of using the statements from the interview schedule as the themes which indicates that no analytic work has been undertaken to identify themes as they emerge from the data set (Braun and Clarke, 2006). I kept this advice in mind throughout the data analysis process and further points that I had to consider during the data analysis, was that analysis did not take place in a linear manner. Rather as Braun and Clarke (2006) suggest, it was a more recursive process

where there was a considerable amount of weaving backwards and forwards through the different stages, as illustrated in Figure 5.1. So although the process of thematic analysis is described in sequential steps, the actual process involved a great deal of recursive movement throughout the different stages.
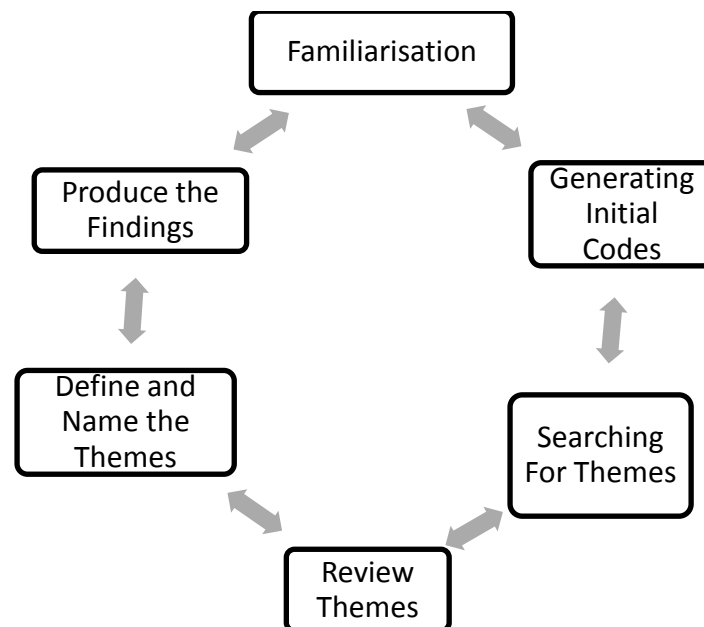
Figure 5.1   Process of Thematic Analysis

5.7.1   Familiarisation with the Data

Familiarisation, according to Braun and Clarke (2006) is essential in order to develop an impression of the completed interviews before identifying and breaking the data up into potential themes and beginning the development of conceptualisation. I started the process of familiarisation by completing the transcriptions at the end of each focus group. Undertaking transcription is arguably a central phase of interpreting data, as suggested by Braun and Clarke (2006), it is where meanings are created. Once transcription of the five focus group interviews was completed, I listened to and reviewed the tapes and the transcripts several times thus ensuring my immersion in the data and the beginning of my search for patterns and meanings. Reading and re-reading the data is consistent with an inductive approach to data analysis (Braun and Clarke, 2006; Burnard et al, 2008). I also made notes of words, or short phrases to sum up what was being said and the notes was where my ideas for coding began to take place. For example, early on in the analysis phase, it became apparent that the participant nurses were committed to providing best quality dementia care nursing but they were

frustrated by poor staffing levels and what they perceived to be a challenging environment of care. The typed transcripts were also compared with the notes compiled by the assistant moderator. No inconsistencies were found.

5.7.2 Generating Initial Codes

I undertook the initial coding process with a firm acknowledgement of Krueger and Casey's (2009) advice to constantly refer back to the aim of the study and the statements in the focus group interview schedule. The use of coding within the qualitative analysis enabled me to reduce the data set, into a number of meaningful segments. This process involved multiple reading of the data to enable me to develop meaningful segments, reading and re-reading also ensured that I did not lose the original nuances of the nurses' words. These coded segments form the most basic sections of the raw data (Braun and Clarke, 2006). This phase involved identifying and coding interesting sentences and paragraphs relevant to the nurses' experiences from the entire data set by using coloured highlighting pens. I am aware of the availability of qualitative data analysis software packages, however, I took the decision to undertake manual analysis, as I wanted to remain as close as possible to the data. I coded the extracts manually using a combination of different coloured marker highlighting pens along with cutting and pasting using a Microsoft office programme to create different files for the emerging codes. The codes come before the themes and are narrower. Table 5.5 provides an example of a data extract and initial codes

Table 5.5   Data Extract and Codes Example

Data Extract and Codes

Data Extract	Codes
We don't have enough staff to sit down and have albums that they can relate to their past (1.2)	(i) Staffing Levels (ii) Meaningful Activities (iii) Organisational Support

At the completion of this phase all extracts of data had been coded. Data was only discarded when it was very obviously irrelevant.

5.7.3 Searching for Themes

This stage required me to organise the coded data into potential sub themes and themes using an inductive approach. At this point and consistent with Braun and Clark (2006) I was searching for themes that captured something significant about the research question or the main topics discussed during the focus group interviews such as the nurses' beliefs about the environment of care or attitudes towards dementia. Some of the codes clearly fitted together into a sub-theme. For example, several codes related to staffing levels and the nurses' perceived lack of management understanding of dementia care nursing and these were collated into the sub-theme, entitled organisational support. Several sub-themes often emerged from a single paragraph and these were identified by using different coloured marker pens. At the end of this process, the codes had been collated into broader sub-themes that were relevant to the focus group discussions and the research question and the intent was to explore the findings from phase one in more depth. Table 5.6 provides an example of data that was contained in a single paragraph which was coded for two different potential sub-themes.

Table 5.6   Data Extract Example

Examples of a Data Extract, Codes and Sub Themes

Data Extract	Codes	Sub Themes
We simply don't have enough time and staff to look after them….	Staffing Levels	Organisational Support
introduce orientation things to help them.. to remind them of the time, they don't have any sense of the time, you know during the day or at night time, some of them get confused between day and night, could use calendars	Meaningful Interaction	Specialist Knowledge
but we don't have any on the wards and we don't have enough staff to sit down and have albums that they can relate to their past. (1.2)	Ward/unit Resources	Organisational Support

Similar coded comments and quotes were then separated from their original background and were grouped together and rearranged into their newly formed sub-themes. The source of the individual quote was managed by creating a code for each participant. This is consistent with the recommendations of Krueger and Casey (2009).

5.7.4   Review Themes

A review of the themes was then undertaken according to Braun and Clarke (2006). I reviewed the created themes and sub themes to ensure that they were meaningful and representative of the coded data.   At this stage and to ensure accuracy, the themes and sub themes were also reviewed and agreed by the focus group moderator and assistant moderator for focus groups 1,2 and 3 and the assistant moderator and myself for focus groups 4 and 5. This was consistent with Burnard (2004) who recommend, that to confirm the accuracy of the development of the created themes requires independent verification.

5.7.5   Define and Name the Themes

This stage is referred to by Braun and Clarke (2006) as recognising the story that each theme articulates.   This is where the themes were given clear and concise names. This stage was developed by identifying the essence of what each theme and sub-theme was about and determining what aspect of the data they captured. For example, in the analysis, the nurses' beliefs about the environment of care was an overarching theme that was embedded in the sub-themes physical environment and organisational environment. Table 5.7 illustrates how the initial themes were aggregated together to form the key themes and subthemes.

Table 5.7   Identification of Focus Group Themes Examples

Data Extract from Transcript	Coded For	Sub Themes	Themes
we have three wards with walls, you cannot see through them (1.1)	Patient Safety	Physical Environment	Environment of Care
they are in a strange environment (1.2)	Unfamiliar Environment		
6 patients, one nurse we are given (4.2)	Staffing Levels/Organisational Support	Organisational Environment	
There are many avenues available that you can take if you feel that you are not competent (2.7)	Support and Training	Skills Acquisition	Nurses' Knowledge about Dementia
60% of the patients ….from medical wards…would have had Ecoli UTIs,…would have turned into full blown delirium (2.8)	Importance of Specialist Knowledge		
We label it senility (2.6)	Cultural Understandings of Dementia	Knowledge Base	
If you are seen with your MMSE that's low, at that point, you have lost your voice (2.8)	Powerlessness/Loss of Voice and Decision Making Capacity	Ethical Dilemmas Experienced in Dementia Care Nursing	Ethical Dilemmas
are you going to let that person starve to death, they don't have the capacity to make that decision (2.8)	Principles of Autonomy, Beneficence & Non-maleficence		
ethical dilemmas that we face into should be debriefed (3.5)	Debriefing and Support	Desire for Support	
Negative attitudes can cause harm (1.1)	Influence of Harmful Attitudes	Influences of Attitude on Dementia Care Nursing	Dementia: A Misunderstood Concept
There is still labelling.it still exists within our MDT (2.8)	Labelling		

5.7.6   Presenting the Findings

The purpose of presenting the findings was to communicate the story of the data collected and analysed. I also had to reflect on the fact that as suggested by Krueger and Casey (2009),

I was the voice of the participants. My task was to ensure that the presentation of the findings accurately represented the participant nurses' views and opinions about dementia care nursing. This was achieved by selecting data extracts from the transcripts that most clearly reflected the themes described. I then embedded the data extracts within an analytic narrative with the purpose of providing a coherent, succinct account of the views and opinions of the participant nurses based on their experiences of dementia care nursing. The quotes were referenced by the focus group that they emerged from, for example either focus group, 1, 2, 3, 4 or 5. They were further referenced as to the seating diagram from each focus group for example 1.2 refers to the first focus group and the second person on the diagram.

5.7.7   Rigour and Trustworthiness

Establishing rigour and trustworthiness within the qualitative paradigm is a contentious issue and the subject of much debate (Robson, 2002). It is widely accepted that the means of attaining reliability and validity within the quantitative paradigm such as the use of structured quantitative measurements and direct replication are not possible to achieve when a qualitative design is used (Robson, 2002; Rolfe, 2006; Creswell, 2007). In contrast, within the qualitative research paradigm the quest for truth involves amongst other issues, using flexible designs, spending prolonged periods of time in the field and working directly with the participants (Creswell, 2007; Moule and Goodman, 2014). It is contended by Robson (2002) that these circumstances are not open to replication. Thus, within the qualitative paradigm, researchers have been challenged to find other methods to confirm rigour in their research (Creswell, 2007; Cope, 2014). Indeed, some qualitative researchers go as far as suggesting that the standards of quantitative enquiry such as reliability and validity are irrelevant when using qualitative flexible designs (Robson, 2002). This argument originates from the notion that as there is a fundamental difference between the topics of interest within qualitative research from those in quantitative research, an alternative language is needed to describe the different concepts (Rolfe, 2006; Cope, 2014). This point is reflected by Creswell (2007) who notes that the language of positivism is incongruent with qualitative work. Unquestionably, there is a need for evaluative criteria such as trustworthiness in qualitative research but it is evident that this requires different criteria than those established for quantitative research (Robson, 2002). To meet this challenge, alternative terms and criteria in keeping with the qualitative paradigm for establishing rigour and trustworthiness have been put forward by Lincoln and Guba (1985). The four key elements within this framework include: credibility, dependability, confirmability and transferability. The criteria as

developed by Lincoln and Guba (1985) were used for establishing the rigour and trustworthiness of the qualitative phase of the current study as will now be described.

5.7.8   Credibility

Credibility is concerned with ensuring that the researcher represents the truth and reality of the research participants through credible interpretation and representation (Tobin and Begley, 2004). Steps that can be taken to ensure credibility within qualitative research include prolonged engagement in the field, peer debriefing, member checking and triangulation (Tobin and Begley, 2004). I have had prolonged engagement in the field of gerontological nursing and I have interpreted my knowledge as having an understanding of dementia care nursing. According to Cope (2014) in the case of qualitative research, the researcher is considered to be the research instrument and measures must be taken to avoid researcher bias. I was aware that prolonged engagement in the research area, could potentially lead to the possibility of personal bias. In an effort to overcome this possibility I formed a research team during phase two of the study. The two collaborators in my research team were both PhD nurses with vast research experience and I was able to call upon them as objective reviewers to establish credibility, for example, by holding debriefing sessions following the focus group interviews. I also shared my ideas and experiences with my supervisors and other nursing colleagues. Peer debriefing also included presenting my work at various nursing conferences and engaging in questions and answers at the end of the presentation.

Cope (2014) also suggests that another important step to establish credibility is member checking. At the end of each focus group interview, a summary was provided and the participants were asked if they agreed that the summary was adequate and correct. A few points of clarification were raised at the end of each interview and following discussion, a full understanding was reached. Additionally, at various points throughout the interviews, the moderator provided a short summary of points raised to ensure that all the discussion points were clarified. By using this process and asking the participants for feedback, they were able to validate or refute the credibility of the data collected. Participants were also informed that they could request a copy of the completed transcript if they so wished. None of the participants requested access to the transcripts. It is suggested by Tobin and Begley (2004) that triangulating data, which is the process of using multiple resources to draw conclusions, can improve the credibility of study findings and that it is a way of increasing the validity of

research findings. Triangulation was achieved in the current study by drawing on multiple methods of data collection, ie quantitative methods in phase one followed sequentially by qualitative methods in phase two.

5.7.9 Dependability and Confirmability

Dependability is akin to confirming reliability in quantitative data (Tobin and Begley, 2004; Rolfe, 2006). Confirmability as described by Tobin and Begley (2004) refers to the objectivity or neutrality of the data. Dependability and confirmability are intertwined according to Moule and Goodman (2014) so they will be considered and presented together in relation to the current study. Dependability of a qualitative research study, is achieved through the development of an audit trail which allows others to examine the researchers' methods and decisions (Tobin and Begley, 2004; Creswell, 2007). An audit trail as defined by Creswell (2007) consists of chronological details of the research activities. The audit trail in the current study, consisted of a chronological account of my research activities to include, entry into the field, sampling, the formation of the research team and the resultant collaborations, the development of the focus group interview schedule, the five focus group interview transcriptions, and the steps undertaken in the thematic data analysis. The audit trail can be reviewed to allow others to reach conclusions about my methods and decisions. Confirmability, to establish that the findings clearly originated from the data will be demonstrated by providing thick, rich quotes from the participant nurses.

5.7.10 Transferability

Transferability according to Tobin and Begley (2004) takes the form of external validity or generalizability. It refers to the extent to which the findings from the data can be applied to other groups or settings (Cope, 2014). As the qualitative phase in the current study consisted of five focus group interviews (n=25) within three hospital sites within one city, using purposive sampling, it is acknowledged that transferability of the findings from phase two are limited. However, Cope (2014) suggests that if researchers provide an adequate amount of detail about the study setting and the participants, others can assess if it is viable to transfer the findings. I have complied with Cope's (2014) suggestions and full details about both the study settings and the participants' inclusion and exclusion criteria have been outlined in the current study. The following section will outline ethical considerations relevant to the current study.

5.8   Ethical Considerations

In order to carry out an ethically sound research study that protects the rights and the needs of participants, the researcher has to be cognisant of ethical codes and regulations. At the local level, Irish registered nurses must be mindful of Ethical Conduct in Research, Professional Guidance (NMBI 2014b). At the international level, the Nuremberg Code was developed in 1949 following the revelations of the Nazi atrocities during the Second World War. This led to the development of the Declaration of Helsinki in 1964, which was later revised in 1975 (Burns and Grove, 2009). In brief, these codes require the researcher to balance the benefit/risk ratio in a study, obtain informed consent from the participants, obtain institutional approval for research, protect the subjects' rights and provide anonymity and confidentiality (Burns and Gove, 2009; NMBI, 2014b).

Ethical approval for the study was granted by the Joint Research Ethics Committee (JREC) (Appendix 21) for all three participant hospitals. Access to hospital (C) was granted by the Nurse Research Access Committee (NRAC) applicable to hospital (C) (Appendix 22) and the Hospital Board applicable to Hospitals (A) and (B) (Appendices 23 & 24 a&b). Ethical approval for the follow up focus group interviews (4th and 5th) was granted by Trinity College Dublin, School of Nursing and Midwifery Ethics Research Ethics Committee (Appendix 25).

5.8.1   Respect for Persons/Autonomy

This principle is concerned with the individuals' right to self-determination, full disclosure, and the right to withdraw from the study (NMBI, 2014b). All participants were fully informed about the study before they agreed to participate, and the participants voluntarily participated in phase one and phase two of the study. The participants in phase one and phase two of the study were provided with written information leaflets which comprehensively outlined the nature of the study, methods, benefits, risks, confidentiality and the right to withdraw from the study at any time without penalty and without giving up any benefits that they had before entering the study. In phase one of the study, completion and return of the questionnaires was taken as consent. The consent form applicable to phase two of the study contained all the information as outlined in the information leaflet. Participants were provided with the consent form in the information pack and had a period of at least seven days to consider and reflect on this information. At the beginning of the focus group interview in phase two, participants were asked if there was anything further they needed to know about the study. Following this action, and prior to the commencement of the focus

group interview, voluntary written consent was obtained from each participant. Each consent form was co-signed and dated by the researcher. One copy of the consent form was given to the participant and the original was retained by the researcher in a secure file.

5.8.2   Beneficence/Non-maleficence

This principle is concerned with research that produces benefits for the participants and society. The research should not cause harm and benefits should be maximised (NMBI, 2014b). The research study should benefit the participating nurses and society in general by contributing to both the body of nursing knowledge and the pool of human knowledge relative to dementia care. The anticipated benefits of the study were that it provided information about nurses' experiences of dementia care nursing within non-dementia specific wards/units, with the ultimate aim of establishing a greater understanding of dementia care nursing. There were no anticipated risks but in recounting experiences of dementia care nursing which is a sensitive issue, there was always the potential that participants may experience upset or distress. In an effort to prevent participant upset or distress, the focus group discussions were conducted within a warm and relaxed milieu and refreshments were provided. Additionally, the researcher had an action plan if any of the participants became upset or distressed during the focus group discussions. This plan included, halting the focus group discussion and giving the participant time to consider if they wished to continue to participate in the interview. If the participant wished to continue, the researcher would acknowledge this and the focus group discussion would resume. If the participant wished to withdraw, this choice would be honoured and following discussion, the data collected from this participant would be excluded from the study.   Participants', who experienced upset or distress, would be given details of the hospital Employee Assistance and Counselling Service Provider (EACSP). Permission was given by the three Directors of Nursing to give contact details of the EACSP to the participants if appropriate. The participants were also aware that they could contact the researcher if any issues related to the study arose that needed further discussion, on conclusion of the interview. No episodes of upset or distress occurred during the five focus group interviews.

5.8.3   Justice

This principle upholds that participants have a right to be treated fairly and equitably prior to during and after the research study is completed (NMBI, 2014b). Participants in phase one and phase two of the study were selected on the basis of their experiences of dementia care

nursing. To ensure fair selection of participants, sampling in both phases of the study was guided by the inclusion criteria (section 5.3.1). This action ensured that all registered general nurses who met the inclusion criteria, employed in a full or part-time capacity practicing within the named settings contained in the three hospital sites had an equal opportunity of participating in both phases of the study.

5.8.4 Confidentiality

This principle refers to protection of the individuals' confidentiality and privacy (NMBI, 2014b). Phase One – Confidentiality and anonymity were maintained throughout the study in relation to the survey data. The questionnaires were anonymous. The sealed boxes containing the completed questionnaires were removed from the various settings by the appointed gatekeeper and given to the researcher. Thereafter, the completed questionnaires were stored in a locked drawer in her private office. Confidentiality of data was further maintained by using code numbers on the completed questionnaires. The data was inputted on to the researcher's personal computer, safe-guarded by a password known only to the researcher.

Phase Two – Confidentiality within group research such as focus groups needs observance from both the researcher and the research participants (NMBI, 2014b). Observance of confidentiality also applied to the research team ie the moderator and the assistant moderator. Prior to the commencement of the focus group discussions, ground rules were agreed to include issues of confidentiality and anonymity. As anonymity could not be guaranteed, it was made clear to the participants, both in writing in the information participant information leaflet and, verbally that in the event of malpractice being revealed the researcher had a responsibility to take appropriate action relevant to the situation and risk involved, such as reporting to the Director of Nursing. Confidentiality was maintained by taking measures to protect the participants' identity during the focus group interviews, by providing them with pseudonyms which were used for the entirety of the focus group discussion. Identity numbers were applied to the qualitative data during the data analysis phase. The audio recordings were uploaded on to my password protected computer. The password was known only to me. The signed consent forms and completed demographic questionnaires were stored in separate secure folders, locked in a filing cabinet drawer in my private office with access restricted to myself. This ensured that, the participants cannot be identified as their personal details are stored separately. All data was kept in secure folders on my computer and on an external hard drive. Individual storage files were password protected with a password

known only to me. My computer and external hard drive were both encrypted. This was achieved by using a password protection system with a password only known by myself. My computer and hard drive were kept within my private locked office. My computer was protected with the latest version of McAfee security software. No data was saved to the cloud.

Overall - To ensure fairness of procedures, all processed data will be stored in accordance with the Data Protection (Amendment) Act (2003) for five years after the completion of the study. The data gathered will only be used for the purpose of this study as consented, to by participants.

5.9   Summary

This chapter presented the methods used in the current study. Information regarding the setting and access to the study sites was reported. The sampling methods and the study population were outlined. Data collection, the pilot studies and data analysis for phase one and phase two of the study were described. Ethical considerations and material relevant to rigour and trustworthiness were also communicated.

In phase one using a quantitative survey approach, nurses (n=129) demographic characteristics were explored in order to conduct analyses by these variables. Nurses' views, opinions, attitudes and beliefs about dementia care nursing based on their experiences of caring for the older person with dementia in non-dementia specific wards/units within dedicated health care services for the older person linked to acute hospital services, namely two acute general hospitals and one affiliated hospital site were also sought. The results of the data collected from phase one along with the themes identified in the literature review led to the development of the focus group interview schedule used in phase two. The survey results on their own provided an overview of the nurses' views and opinions related to dementia care nursing in the identified acute care setting. Phase two used a qualitative approach with five focus groups interviews to include 12 staff nurses in three of the interviews and 13 clinical nurse managers in the other two. The purposive sample of participants for the five focus group interviews were drawn from the same settings as phase one. The focus groups proved to be a suitable forum with which to elaborate and probe the results from phase one. They provided rich data and the participants freely discussed sensitive topics such as quality of care and organisational support that otherwise would have remained hidden. The following chapter will report the findings from the quantitative phase.

Chapter Six - Results – Quantitative Phase One

6.1 Introduction

This chapter reports quantitative findings from phase one of the study which collected data from four self- administered questionnaires (Section 5.5.2). The aim of this sequential explanatory mixed methods research study was to explore nurses' views and opinions about dementia care nursing based on their experiences of caring for the older person with dementia in non-dementia specific wards/units that include acute, rehabilitation and residential, contained in dedicated health care services for the older person linked to acute general hospital services.

6.2. Responses

Out of a total of 199 questionnaires distributed, 129 were returned giving an overall response rate of 65%. Hospital A, is a university teaching hospital with age related units, affiliated to Hospital B. Hospital B is a university teaching hospital with age related units. Hospital C is a university teaching hospital with ten age related units. The study sites are fully described and presented in Appendix Three. The breakdown of the accessible population and the number of returned questionnaires by hospital is given in Table 6.1.

Table 6.1　Response Rate

Hospital	Accessible Population	Number of Respondents
Hospital A	30	18 (60%)
Hospital B	30	17 (57%)
Hospital C	139	94 (68%)
		Total 129 (65%)

One of the identified problems with questionnaires is the potentially low response rate (Parahoo, 2006). The response rate for the individual hospitals was over 50% representing a sizable return. The positive return rate may be attributable to the fact that all three sites are university teaching hospitals with an emphasis on education and research. Another contributing factor may have been that the questionnaires were anonymous.

The findings from the four questionnaires will be presented in the following manner:

- Respondents' demographic characteristics
- Respondents' view and opinions about dementia care nursing
- Respondents' attitudes towards dementia
- Respondents' beliefs about the environment of care
- Correlation analysis (Pearson's r) is reported
- Hospital aggregates are reported

Finally, multiple regression results in relation to the predictive power of the demographic characteristics of the respondents are reported. The section ends with a conclusion.

6.3 Demographics

An overview of the respondents' demographics can be found in Table 6.2. The respondents represented a mature, experienced, settled workforce, with 77.5% in the 30-49 years age bracket and 73.6% registered for between 11-25 years with 48% employed in their practice setting for between 6 to 10 years. A third of the respondents (32.2%) received their nursing education in the Philippines. Proportionally, the greatest number of respondents worked in residential units (37.2%), followed by those working in rehabilitation (rehab) units (34.1%) with (14%) from the acute units.

More than half of the respondents (62.8%) were educated to degree level; however, only 37.2% were in possession of specialist qualifications in gerontological nursing (GN) or dementia specific education. Respondents with 6-10 years (48%) in their particular practice area were the least likely to have a specialist qualification. Irish educated nurses (52%) were most likely to have a specialist qualification compared to other groups.

The majority of the respondents came from the staff nurse grade (78.9%). Of those educated in India, 96.7% were staff nurses, 92.5% of Philippine educated nurses were staff nurses, 66.6% UK educated nurses were staff nurses and the percentage dropped to 41.9% of Irish educated nurses who were staff nurses. Those who received their nursing education in Ireland had the greatest proportion in management positions (58%). Of those in management positions, almost half (48%) held specialist gerontology qualifications (degree/diploma(dip)/certificate(cert) and another 14.8% held a masters level gerontology qualification.

Table 6.2   Respondents' Demographics

Demographic	n	%	Demographic	n	%
Gender			*Length Employed in Hospital*		
Female	122	94.5%	1-5 years	18	14%
Male	7	5.4%	6-10 years	60	46.5%
			11-15 years	32	24.8%
			16-30 years	19	14.7%
Age Group in years			*Length Employed in Area*		
20-29	11	8.5%	1-5 years	36	28%
30-39	58	45%	6-10 years	62	48%
40-49	42	32.5%	11-15 years	23	17.8%
50-65	18	14%	16-25 years	7	5.2%
Country of Nursing Education			*How Long Registered*		
Philippines	40	32.2%	1-5 years	6	4.7%
Ireland	31	25%	6-10 years	12	9.3%
India	31	25%	11-15 years	38	29.5%
United Kingdom	13	10.4%	16-20 years	37	28.7%
Other	9	7.2%	21-25 years	20	15.5%
			26-40 years	16	12.3%
Nursing Grade			*Type of Ward/Unit*		
Staff Nurse	101	78.9%	Acute Admission	18	14%
CNM1	6	4.7%	Rehabilitation	44	34.1%
CNM2/CNS/Mgt	21	16.4%	Residential	48	37.2%
			Other	19	14.7%
Nurse Qualifications			*Specialist Qualifications*		
MSc	10	7.8%	No Specialist Qualification	81	62.8%
Degree	81	62.8%	**Gerontology**		
Diploma			MSc	8	6.2%
Pre-Registration	19	14.7%	Degree/Dip/Cert	29	22.5%
Post Registration	12	9.3%	**Dementia**		
Certificate	7	5.4%	Certificate/Degree	11	8.5%

NB - Gender was excluded from the analysis as 94.5% of the respondents were female, thus there is a gender imbalance.

Table 6.3 gives a count of the number of nurses by their Country of Education, Length Employed in Hospital, Nursing Grade, and Specific Qualifications.

Table 6.3   A Frequency Table of Demographics

Country of Education	Specific Qualification	Staff Nurse				CNM1				CNM2/CNS/management				Total
		1-5	6-10	11-15	16-30	1-5	6-10	11-15	16-30	1-5	6-10	11-15	16-30	
Philippines	Dementia degree/cert	0	2	2	0	0	0	0	0	0	0	0	0	4
	GN MSc	0	0	0	0	0	0	0	0	0	0	0	0	0
	GN degree/dip/cert	0	5	3	0	0	0	0	0	0	0	0	0	8
	No Specialist Qualification	0	20	3	2	0	1	1	0	0	1	0	0	28
India	Dementia degree/cert	3	1	0	0	0	0	0	0	0	0	0	0	4
	GN MSc	0	0	0	0	0	0	0	0	0	0	0	0	0
	GN degree/dip/cert	1	2	0	0	0	1	0	0	0	0	0	0	4
	No Specialist Qualification	6	14	2	1	0	0	0	0	0	0	0	0	23
Ireland	Dementia degree/cert	1	0	0	0	0	0	0	0	0	1	0	0	2
	GN MSc	0	1	0	0	0	0	0	0	0	0	0	4	5
	GN degree/dip/cert	1	0	0	0	0	0	0	0	0	1	5	2	9
	No Specialist Qualification	3	1	2	4	0	0	0	1	0	1	2	1	15
UK	Dementia degree/cert	0	0	0	0	0	0	0	0	0	0	0	0	0
	GN MSc	0	0	0	0	0	0	0	0	0	0	0	1	1
	GN degree/dip/cert	0	0	2	0	0	0	1	0	0	0	0	2	5
	No Specialist Qualification	1	2	3	0	0	0	0	0	0	0	1	0	7
Others	Dementia degree/cert	0	1	0	0	0	0	0	0	0	0	0	0	1
	GN MSc	0	1	0	1	0	0	0	0	0	0	0	0	2
	GN degree/dip/cert	0	1	0	0	0	0	0	0	1	0	0	0	2
	No Specialist Qualification	1	1	1	1	0	0	0	0	0	0	0	0	4

Nursing Grade

Length Employed in Current Hospital (years)

6.3.1. Exploration of Association within the Demographic Data

A Mantel-Haenszel linear-by-linear association test was run on the ordinal demographic characteristics. This test is valid even when a Chi-square test of independence is not, provided the total number of observations is at least 30. Many of these linear associations appear to be intuitive, for example, in that the longer the nurse was qualified, the longer they worked in a particular area, for a particular hospital. The correlation analysis of the demographic characteristics was conducted via Spearman's rho, note that a correlation greater than 0.8 is generally described as *s*trong, whereas a correlation less than 0.5 is generally described as weak. This analysis compliments the above Mantel-Haenszel linear-by-linear association test, and allows for further interpretation of the associations between the characteristics, *i.e.*, we can now see how strong/weak this relationship is. This analysis showed that the age group of the nurses related to length of time qualified ($\rho = 0.77$, $p<0.01$), length of time in this area ($\rho = 0.28$, $p< 0.01$), and length of time in this hospital ($\rho = 0.44$, $p<0.01$). Length qualified is related to both length in this area ($\rho = 0.30$, $p<0.01$) and length in this hospital ($\rho = 0.45$, $p<0.01$). Length of time in this area and length of time in this hospital are also related ($\rho = 0.56$, $p<0.01$).

Next a Monte-Carlo Method of simulation was used to explore any further association between the demographic variables. This technique is used when the assumptions of a Chi-square test of independence are violated; it repeatedly samples in order to obtain an unbiased estimate of the true *p*-value. Data is simulated and a Fisher Exact test statistic is calculated. There was a significant difference between the number of staff nurses who held a Gerontological Nursing (GN) degree/diploma(dip/certificate(cert) (14.8%) and the number of CNM1s who held the same qualification (50%), this number also differed significantly from the CNM2/CNS/management group (47.6%).

There was also a significant difference between the number of staff nurses who held no specialist qualifications (71%) and the number of CNM1 who held no specialist qualification either (50%). This number also differed with the number of CNM2/CNS/management who held no specialist qualification either (28.5%).

There was a significant difference between the numbers of years worked in a particular area by staff nurses, the majority of staff nurses worked in their particular area for 1-5 years (29.7%) and 6-10 years (53.4%), compared with the 16-25 years bracket ($\chi^2=15.73$, $p=0.005$).

CNM2/CNS/management were employed by the same hospital for the longest number of years, whilst the majority of staff nurses were employed by the same hospital for the lower group of years (χ^2=22.492, p<0.001). Lastly, looking at the nursing grade and country of nursing education, there was a significant relationship (χ^2=43.25, p<0.001). The number of Philippine educated (n=37) and Indian educated (n=30) staff nurses was significantly higher than the number of Irish educated (n=13) and UK educated (n=8) staff nurses. In addition, the number of CNM2/CNS/management nurses Philippines educated (n=1) and Indian educated (n=0) was significantly lower than the number of Irish educated (n=17) and UK educated (n=3) CNM2/CNS/management nurses.

To complete the analysis, it was decided to explore smaller groupings of the demographic characteristics. A Chi-square test of independence was used for the following analyses. There was a significant relationship between specialist qualifications (there were two categories here: Specialist Qualifications and No Specialist Qualifications) and the nursing grade (two categories: Staff Nurses and CNMs/CNS/management) (χ^2=13.208, p<0.001) indicating that these groups are not independent. As a Chi-square test of Independence only shows a relationship between two variables and does not state the relationship, the odds ratio for this was calculated; the odds of having a specialist qualification for a CNMs/CNS/management role were 4.96 times than that of a staff nurse having specialist qualifications (χ^2=5.584, p<0.05). The odds ratio also indicated that the odds of having a specialist qualification for an Irish/UK educated nurse, is 2.55 times than that of an Indian/Philippine educated nurse. There was also a significant relationship reported between nursing grade and country of education (χ^2=31.532, p<0.001); the odds of being a CNM/CNS/management for an Irish/UK educated nurse is 17.54 that of an Indian/Philippine educated nurse.

6.4.   Analytical Techniques for Questionnaires

As outlined in chapter five (section 5.6) as the data was measured using Likert scales, which may be considered to be interval in nature (Carifio and Perla, 2007, 2008; Norman, 2010), parametric tests, were applied to the data in order to compare variability between the demographic characteristics. According to Pallant (2010) ANOVA is useful for assessing group differences but it does not show where the significant difference is. However, post hoc comparisons can be conducted which will demonstrate which groups are significantly different from the others (Pallant, 2010). Independent t -tests were used to compare the

means for two groups of cases. Note that where the assumptions of the parametric tests were violated, appropriate non-parametric analyses were used to include, Kruskal-Wallis H and Mann Whitney U tests. The level of significance was set by α- level $< .05$ in order to minimise the possibility of a Type I or Type II error. A Type I error occurs when the null hypotheses is rejected when it is true, a Type II error occurs when the null hypotheses is not rejected when it is false (Parahoo, 2006; Corty, 2007).

6.5.   Nurses Views and Opinions about Dementia Care Nursing Based on their Experiences of Caring for the Older Person with Dementia in Non-dementia Specific Units

The Satisfaction with Nursing Care and Work Assessment Scale (SNCW) was employed to explore nurses' views and opinions regarding various aspects of dementia care nursing. Preliminary analysis indicated that the data was normally distributed with a non-significant Shapiro-Wilk statistic being reported ($SW=.067$, $p>0.05$). In addition, the total score and the totals of the sub-scale were examined for outliers and as there were only a small number, it was decided to run the analyses with the complete dataset. Internal consistency of the SNCW is discussed in chapter five (section 5.5.4). In the current study internal consistency was achieved (α =.901). A Cronbach's alpha co-efficient was also calculated for the five sub-scales and is displayed, along with descriptive statistics, in Table 6.4. The SNCW was scored as outlined in chapter five (section 5.5.4). The SNCW questions are consistent with the emergent themes from the literature review as discussed in chapter five (section 5.5.4).

Table 6.4   Measures for the (SNCW)

SNCW	Response Rate *n* (%)	Range of Scores	Mean	SD	No of Items	Cronbach's Alpha
Total Score	122 (94.5%)	77-152	117.97	14.06	32	.901
Work Co-operation	126 (97.6%)	15-39	28.91	4.72	8	.810
Knowledge of Patients	129 (100%)	12-25	18.02	2.70	5	.581
Personal and Professional Development	128 (99.2%)	10-30	23.47	3.71	6	.847
Quality of Care	127(98.4%)	22-44	34.06	4.30	9	.742
Workload and Work Satisfaction	127 (98.4%)	6-19	13.32	2.99	4	.648

It has to be noted that it can be difficult to obtain a reasonable Cronbach's alpha, *i.e.* $\alpha > .7$, for scales with a small number of items (Pallant, 2010). However overall the individual sub-scales are satisfactory.

6.5.1. (SNCW) Total Score

A total of 94.5% (*n*=122) of respondents completed all 32 items. The total theoretical score ranges between 32 and160, and higher scores indicate higher satisfaction. In this study the scores ranged between 77 and 152 (*mean*=117.97, *SD*=14.06). These scores indicated that the majority of the respondents' held views and opinions about dementia care nursing that were positive.

A series of one-way ANOVAs were conducted to compare the total scores of the SCNW with the demographic characteristics of the respondents. These proved to be non-significant (*p*=0.05, with non-significant *F*-values).   The Levene's statistics, which indicates homogeneity of variances, were non-significant for all demographic characteristics except nursing grade and type of ward currently working on. In relation to nursing grade, as homogeneity could not be assumed Games-Howell post hoc tests were used, where local homogeneity could be assumed Gabriel's test was used. These tests revealed a non-significant difference between the nursing grade groups. This was also the case for the type of ward that the respondent currently worked on.

In Fig. 6.1 it is noted that the majority of the total scores of the respondents cluster towards the positive end of the scale and in Fig. 6.2 it can be seen that the respondents choose "agree" for the majority of the questions.
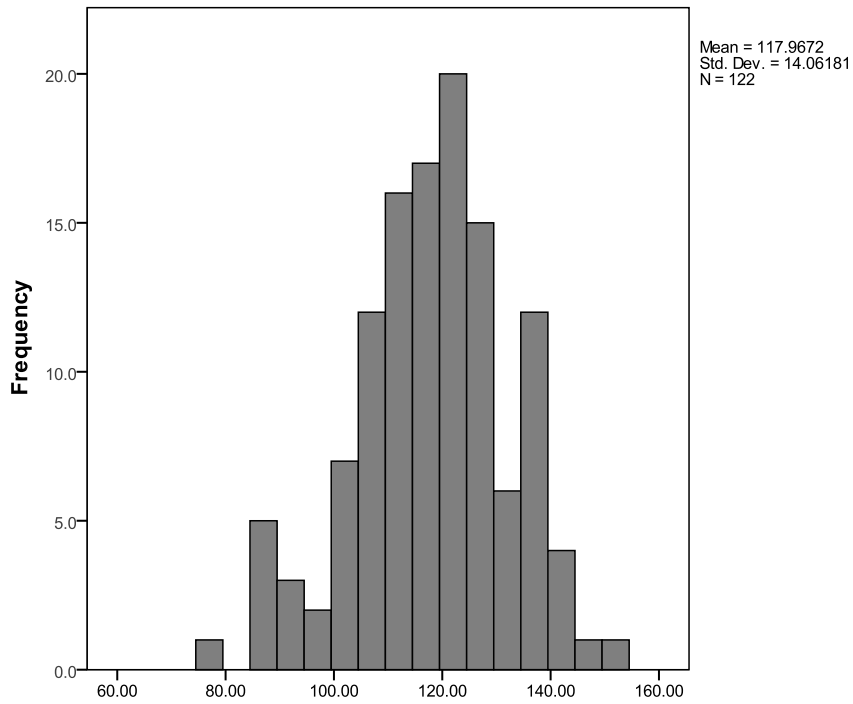
Fig. 6.1   Total Scores of the SNCW by frequency.
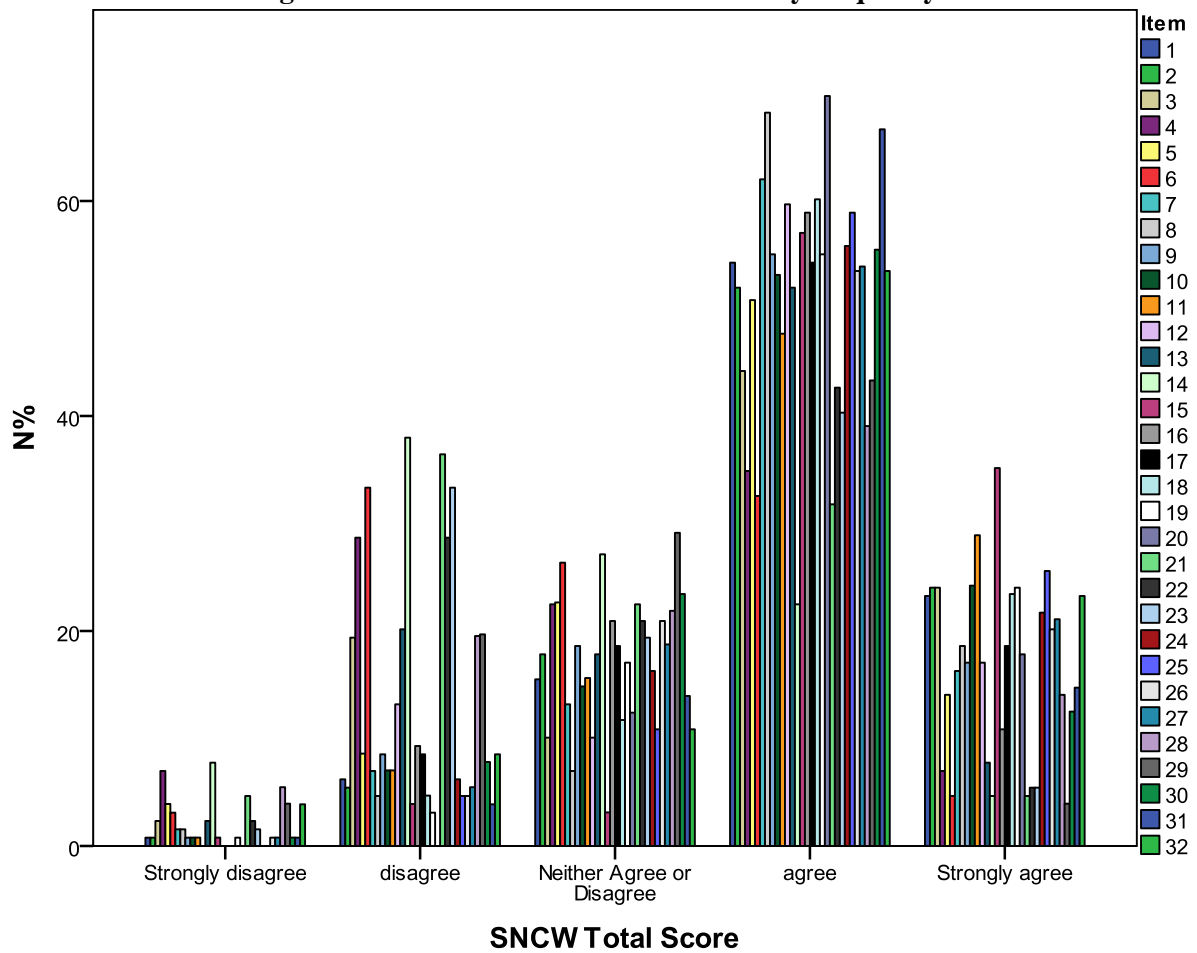
Fig. 6.2   SNCW scale broken down by item.

6.5.2. Work Co-operation (Social Integration)

In this sub-scale, items were completed by 97.6% (n=126) of the respondents. The total theoretical score ranges between 8 and 40, and higher scores indicate higher satisfaction. The range for this study was between 15 and 39 (*mean*=28.91, *SD*=4.72). Thus indicating that the majority of respondents held views and opinions that both the quality of and quantity of social integration at work were positive. In this sub-scale, item 6 was negatively scored and reverse coded. Table 6.5 gives a summary of the descriptive statistics and also a breakdown of response rates for each item. Preliminary analysis indicates that the data is not normally distributed with a significant Shapiro-Wilk statistic being reported (*SW*=.111, *p*=0.01).

Table 6.5   Work Co-operation descriptive statistics and items

Work Co-Operation					
Response Rate *n* (%)		**Range**	**Mean**	**SD**	**No of Items**
126 (97.6%)		15-39	28.91	4.72	8
Item	***n***	**Strongly Agree/ Agree (n) (%)**	**Neither Agree/ Disagree (n) (%)**	**Strongly Disagree/ Disagree (n) (%)**	
5. My opinions are considered when changes are made at work	128	83 (64.8%)	29 (22.4%)	16 (12.5%)	
6. I worry that my own job situation will change because of changes to the organization	129	47 (36.5%)	34 (26.5%)	48 (37.2%)	
9. Our work organization is good	129	93 (72%)	24(18.6%)	12 (9.3%)	
10. Our staff work well together	128	99 (77.3%)	19 (14.8%)	10 (7.8%)	
11. There is a friendly atmosphere at work	128	98 (76.5%)	20 (15.5%)	10 (8%)	
14. There are enough opportunities at work to discuss the psychological stress of the job	129	35 (27.3%)	35 (27.3%)	59 (45.7%)	
25. I enjoy my current work situation	129	109 (84.4%)	14 (10.8%)	6 (4.6%)	
30. My colleagues value what I do at work	128	87 (67.9%)	30 (23.4%)	11 (8.5%)	

NB. Question 6 is reverse coded.

A series of one-way Kruskal-Wallis H ANOVAs was conducted to compare the total scores of the sub-scale Work Co-operation with the grouped demographic characteristics of the

respondents. These proved to be non-significant (p=0.05). As the Kruskal-Wallis H test is robust to the violations of the assumption of homogeneity of variance between the groups, there is no need to check for this.

In Fig. 6.3 it is noted that the majority of the total scores of the respondents cluster towards the lower end of positive scoring indicating that the responses here averaged to the nurses expressing more positive opinions and views as measured by this scale. From Fig. 6.4 we can see that the respondents choose "agree" for the majority of the items. However, items 6 and 14 had large numbers responding with "disagree". Item 6, which is negatively worded and hence reverse coded, stated: "I worry that my job situation will change because of changes to the organisation" with almost equal numbers of respondents disagreeing (37.2%) and agreeing (36.5%) and just over a quarter (26.5%) neither agreeing nor disagreeing. The most negative statement (item 14) within this domain was in relation to opportunities to discuss the psychological stress of the job with 45.7% disagreeing with the statement "there are enough opportunities to discuss the psychological stress of the job". Here, there were only 27.3% in agreement and 27.3% neither agreeing nor disagreeing with this statement. With 27.3% neither agreeing or disagreeing regarding the opportunity to discuss the psychological stress of the job, the picture is somewhat indistinct.
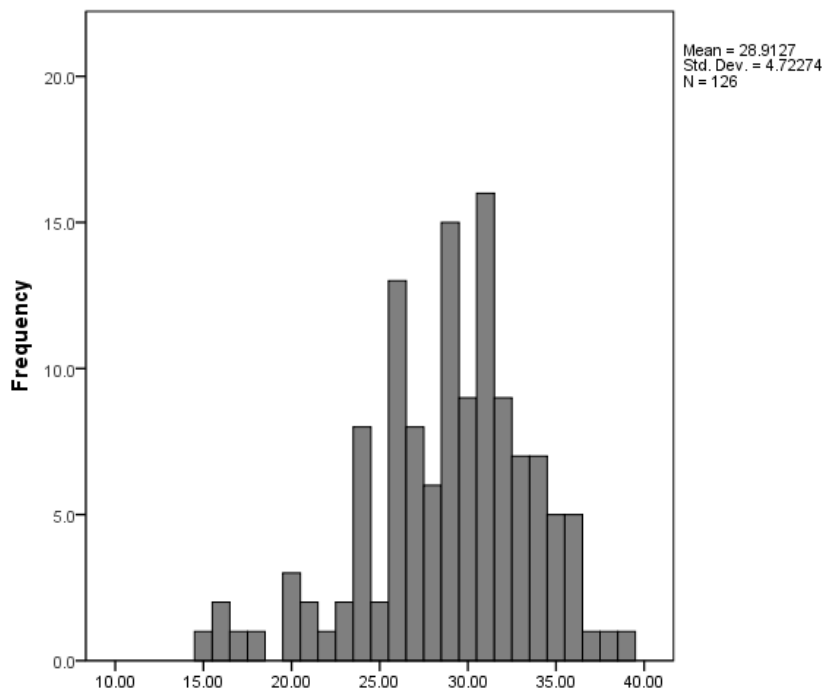
Fig. 6.3   Total Scores of Work Co-operation by frequency.

Work Co-Operation Sub-Scale
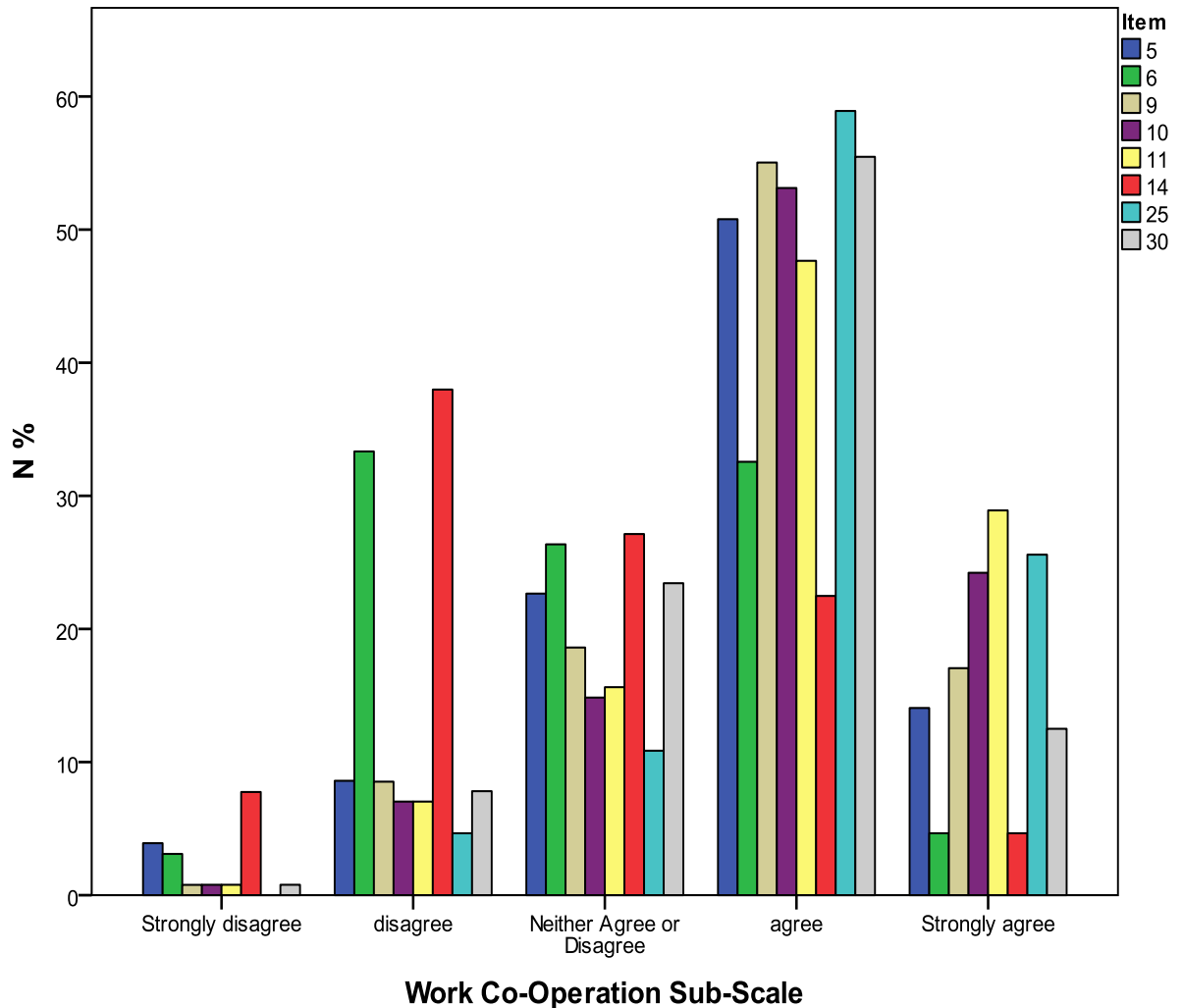
Fig. 6.4   **Work Co-operation Sub- scale broken down by item.**

6.5.3. Knowledge of Patients (Communication)

This sub-scale was completed by 100% of the respondents. The total theoretical score ranges between 5 and 25, and higher scores indicate higher satisfaction. In this study the scores ranged between 12 and 25 (*mean*=18.02; *SD*=2.70) suggesting that the majority of respondents replied positively to the items on this sub-scale. Table 6.6 gives a summary of the descriptive statistics and also a breakdown of response rates for each question. Preliminary analysis indicates that the data was not normally distributed with a significant Shapiro-Wilk statistic being reported (*SW*=.163, *p*<0.01)

Table 6.6   Knowledge of Patients' descriptive statistics and items

Knowledge of Patients

Response Rate *n* (%)		Range	Mean	SD	No of Items
129 (100%)		12-25	18.02	2.70	5

Item	*n*	Strongly Agree/ Agree (n) (%)	Neither Agree/ Disagree (n) (%)	Strongly Disagree/ Disagree (n) (%)
12. I often feel that I know too little about the patients'/residents' disease and treatment	129	17 (13%)	13(10%)	99 (76.7%)
13. I often feel that I know too little about the patients'/residents' personal background, habits and wishes	129	29 (22.5%)	23 (17.8%)	77 (59.6%)
21. It is too much to expect that I can involve myself with every patient/resident	129	53 (41%)	29(22.4%)	47 (36.4%)
24. It is boring to work with the same patients/residents every day	129	8 (6.2%)	21 (16.2%)	100 (77.5%)
31. My colleagues often ask me for information I can give about particular patients	129	105 (81.3%)	18 (13.9%)	6 (4.6%)

NB.   Questions 12, 13, 21 and 24 are reverse coded.

Mean = 18.0233
Std. Dev. = 2.70262
N = 129
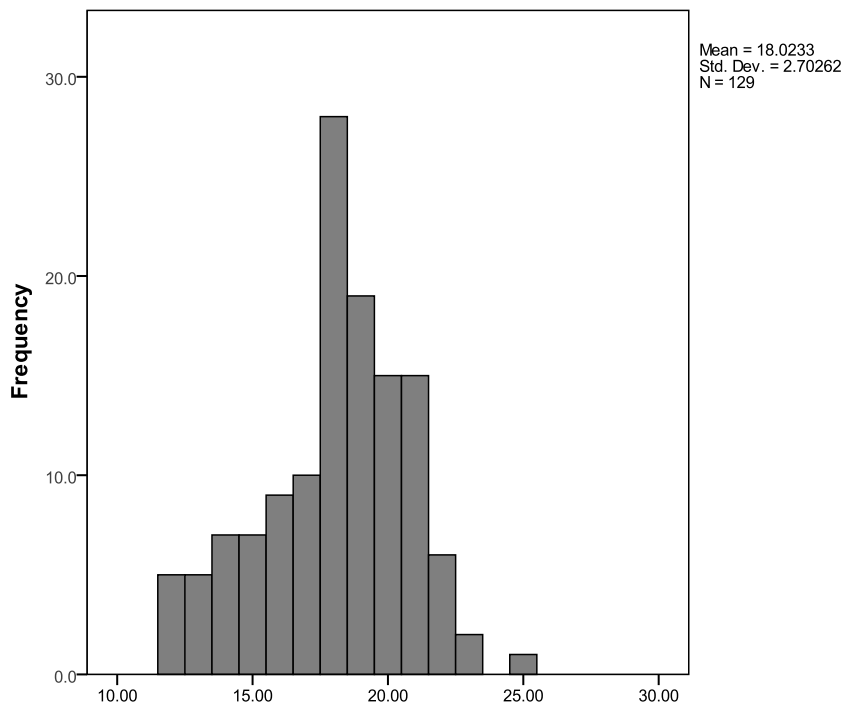
Fig. 6.5   Total Scores of Knowledge of Patients by frequency.

In Fig. 6.5 it is noted that the majority of the total scores of the respondents are skewed towards the more positive end of the scale. From Fig. 6.6 we can see that the respondents choose "agree" for the majority of the items, although it is evident that the "neither agree or disagree" and "disagree" responses are causing the overall mean to reflect a less positive overall picture.
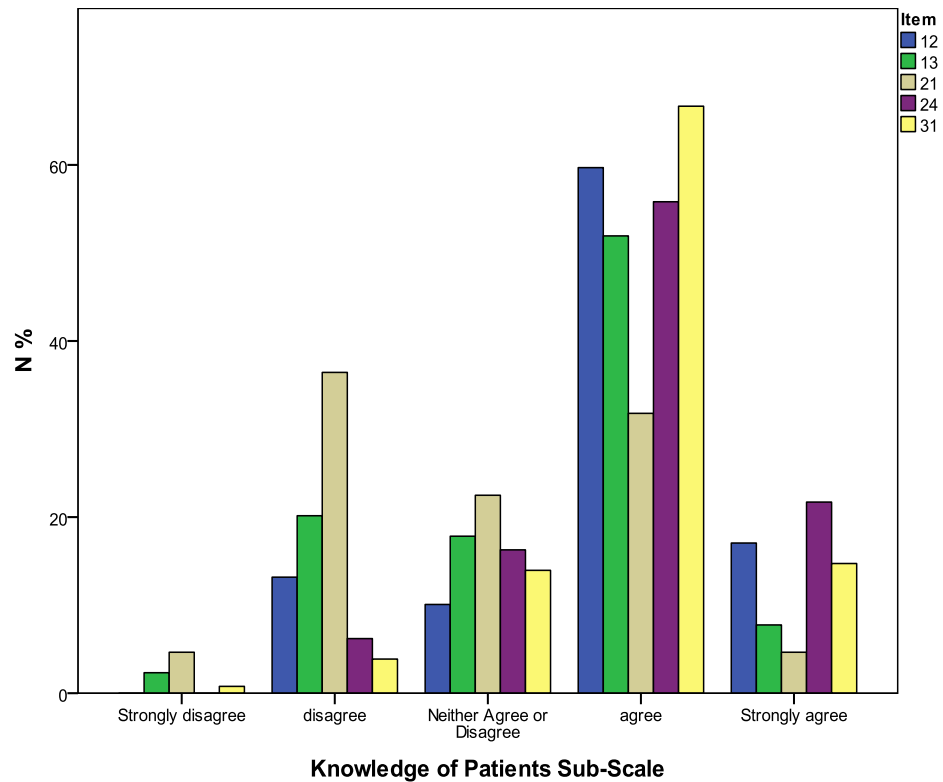
Fig. 6.6   Knowledge of Patients broken down by item.

A series of one-way Kruskal-Wallis H ANOVAs was conducted to compare the total scores of the sub-scale of Knowledge of Patients with the demographic characteristics of the respondents. The Kruskal-Wallis H test showed that there was a statistically significant difference in Knowledge of Patients score between the different groupings by length of time qualified (these were broken down into six groups: 1-5 years (mean rank=34.08), 6-10 years (mean rank=60.29), 11-15 years (mean rank=79.14), 16-20 years (mean rank=53.97), 21-25 years (mean rank=67.97), and 26-40 years (mean rank=68.31), $(\chi^2 (5)=13.45, p=0.02)$. Further analysis using Mann-Whitney U showed that there was a significant difference between groups 1-5 years and 11-15years, $(U=38.0, p<0.01)$. This indicates that the latter group were more positive regarding the Knowledge of Patients sub-scale as they scored a higher mean value than the 1-5 years group. In addition, there was a significant difference

between the groups 1-5 years and 26-40 years, (U=18.5, p=0.27), and a significant difference between the groups 11-15 years and 16-20 years, (U=449.0, p<0.01).

There was also a significant difference of the sub-scale between the type of ward the respondent worked in; these were grouped as: Acute/Admission (mean rank=42.28), Rehab (mean rank=61.48), Residential (mean rank=77.39), and Other (mean rank=63.39), (U=511.5,p=0.04). Further analysis using Mann-Whitney U showed that there was a significant difference between the Acute/Admission and the Residential groups (U=196.5, p<0.01). This indicates that those working in Residential were more positive than those working in Acute/Admissions regarding the Knowledge of Patients sub-scale as they scored a higher mean value. There was also a significant difference between the Rehab group and the Residential group, (U=805.0, p=0.048).

Exploration of the individual items revealed that according to the respondents, communication is very positive between colleagues, the most agreed statement was "My colleagues often ask me for information" with 81.3% agreement and, furthermore they believed that their knowledge about their patients' disease and treatment was satisfactory with 77% strongly disagreeing/disagreeing that they knew too little. When it came to knowledge about the patients/residents personal background, habits and wishes, the level of disagreement with this statement reduced to 59.6%.

6.5.4. Personal and Professional Development (Self-Concept)

Within this sub-scale items were completed by 99.2% of respondents (n=128). The total theoretical score ranges between 6 and 30, and higher scores indicate higher satisfaction. In this study the scores ranged between 10 and 30 ($mean$=23.47; SD=3.71) and were skewed towards the upper end of the range, reflective of generally more positive views and opinions in relation to personal and professional development. Table 6.7 gives a summary of the descriptive statistics and also a breakdown of response rates for each item. Preliminary analysis indicates that the data was not normally distributed with a significant Shapiro-Wilk statistic being reported (SW=.166, p<0.01).

Table 6.7   Personal and Professional Development descriptive statistics and items

Personal and Professional Development

Response Rate *n* (%)		Range	Mean	SD	No of Items
128 (99.2%)		10-30	23.47	3.71	6

Item	*n*	Strongly Agree/ Agree (n) (%)	NeitherAgree/ Disagree (n) (%)	Strongly Disagree/ Disagree (n) (%)
1. My duties at work are stimulating	129	100 (77.5%)	20 (15.5%)	9 (6.9%)
2. My duties at work are varied	129	98(75.9%)	23 (17.8%)	8 (6.2%)
7. I am satisfied with the independence I have in my job	129	101 (78.2%)	17(13%)	11 (8.5%)
8. I am satisfied with the responsibility I have in my job	129	112 (86.8%)	9 (6.9%)	8(6.2%)
26. I feel that I am developing as a person from my work here	129	95 (73.6%)	27(20.9%)	7 (5.4%)
27. I feel that I am developing professionally from my work here	128	96 (75%)	24(18.7%)	8 (6.2%)

A series of one-way Kruskal-Wallis H ANOVAs was conducted to compare the total scores of the sub-scale of Personal and Professional Development with the demographic characteristics of the respondents. The Kruskal-Wallis H test showed that there was a statistically significant difference in Personal and Professional Development score between the different groupings of nursing grade: Staff Nurse mean rank=59.79; CNM1 mean rank=57.42; CNM2/CNS/management mean rank=85.14);(χ^2 (2)=9.11, *p*=0.011). Further analysis using Mann-Whitney U showed that there was a significant difference between the staff nurses and the CNM2/CNS/management nurses (*U*=628.5, *p*=0.004), and between the CNM2/CNS/management nurse and CNM1 nurses (*U*=23.5, *p*=0.018). This indicates that the CNM2/CNS/management nurses expressed more positive views in relation to their personal and professional development in comparison to the other groups.

In Fig. 6.7 it is noted that the majority of the total scores of the respondents cluster towards the more positive end of the range. From Fig. 6.8 we can see that the respondents choose "agree" for the majority of the items. Overall the views and opinions of the respondents regarding personal and professional development were very positive, as reflected by the high response in the strongly agree and agree.

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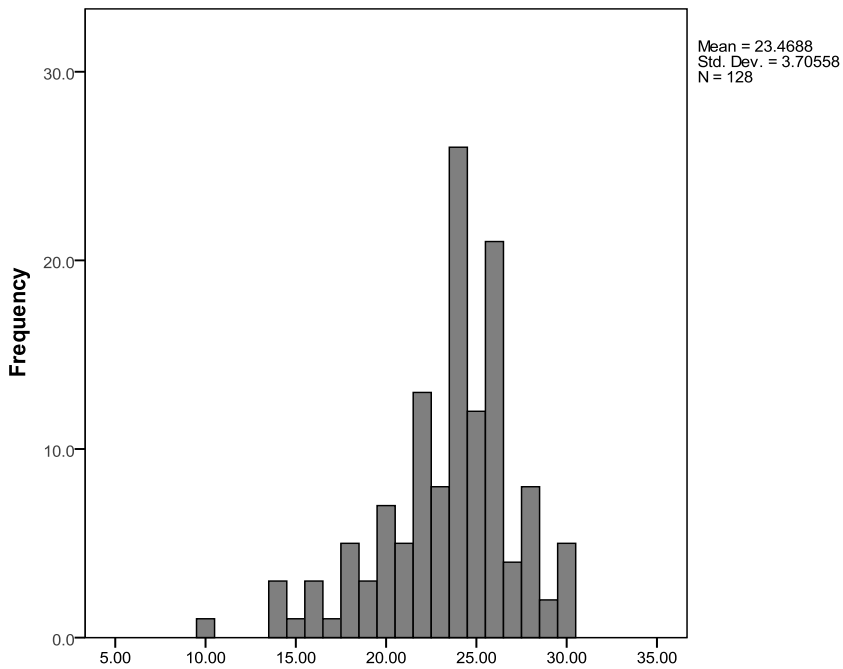
Fig. 6 7   Total Scores of Personal & Professional Development by frequency.
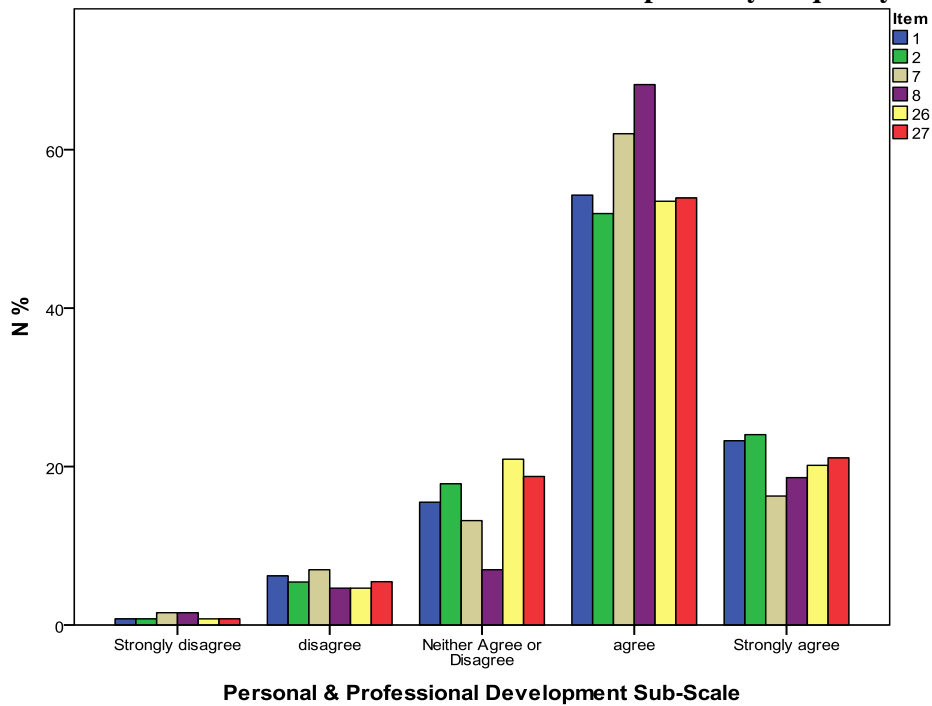
Fig. 6. 8   Personal & Professional Sub-Scale broken down by item

6.5.5. Quality of Care (Participation)

For this sub-scale items were completed by 98.4% (n=127) of respondents.   The total theoretical score ranges between 9 and 45, and higher scores indicate higher satisfaction.   In this study the scores ranged between 22 and 44 (*mean*=34.06; *SD*=4.30) suggesting that the

majority of respondents replied more positively towards the items in this sub-scale. Table 6.8 gives a summary of the descriptive statistics and also a breakdown of response rates for each item. Preliminary analysis indicates that the data is normally distributed with a non-significant Shapiro-Wilk statistic being reported (*SW*=.074, *p*=0.081).

Table 6.8   Quality of Care descriptive statistics and items

Quality of Care					
Response Rate *n* (%)		**Range**	**Mean**	**SD**	**No of Items**
127 (98.4%)		22-44	34.06	4.30	9
Item	***n***	**Strongly Agree/ Agree (n) (%)**	**NeitherAgree/ Disagree (n) (%)**	**Strongly Disagree/ Disagree (n) (%)**	
15. The patients/residents at work nearly always receive good care	128	118(92%)	4(3%)	6(5%)	
16. The patients/residents are given enough information about their disease	129	90(69.7%)	27(21%)	12(9.3%)	
17. The patients/residents are given enough information before examinations and treatments	129	94(72.8%)	24(18.6%)	11(8.5%)	
18. Newly admitted patients /residents are given enough information about the routine in the place where I work	128	107(83.5%)	15(11.7%)	6(4.6%)	
19. Relatives are given enough information about care and treatment	129	102(79%)	22(17%)	5(4%)	
20. It is important to try and enter into the way patients/residents experience what happens to them	129	113(87.5%)	16(12.4%)	0(0%)	
22. It is difficult to manage the job if you get too involved with the patients/residents	129	40(31%)	27(20.9%)	62(48%)	
23. I seldom have time to try and understand what the patients/residents think about our care	129	45(34.8%)	25(19.3%)	59(45.7%)	
32. We often discuss ways of improving the care we give (e.g. alternative care methods, setting care goals, changing the work routine)	129	99(76.7%)	14(10.8%)	16(12.4%)	

NB. Items 22 and 23 were reverse coded.

In Fig. 6.9 it is noted that the majority of the total scores of the respondents cluster towards the positive end of the range. From Fig. 6.10 we can see that the respondents choose "agree" for the majority of the items.

Mean = 34.0551
Std. Dev. = 4.29711
N = 127
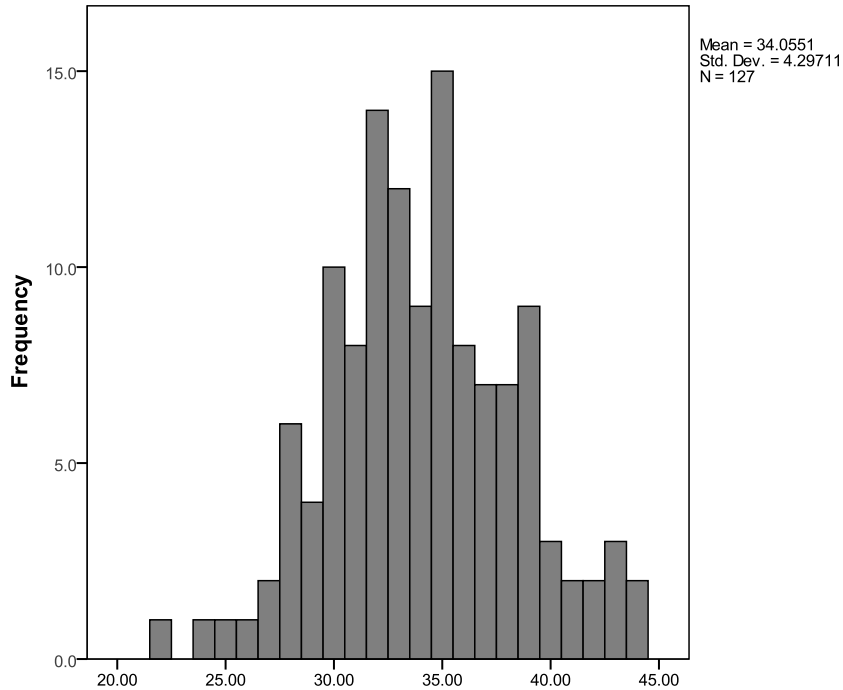
Fig. 6.9   Total Scores of Quality of Care by frequency.

A series of one-way ANOVAs was conducted to compare the total scores of the sub-scale Quality of Care with the demographic characteristics of the respondents. These proved to be non-significant ($p=0.05$, with non-significant F-values). All the Levene's statistics were non-significant indicating homogeneity of variances.
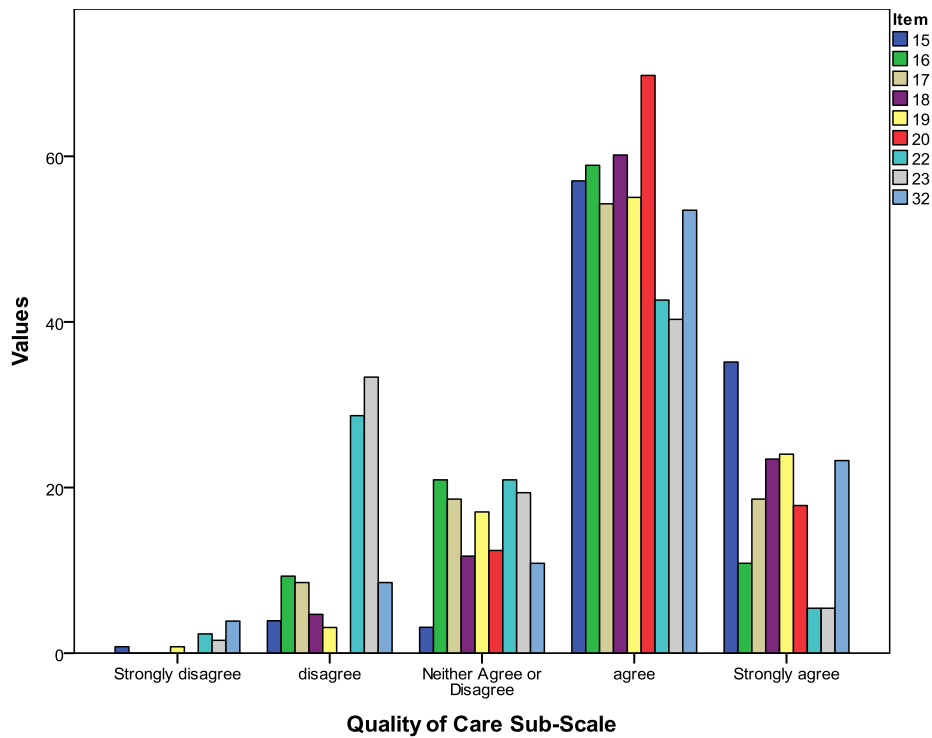
Fig. 6.10 **Quality of Care Sub-Scale broken down by item**.

6.5.6. Workload and Work Satisfaction (Achievement)

The sub-scale statements were completed by 98.4% (*n*=127) of the respondents. The total theoretical score ranges between 4 and 20, and higher scores indicate higher satisfaction. In this study the scores ranged between 6 and 19 (*mean*=13.32, *SD*=2.99) and tended toward the positive end of the range. Table 6.9 gives a summary of the descriptive statistics and also a breakdown of response rates for each question. Preliminary analysis indicates that the data is not normally distributed with a significant Shapiro-Wilk statistic being reported (*SW*=.114, *p*<0.001).

Table 6.9   Work Load &Work Satisfaction descriptive statistics and items

Work Load & Work Satisfaction					
Response Rate *n* (%)		**Range**	**Mean**	**SD**	**No of Items**
127 (98.4%)		6-19	13.32	2.99	4

Item	***n***	**Strongly Agree/ Agree *n* (%)**	**NeitherAgree/ Disagree *n* (%)**	**Strongly Disagree/ Disagree *n* (%)**
3. I am able to organise my working conditions so that I can work at a pace which is comfortable to me	129	88(68.2%)	13(10%)	28(21.7%)
4. I often find that I do not complete everything that I should in my job	129	46(35.6%)	29(22.4%)	54(41.8%)
28. I often receive encouragement from others for the work I do	128	68(53%)	28(21.8%)	32(25%)
29. I often receive constructive (i.e. helpful) criticism about the work I do	127	60(47.2%)	37(29%)	30(23.6%)

NB. Item 4 was reverse coded.

A series of one-way Kruskal-Wallis H ANOVAs was conducted to compare the total scores of the sub-scale of Workload and Work Satisfaction with the demographic characteristics of the respondents. The Kruskal-Wallis H test showed that there was a statistically significant difference in Workload and Work Satisfaction score between the different groupings of nursing qualification: MSc mean rank=73.5; Degree mean rank=70.18; Pre-reg Diploma mean rank=48.39; Post-reg Diploma mean rank=53.08; and Certificate mean rank=38.71); (χ^2 (4)=10.636, *p*=0.031).   Further analysis using Mann-Whitney U showed that there was a significant difference between the nurses with a Certificate versus an MSc (*U*=13.5, *p*=0.033), versus a Degree (*U*=144.0, *p*=0.033).   Those with a Certificate rated this scale significantly lower in comparison to those with a Degree or an MSc and between the nurses with a Degree and those with a Pre-reg Diploma (*U*=476.0, *p*=0.024).

In Fig. 6.11 it is noted that the majority of the total scores of the respondents cluster towards the positive end of the range for agree/strongly agree. From Fig. 6.12 we can see that the respondents choose "agree" for the majority of the items.
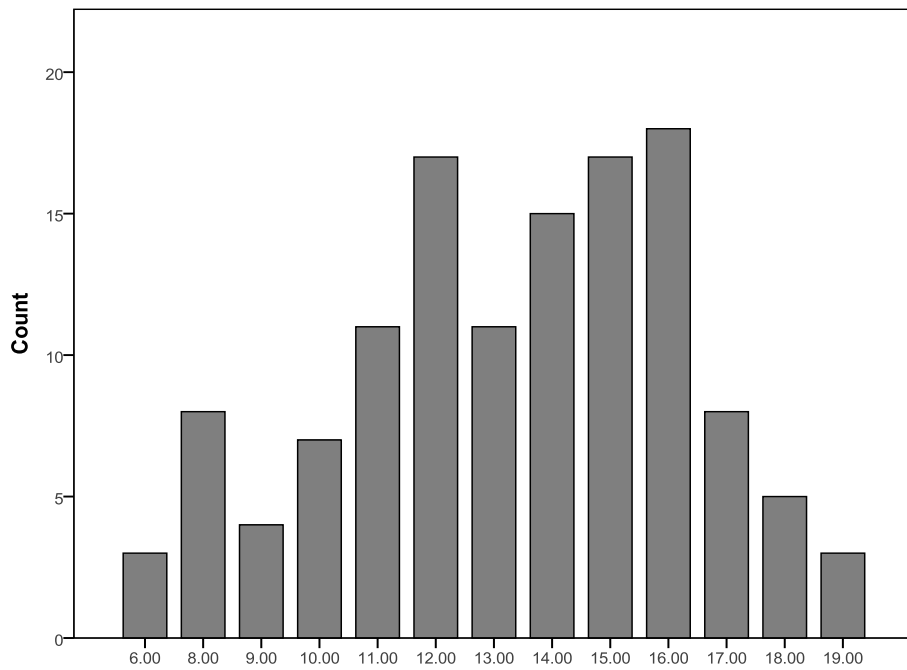
Fig. 6.11   **Total Scores of Workload & Work Satisfaction by frequency.**
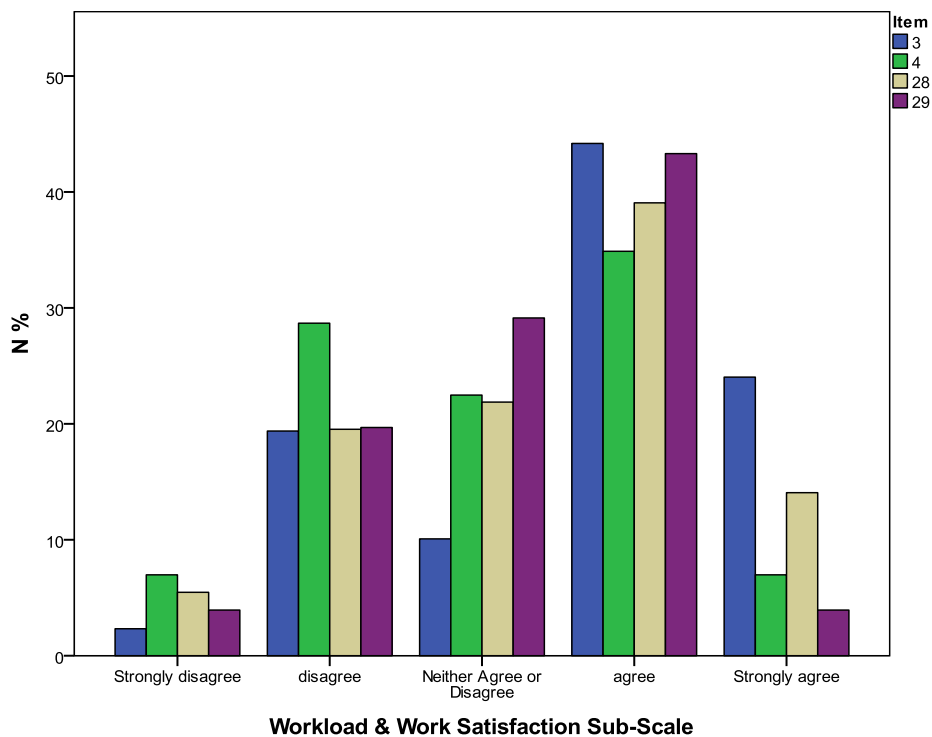
Fig. 6.12   **Workload & Work Satisfaction Sub-scale broken down by item.**

The Kruskal-Wallis H test also showed that there was a statistically significant difference in Workload and Work Satisfaction score between the different groupings of how long the nurse was employed in their current area; these were broken down into four groups: 1-5 years (mean rank=61.86), 6-10 years (mean rank=72.30), 11-15 years (mean rank=47.39), and 16-

25 years (mean rank=45.93), χ^2 (3)=9.623, p=0.022. A Mann-Whitney U test was conducted and found that there was a significant difference between nurses who were employed in their current area for 6-10 years and those employed for 11-15 years (U=414.0, p=0.008). This indicates that those employed for between 6-10 years in this area gave a higher, thus more positive rating, on the Workload and Work Satisfaction sub-scale in comparison to those who worked between 11 and 15 years.

In addition, the Kruskal-Wallis H test showed that there was a statistically significant difference in Workload and Work Satisfaction score between the different countries of nursing education; these were broken down into five groups: Philippines (mean rank=76.16), India (mean rank=70.28), Ireland (mean rank=47.82), UK (mean rank=41.50) and Other (mean rank=49.78), χ^2 (4)=18.42, p=0.001. A Mann-Whitney U test was conducted and found that there was a significant difference between nurses educated in the Philippines and those educated in Ireland (U=347.0, p=0.001) and the UK (U=121.0, p=0.004). This indicates that those educated in the Philippines gave a higher, thus more positive rating, on the Workload and Work Satisfaction sub-scale in comparison to those who were educated in Ireland or the UK. A Mann-Whitney U test was conducted and found that there was a significant difference between nurses educated in India and those educated in Ireland (U=248.0, p=0.008) and the UK (U=92.0, p=0.008). This indicates that those educated in India gave a higher, thus more positive rating, on the Workload and Work Satisfaction sub-scale in comparison to those who were educated in Ireland or the UK.

As the statistical differences appeared to emanate from the countries of nursing education category, a decision was made to undertake a Mann Whitney U test to compare the means of the India and Philippine nurses (Group1) and the Irish and UK nurses (Group2). This analysis showed that there was a statistically significant difference between the India / Philippine educated group (mean rank=67.46) and the Ireland/UK educated group (mean rank=41.66) in relation to the Workload and Work Satisfaction Sub-scale (U=843.0, p<0.001). The main area of difference as presented in Table 6.10 emanated from the two work load questions where there was higher levels of agreement from those educated in the Philippines and India that the work pace was comfortable and that they achieved job completion during their working day.

Table 6.10   Work Load & Work Satisfaction

Item	n	Strongly Agree/ Agree n (%)	Neither Agree/ Disagree n (%)	Strongly Disagree/ Disagree n (%)
3. I am able to organise my working conditions so that I can work at a pace which is comfortable to me				
Philippines	40	33 (82.5%)	2 (5%)	5 (12.5%)
India	31	26 (83.87%)	2(6.45%)	3(9.67%)
Ireland	31	12 (38.7%)	6 (19.35%)	13 (41.93%)
UK	13	8 (61.53%)	0	5 (38.4%)
Other	9	5 (55.5%)	2(22.2%)	2 (22.2%)
4. I often find that I do not complete everything that I should in my job				
Philippines	40	7 (17.5%)	14 (35%)	19 (47.5%)
India	31	7 (22.5%)	8 (25.8%)	16 (51.6%)
Ireland	31	21(67.74%)	1 (3.2%)	9 (29.03%)
UK	13	1 0(76.92%)	2 (15.38%)	1 (7.69%)
Other	9	1(11.1%)	4 (44.4%)	4 (44.4%)

6.5.7   Summary

In summary, and in answer to the research question, the nurses' views and opinions about dementia care nursing in the identified setting, were generally positive with a total mean score of 117.97 (*SD*=4.72) out of a possible 160. Considering scores within the five sub scales, positive views and opinions were evident in all of the sub scales.

Significant, statistical differences were noted in relation to the sub scales Knowledge of Patients, Personal and Professional Development and Workload and Work Satisfaction. More positive views and opinions about Knowledge of Patients were significantly correlated with those respondents qualified between 11 and 15 years and those working in Residential units. As would be expected, the most positive views and opinions regarding Personal and Professional Development correlated with those respondents at the CNM2/CNS/Mgt nursing grade.   Greater satisfaction with Work Load was significantly correlated with those respondents who held an MSc in nursing qualification, employed in the area for 6-10 years and those educated in the Philippines and India. The findings of these ANOVAS are summarised in Appendix 26.

6.6. Nurses' Attitudes towards Dementia and Nurses' Views and Opinions Based on their Experiences of Caring for Older Person with Dementia in Non-Dementia Specific Wards/Units

The instrument used to measure nurses' attitudes towards dementia and nurses' views and opinions based on their experiences of caring for the older person with dementia was the Approaches to Dementia Questionnaire (ADQ) (Lintern et al, 2000) which explores the correlation between the caregivers' attitude and behaviour. The questionnaire consists of two sub-scales, hopefulness for the person with dementia and a person-centred approach to care. The ADQ (Lintern et al, 2000) was scored as outlined in chapter five (section 5.5.5). The ADQ questions are consistent with the emergent themes from the literature review as discussed in chapter five (section 5.5.5). Internal consistency of the ADQ is discussed in chapter five (section 5.5.5). In the current study internal consistency was achieved ($a = .789$). A Cronbach's alpha coefficient was also calculated for the two sub scales and is displayed along with descriptive statistics in Table 6.11. Exploration of the data indicated no outliers and so all data points were used in the analyses. The range of scores was wide 58-93 but the median score 72.00 was very similar to the mean which was 72.73.

Table 6.11   Measures for the (ADQ)

ADQ	Response Rate *n* (%)	Range of Scores	Mean	SD	No of Items	Cronbach's Alpha
Total Score	124(96.1%)	58-93	72.73	7.51	19	.789
Hope	124(96.1%)	14-38	26.35	4.96	8	.749
Person Centred Approaches	127(98.4%)	38-55	46.33	4.31	11	.757

6.6.1. ADQ Total Score

A total of 96.1% (*n*=124) of respondents completed all 19 statements. The total theoretical score ranges between 19 and 95 and higher scores indicate positive attitudes. In this study, the mean total was 72.73 (*SD*=7.51). Thus, these scores indicated that the majority of the respondents held positive attitudes towards dementia and dementia care nursing. Further analysis was undertaken to explore for associations between the nurses' attitudes towards dementia and dementia care nursing and their demographic characteristics. Preliminary analysis indicates that the data is not normally distributed with a significant Shapiro-Wilk statistic being reported (*SW*=.951, *p*<0.001). A series of one-way Kruskal-Wallis H ANOVAs

was conducted to compare the total scores of the ADQ, with the demographic characteristics of the respondents. These proved to be significant on a number of demographic characteristics.

The Kruskal-Wallis H test showed that there was a statistically significant difference in ADQ total score between the different groupings of nursing qualifications; these were broken down into four groups: dementia degree/certificate (mean rank=68.64), GN, MSc (mean rank=80.38), GN degree/diploma/certificate (mean rank=76.52), and no specialist qualifications (mean rank=54.67), χ^2 (3)=10.248, p=0.017. A Mann-Whitney U test was conducted and found that there was a significant difference between nurses who held a GN MSc qualification and those who held no specialist qualification (U=175.5, p=0.046). There was also a significant difference between nurses with a GN degree/diploma/certificate and those with no specialist qualification (U=400.5, p=0.006). This indicates that those with specialist qualifications gave a higher, thus more positive rating, on the ADQ total scale in comparison to those with no specialist qualification.

The results of the ANOVA also indicate a statistically significant difference in the Total Score of the ADQ in relation to the Nursing Grade of the respondents; these were broken down into three groups: staff nurse (mean rank=55.16), CNM1 (mean rank=88.67), and CNM2/CNS/management (mean rank=87.15), χ^2 (2)=16.931, p<0.001. A Mann-Whitney U test was conducted and found that there was a significant difference between staff nurses and CNM1 nurses (U=145.5, p=0.036). There was also a significant difference between staff nurses and CNM2/CNS/management nurses (U=455.5, p<0.001). This indicates that staff nurses gave a lower, thus less positive rating, on the ADQ total scale in comparison to other nursing grades.

In addition, the ANOVA indicated a statistically significant difference in the Total Score of the ADQ in relation to the length of time employed in this area; these were broken down into four groups: 1-5 years (mean rank=67.33), 6-10 years (mean rank=53.25), 11-15 years (mean rank=73.30), and 16-25 years (mean rank=78.33), χ^2 (3)=8.013, p=0.046. A Mann-Whitney U test was conducted and found that there was a significant difference between nurses employed in this area for 6-10 years and those nurses employed for 11-15 years (U=461.0, p=0.016). This indicates that nurses employed in this area for 6-10 years gave a lower, thus less positive rating, on the ADQ total scale in comparison to those employed for 11-15 years.

In Fig. 6.13 it is noted that the majority of the total scores of the respondents cluster towards the positive range for agree/strongly agree. From Fig. 6.14 we can see that the respondents choose "agree" and "strongly agree" for the majority of the items.
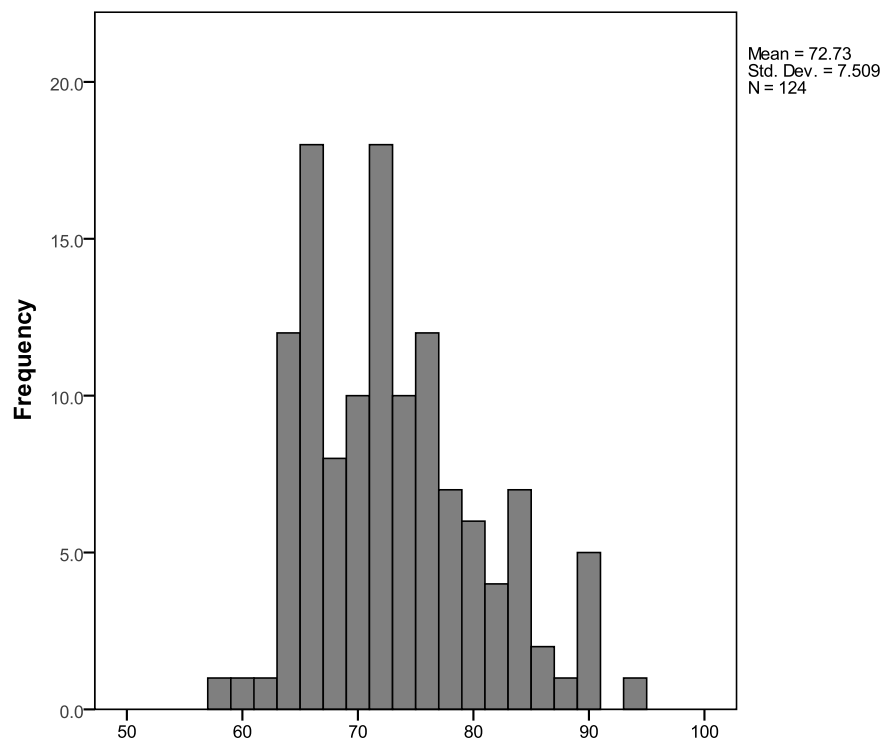
Fig. 6.13   **Total Scores of ADQ by frequency.**
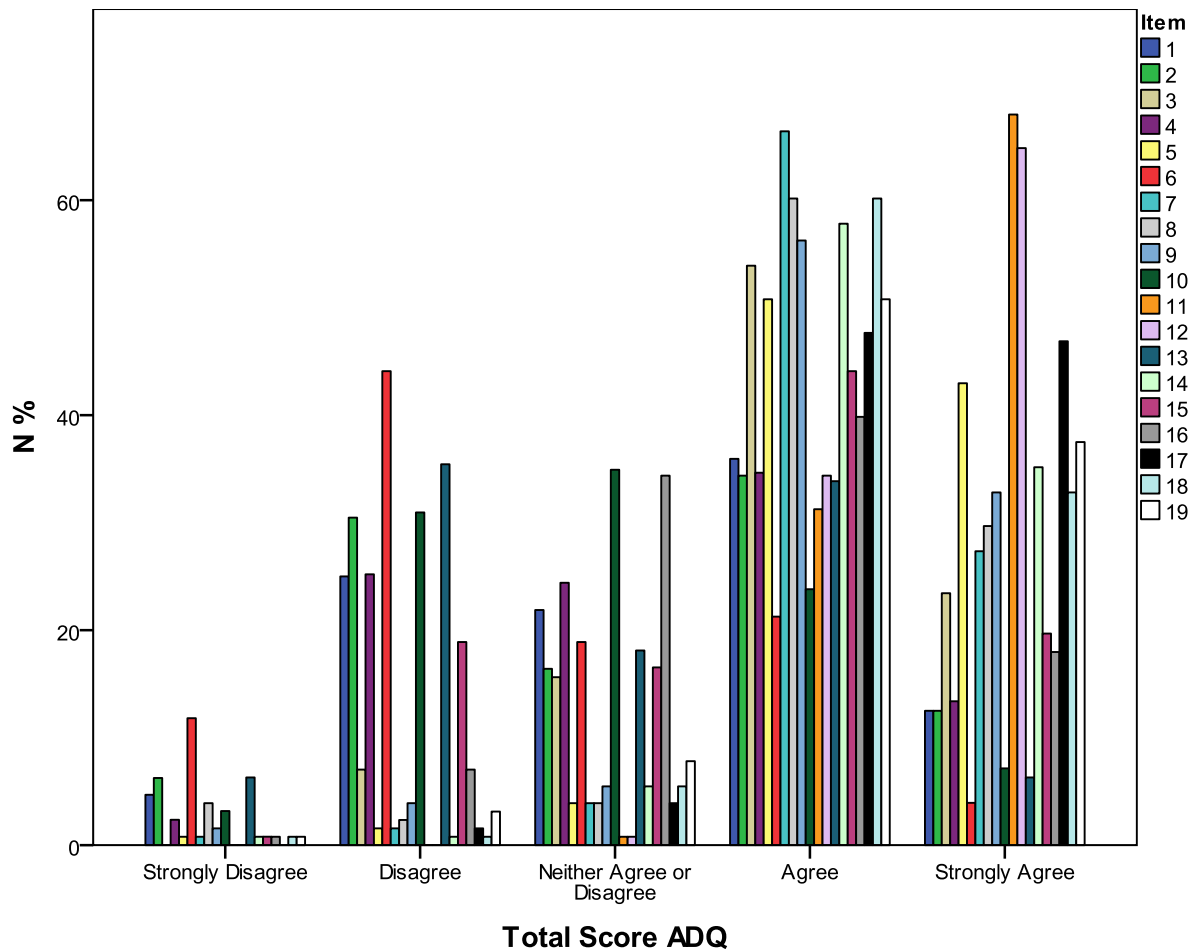
Fig. 6.14   ADQ Scale broken down by item.

As participants move between different areas in the hospital, they could have been employed in the hospital longer than in the research setting which potentially could influence their attitudes towards the older person with dementia, especially if they specifically requested to move to the research setting. A significant difference was also found in the ADQ total scores in relation to how long employed by the hospital (these were broken down into four groups: 1-5 years (mean rank=68.71), 6-10 years (mean rank=54.68), 11-15 years (mean rank=76.47), and 16-30 years (mean rank=57.78), (χ^2 (3)=8.272, p=0.041). A Mann-Whitney U test was conducted and found that there was a significant difference between nurses employed in this hospital for 6-10 years and those nurses employed for 11-15 years (U=547.0, p=0.005). This indicates that nurses employed in this hospital for 6-10 years gave a lower, thus less positive rating, on the ADQ total scale in comparison to those employed for 11-15 years.

Finally, a significant difference was noted in country of education in relation to this scale; these were broken into five groups: Philippines (mean rank=48.54), India (mean rank=43.58),

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Ireland (mean rank=84.72), UK (mean rank=78.54), and Other (mean rank=55.39), χ^2 (4) = 29.596, p<0.001. A

Mann-Whitney U test was conducted and found that there was a significant difference between nurses educated in the Philippines and those educated in Ireland (U=205.5, p<0.001). There was also a significant difference between nurses educated in India and those educated in Ireland (U=147.0, p<0.001). This indicates that nurses educated in the Philippines and India scored significantly lower than their colleagues who were educated in Ireland. A significant difference was also found between nurses educated in the Philippines and those educated in the UK (U=122.5, p=0.006). There was also a significant difference between nurses educated in India and those educated in the UK (U=75.5, p=0.001). This indicates that nurses educated in the Philippines and India scored significantly lower than their colleagues who were educated in the UK.

As the statistical differences appeared to emanate from the country of nursing education category, a decision was made to compare the means of the India and Philippine educated nurses (Group1) and the Irish and UK educated nurses (Group2). This analysis showed that there was a statistically significant difference between the India/Philippine educated group (mean rank=42.6) and the Ireland/UK educated group (mean rank=76.39) in relation to the ADQ total scale (U=550.5, p<0.001). These results indicated that those educated in the Philippines and India had significantly different attitudes towards dementia and dementia care nursing than those educated in Ireland and the UK. The findings of these ANOVAs are summarised in Appendix 27.

6.6.2. Hope

A total of 96.1% (n=124) respondents completed all eight statements for the Hope sub-scale. The total theoretical score ranges between 8 and 40, and higher scores indicate higher satisfaction. The range for this study was between 14 and 38 (*mean*=26.35, *SD*=4.96). Thus, indicating that the majority of the respondents held mixed views in relation to the hopefulness scale for older persons with dementia and dementia care nursing. Preliminary analysis indicates that the data is normally distributed with a non-significant Shapiro-Wilk statistic being reported (*SW*=.070, p>0.05). Table 6.12 gives a summary of the descriptive statistics and also a breakdown of response rates for each statement.

Table 6.12   Hope descriptive statistics and items

Hope				
Response Rate (n)	**Range**	**Mean**	**SD**	**No of Items**
124 (96%)	14-38	26.35	4.96	8

Item	**n**	**Strongly Agree/ Agree** *n (%)*	**NeitherAgree/ Disagree** *n (%)*	**Strongly Disagree/ Disagree** *n (%)*
1. It is important to have a very strict routine when working with dementia sufferers	128	38(29.6%)	28(21.8%)	62(48.4%)
2. People with dementia are very much like children	128	47 (36.7%)	21 (16.4%)	60(46.8%)
3. There is no hope for people with dementia	128	9 (7.0%)	20 (15.5%)	99 (77.3%)
4. People with dementia are unable to make decisions for themselves	128	36 (28.1%)	31(24.2%)	61 (47.6%)
6. Dementia sufferers are sick and need to be looked after	127	71 (55.9%)	24 (18.8%)	32 (25.1%)
8. Nothing can be done for people with dementia, except for keeping them clean and comfortable	128	8(6.2%)	5(3.9%)	115(89.8%)
10. Once dementia develops in a person, it is inevitable that they will go down hill	126	43 (34.1%)	44 (34.9%)	39 (30.9%)
13. It is important not to become too attached to patients/residents	127	53(41.7%)	23(18.1%)	51(40.1%)

NB.   Note items 1, 2, 3, 4, 6, 8, 10, and 13 were reverse coded

In Fig. 6.15 it is noted that the majority of the total scores of the respondents cluster towards the lower end of the positive range for agree/strongly agree. From Fig. 6.16 we can see that the respondents choose "agree" for the majority of the statements.

Mean = 26.35
Std. Dev. = 4.962
N = 124
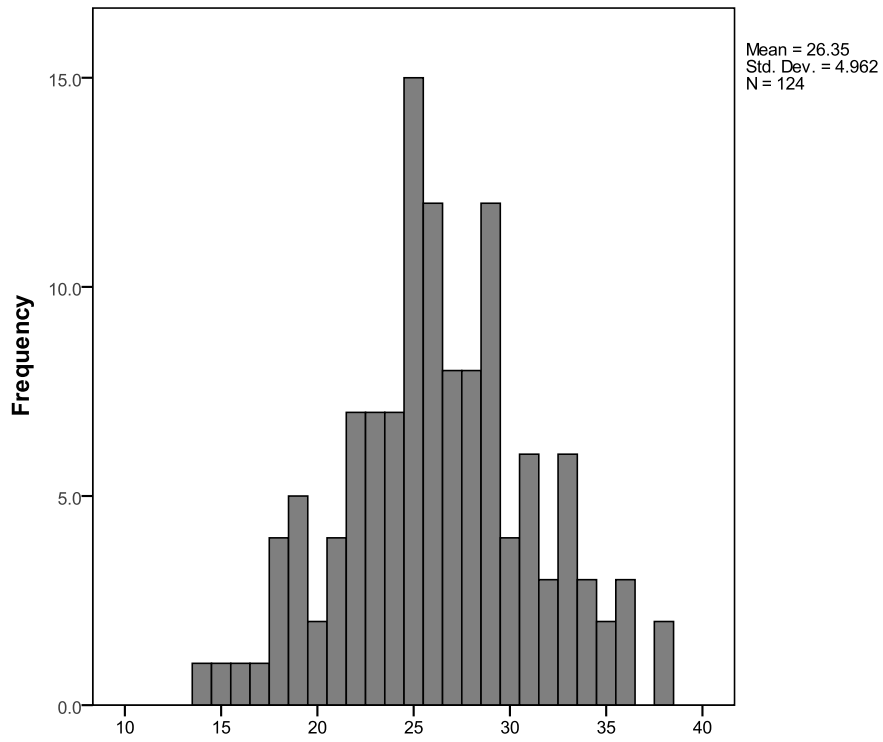
Fig. 6.15   Hope Sub-Scale of ADQ by frequency
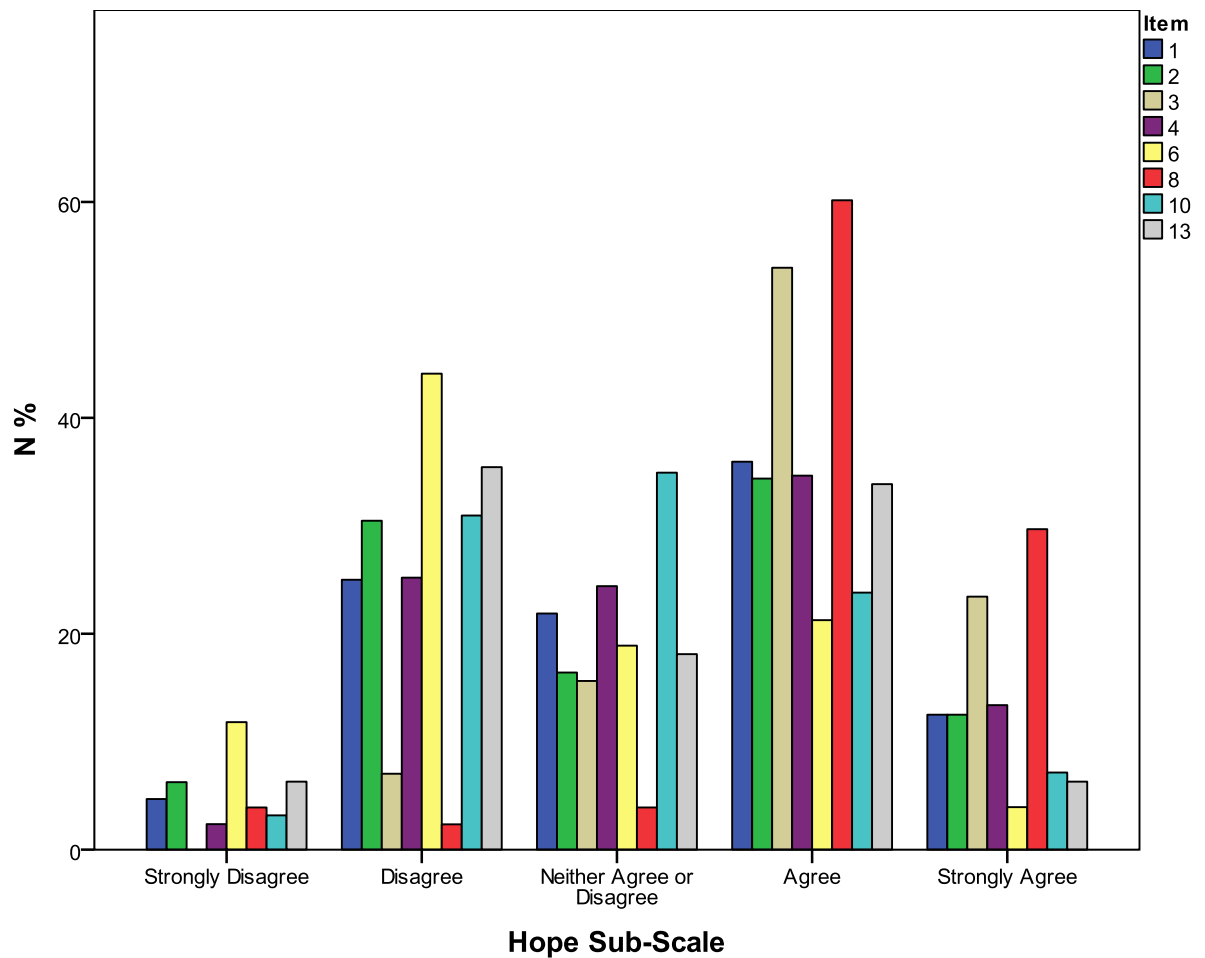
Fig 6.16   Hope Sub-Scale broken down by item

The results of the ANOVA also indicate a statistically significant difference in Hope in relation to the Nursing Grade of the respondents; these were broken down into three groups: staff nurse, CNM1, CNM2/CNS/management), $F(2,120)=8.276$, $p<0.001$.   The effect size was medium, $\eta^2=.12$.   Further analysis using Tukey's HSD showed that there was a significant difference between staff nurses (*mean*=25.43, *SD*=4.873) and CNM1s (*mean*=30.83, *SD*=4.446), mean difference=5.40, *p*=0.019.   Tukey's HSD also indicated a significant difference between staff nurses (*mean*=25.43, *SD*=4.873) and CNM2/CNS/management (*mean*=29.20, *SD*=3.722), mean difference=3.767, *p*=0.004.   The category, staff nurses, those who deliver hands on care, recorded a lower score than the other categories indicating that staff nurses were less "*hopeful*" in their attitudes than those within the management grades.

In addition, the results of the ANOVA indicate a statistically significant difference in this sub-scale and Length Employed in Area; these were broken down into four groups: (1-5 years, 6-10 years, 11-15 years, and 16-25 years), $F(3,119)=5.65$, $p=0.001$. The effect size was medium, $\eta^2=.12$. Further analysis using Tukey's HSD showed that there was a significant difference between the groups 1-5 years (*mean=27.39, SD=5.208*) and 6-10 years (*mean=24.70, SD=4.406*), mean difference=2.689, $p=0.045$. This indicates that 6-10 years group were less positive in their attitudes of hopefulness compared with the other group. In addition, Tukey's HSD indication a significant difference between the 6-10 years (*mean=24.70, SD=4.406*) and 11-15 years (*mean=28.78, SD=4.188*), mean difference=4.078, $p=0.003$. This indicates that 6-10 years group were less positive in their attitudes compared with the other group.

There was also a statistically significant difference in Hope in relation to the Length Employed in the Hospital, as indicated by an ANOVA. This category was broken down into four groups: 1-5 years, 6-10 years, 11-15 years, and 16-30 years, $F(3,120)=4.861$, $p=0.003$. The effect size was medium, $\eta^2=.11$. Further analysis using Tukey's HSD showed that there was a significant difference between the groups 6-10 years (*mean=24.69, SD=4.721*) and 11-15 years (*mean=28.45, SD=4.493*), mean difference=3.782, $p=0.003$. This indicates that 6-10 years group were less positive in their attitudes of hopefulness compared with the other group.

Finally, the results of the ANOVA indicate a statistically significant difference in the sub-scale of Hope in relation to the Country of Nursing Education; these were broken down into the following five groups Philippines, India, Ireland, UK, and Other), $F(4,114)=8.462$, $p<0.001$. The effect size was large, $\eta^2=.23$. Further analysis using Tukey's HSD showed that there was a significant difference between the Philippine educated (*mean=24.05, SD=4.883*) and Ireland educated groups (*mean=29.62, SD=3.923*), mean difference=5.569, $p<0.001$. The group, Philippine nursing educated, recorded a lower mean score than the other groups indicating that those who were Philippine nursing educated were less positive in their attitudes of hope towards older persons with dementia than those from the Irish educated group. Tukey's HSD also indicated a significant difference between the groups India educated (*mean=25.21, SD=4.048*) and Ireland educated (*mean=29.62, SD=3.923*), mean difference=4.414, $p=0.003$. This also indicates that those educated in India are less positive in their attitudes towards older persons with dementia than those from the Irish educated

group. Tukey's HSD indicated that there was a significant difference between the UK educated (*mean*=29.38, *SD*=4.788) and Indian educated group (*mean*=25.21, *SD*=4.048), mean difference= 4.178, *p*=0.049, and the UK educated (*mean*=29.38, *SD*=4.788) and Philippine educated groups (*mean*=24.05, *SD*=4.883), mean difference=5.33, *p*=0.003. This is also indicative of the UK educated nurses having a more positive attitude of hope towards older persons with dementia when compared to nurses who are educated in India and the Philippines. The findings of these ANOVAs are summarised in Appendix 28.

As the statistical differences appeared to emanate from the countries of nursing education category, a decision was made to carry out an independent sample t test to compare the means of the India and Philippine educated nurses (Group1) and the Irish and UK educated nurses (Group2). This analysis showed that there was a statistically significant difference between the India/Philippine educated group (*mean*=24.54, *SD*=4.55) and the Ireland/UK educated group (*mean*=29.55, *SD*=4.151) in relation to the ADQ Hope Sub-scale ($t_{(108)}$=-5.791, *p*<0.001). These results indicated that those respondents educated in the Philippines and India had significantly different attitudes in relation to hope than those educated in Ireland and the UK.

6.6.3. Person-Centred Care

A total of 98.4% (*n*=127) of the respondents completed all 11 statements for the Person-Centred Care Sub Scale. The total theoretical score ranges between 11 and 55, and higher scores indicate higher satisfaction. The range for this study was between 38 and 55 (*mean*=46.33, *SD*=4.31). Thus, indicating that the majority of the respondents believed that they practiced a person-centred approach to care. Preliminary analysis indicates that the data is not normally distributed with a significant Shapiro-Wilk statistic being reported (*SW*=.104, *p*=0.002). Table 6.13 gives a summary of the descriptive statistics and also a breakdown of response rates for each statement.

Table 6.13   PCC descriptive statistics and items

Person-Centred Care

Response Rate (n)		Range	Mean	SD	No of Items
127 (98.4%)		38-55	46.33	4.31	11

| Item	*n*	Strongly Agree/ Agree *n* (%)	NeitherAgree/ Disagree *n* (%)	Strongly Disagree/ Disagree *n* (%)
5. It is important for people with dementia to have stimulating and enjoyable activities to occupy their time	128	120 (93.7%)	5 (3.9%)	3 (2.3%)
7. It is important for people with dementia to be given as much choice as possible in their daily lives	128	120 (93.7%)	5 (3.9%)	3 (2.3%)
9. People with dementia are more likely to be contented when treated with understanding and reassurance	128	114 (89.2%)	7 (5.4%)	7 (5.4%)
11 People with dementia need to feel respected, just like anybody else	128	127 (99.2%)	0(0%)	1 (0.8%)
12. Good dementia care involves caring for a person's psychological needs as well as their physical needs	128	127 (99.2%)	1 (0.8%)	0 (0%)
14. It does not matter what you say to people with dementia because they forget anyway	128	2 (1.5%)	7 (5.5%)	119 (93%)
15. People with dementia often have good reason for behaving as they do	127	81 (64%)	21 (16.5%)	25 (19.5%)
16. Spending time with people with dementia can be very enjoyable	127	74 (58%)	44(35%)	9 (7%)
17. It is important to respond to people with dementia with empathy and understanding	128	121(94.5%)	0(0%)	7(5.5%)
18. There are a lot of things that people with dementia can do	128	119 (93%)	7 (5.5%)	2 (1.5%)
19. People with dementia are just ordinary people who need special understanding to fulfil their needs	128	113 (88%)	10 (8%)	5 (4%)

NB   Item 14 was reverse coded.

In Fig. 6.17 it is noted that the majority of the total scores of the respondents cluster towards the more positive range for agree/strongly agree. This is the highest mean thus far for any of the scales and sub-scales discussed already.   From Fig. 6.18 we can see that the majority of respondents choose "agree" or "strongly agree" for these items.
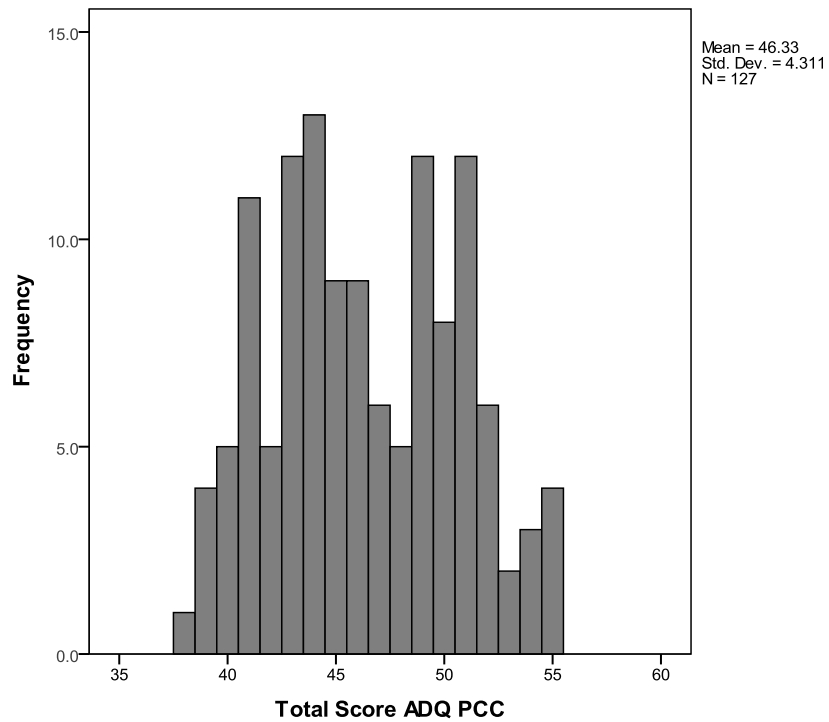
Fig 6.17   Person-Centred Care Sub-Scale of ADQ by Frequency
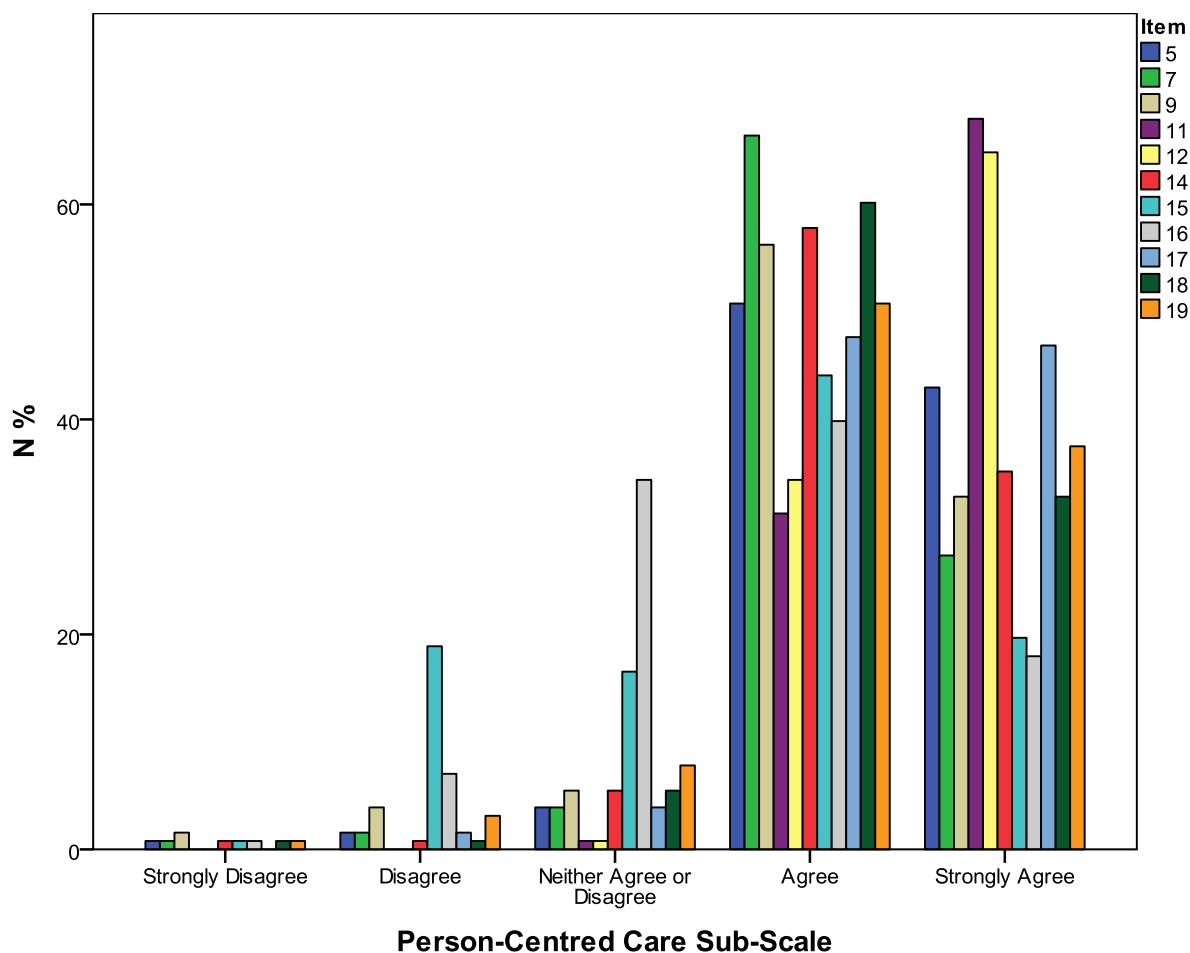
Fig. 6.18 Person-Centred Care Sub-Scale broken down by item.

A series of one-way Kruskal-Wallis H ANOVAs was conducted to compare the total scores of the Person-Centred Care sub scale of the ADQ with the demographic characteristics of the respondents. These proved to be significant for two of the demographic characteristics. The Kruskal-Wallis H test showed that there was a statistically significant difference in the Person-Centred Care sub scale total score between the different groupings of nursing grade; these were broken down into: staff nurses (mean rank=58.54), CNM1 (mean rank=82.92), and CNM2/CNS/management (mean rank=82.50), χ^2 (2)=9.009, p=0.011. A Mann-Whitney U test was conducted and found that there was a significant difference between staff nurses and CNM/CNS/management (U=613.5, p=0.006). This indicates that staff nurses held less positive opinions and views in relation to person-centred care for older persons with dementia than CNM2/CNS/management nurses.

Finally, a significant difference was noted in the Country of Nursing Education category in relation to this scale; these were broken into: Philippines (mean rank=59.41), India (mean rank=41.18), Ireland (mean rank=81.62), UK (mean rank=67.54), and Other (mean rank=63.61), $\chi^2(4)$=20.301, p=0.023. A Mann-Whitney U test was conducted and found that there was a significant difference between nurses educated in the Philippines and those educated in India (U=408.5, p<0.023). There was also a significant difference between nurses educated in India and those educated in Ireland (U=171.0, p<0.001). A Mann-Whitney U test was conducted and found that there was a significant difference between nurses educated in the Philippines and those educated in Ireland (U=367.0, p=0.006). This indicates that nurses educated in the Philippines and India scored significantly lower than their colleagues who were educated in Ireland. A significant difference was also found between nurses educated in India and those educated in the UK (U=102.5, p=0.013).

As the statistical differences appeared to emanate from the countries of nursing education category, a decision was made to compare the means using a Mann Whitney U test of the India and Philippine educated nurses (Group1) and the Irish and UK educated nurses (Group2). This analysis showed that there was a statistically significant difference between the India/Philippine educated group and the Ireland/UK educated group (U=864.5, p<0.001) in relation to the ADQ Person-Centred Care sub scale. These results indicated that those respondents educated in the Philippines and India had significantly different views and opinions regarding attitudes in relation to a person-centred approach to care than those educated in Ireland and the UK. The findings of these ANOVAs are summarised in Appendix 29.

6.6.4 Summary

In answer to the research question that focused on Nurses' Attitudes towards Dementia and Nurses' Views and Opinions Based on their Experiences of Caring for the Older Person with Dementia, the findings suggest that overall nurses' attitudes towards dementia and dementia care nursing were skewed towards a positive attitude with a mean score of 73.73 (*SD*=7.51) out of a possible total score of 95. However, exploration of the two subscales revealed that whilst respondents espoused a strong belief in Person-Centred Care (*mean*=46.33, *SD*=4.31), they were less hopeful for the older person with dementia (*mean*=26.35, *SD*=4.96).

The strongest correlations between demographic characteristics and less favourable attitudes towards the older person with dementia and dementia care nursing, are displayed in figures

6.13 (total score) and 6.15 (Hope sub scale) and include: non Specialist Qualifications; Staff Nurse grade; 6-10 years employed in both the hospital and in the area and respondents educated in the Philippines and India. Finally, as displayed in figure 6.17 (PCC sub scale) two demographic characteristics were associated with less favourable attitudes, these included Staff Nurse grade and Philippine and Indian educated respondents.

6.7. Nurses' Beliefs about the Environment of Care and its Impact on Nurses Experiences of Dementia Care Nursing in Non-dementia Specific Units

The instrument used to measure the nurses' beliefs about the environment of care was the WOFS sub scale, Physical Environment of the Ward (PEW). This scale was one of six scales which form the WOFS (Adams et al, 1995). Each of the six scales can be used independently and within this study the aforementioned sub scale PEW was employed. According to Adams et al (1995), the PEW sub scale provides a measure with which to explore the effects of the ward environment on various aspects of nursing care. The total score of the PEW sub scale was examined along with the total scores of the individual sub-scales. Internal consistency of the PEW is discussed in chapter five (section 5.5.6). In the current study internal consistency was achieved (a = .801). A Cronbach's alpha co-efficient was calculated for the four sub-scales and is displayed, along with descriptive statistics, in Table 6.14. In addition, the total score and the totals of the sub-scales were examined for outliers and there was one extreme outlier (observation 25), the observation was removed and the total scores and total scores of the sub-scales were checked for normality. However, as they did not follow a normal distribution it was decided to analyse the complete data set. The WOFS sub scale, PEW (Adams et al, 1995) was scored as outlined in chapter five (section 5.5.6). The items are consistent with the themes that emerged from the literature review as outlined in chapter five (section 5.5.6).

Table 6.14   Measures for the (WOFS) (PEW) Sub Scale

WOFS (PEW)	Response Rate	Range of Scores	Mean	SD	No of Items	Cronbach's Alpha
Total Score	120 (93%)	20-40	23.89	3.55	20	.801
Ward Facilities	126 (97.6%)	5-10	5.65	1.11	5	.677
Staff Organisation	123 (95.3%)	5-10	6.19	1.43	5	.703
Ward Layout	121 (93.7%)	6-12	7.60	1.68	6	.730
Quality of Ward Services	125 (96.8%)	4-8	4.42	.699	4	.371

In relation to Cronbach's alpha coefficient, overall the scores appeared to be satisfactory, with the exception of "Quality of Ward Services" with a Cronbach's Alpha of .371, this is considerably lower than that reported by Adams et al (1995) and may be due to the difference in the numbers of respondents. For example, in Adams et al's (1995) study which details the scale development, the response rate was 834 respondents compared to 129 in the current study.

6.7.1   (WOFS) (PEW) Sub Scale Total Score

A total of 93% (n=120) respondents completed all 20 statements. The total theoretical score ranged between 20 and 40 and lower scores indicated greater satisfaction. In this study, scores clustered around the lower quartile of the scale (*mean*=23.89, *SD*=3.55). Thus indicating generally positive beliefs held by the nurses about the environment of care within which they provide dementia care nursing. Further analysis was undertaken to explore for associations between the nurses' beliefs about the environment of care and dementia care nursing and their demographic characteristics. Preliminary analysis indicated that the data was not normally distributed with a significant Shapiro-Wilk statistic being reported (*SW*=.896, p<0.001).

A series of one-way Kruskal-Wallis H ANOVAs was conducted to compare the total scores of the WOFS, PEW sub scale with the demographic characteristics of the respondents. These proved to be non-significant at the p<0.05 level with non-significant χ^2-values. A histogram for the total score and each of the sub-scales of how each item was answered can be seen in Appendix 30.

6.7.2.   Ward Facilities

A total of 97.6% (n=126) of the respondents completed all five statements. The total theoretical score ranges between 5 and 10. Lower scores indicate greater satisfaction. In this study the scores clustered around the lower range (*mean*=5.65, *SD*=1.105), indicating that the majority of the respondents, perceived that they worked in an environment that has a good influence on the facilities provided for both staff and patients. A summary of this sub-scale can be found in Table 6.15. Preliminary analysis indicates that the data is not normally distributed with a significant Shapiro-Wilk statistic being reported (*SW*=.645, p<0.001).

Table 6.15   Ward Facilities descriptive statistics and items

Ward Facilities (Influence on Work)					
Response Rate *n* (%)		**Range**	**Mean**	**SD**	**No of Items**
126 (97.6%)		5-10	5.65	1.105	5
Item	***n***	**Very Good Influence**		**Very Bad Influence**	
1 Facilities for Relatives	126	104(82.53%)		22(17.46%)	
2 Facilities for Patients	126	109(86.50%)		17(13.49%)	
3 Facilities for Staff	126	103(81.74%)		23(18.25%)	
4 Availability of Equipment	126	118(93.65%)		8(6.34%)	
5 Quality of Ward Maintenance Services	126	114(90.47%)		12(9.52%)	

A series of one-way Kruskal-Wallis H ANOVAs was conducted to compare the total scores of the Ward Facilities sub-scale with the demographic characteristics of the respondents. These proved to be non-significant at the *p*=0.05 level with non-significant χ^2-values, with the exception of age group; these were broken into four groups: 20-29 years (mean rank=74.09), 30-39 years (mean rank=59.26) 40-49 years (mean rank=71.74), and 50-65 years (mean rank=50.97), χ^2 (3)=8.518, *p*=0.036. Further analysis using Mann-Whitney U showed that there was a significant difference between those aged between 30 and 39 years and those aged between 40 and 49 years, (*U*=936.0, *p*=0.046), the latter also differed significantly on their score totals on this scale from those aged 50 to 65 years (*U*=234.5, *p*=0.021). This analysis indicates that the age group 40-49 years scored higher on the Ward Facilities sub-scale in comparison to the 50-65 years and 30-39 years age groups. Therefore, they held less positive beliefs about the influence of the ward facilities on their work environments.

6.7.3   Staff Organisation

The five Staff Organisation scale statements were completed by 95.3% (*n*=123) of the respondents. The total theoretical score ranges between 5 and 10 and lower scores indicate higher satisfaction. In this study the scores ranged between 5 and 10 (*mean*=6.19, *SD*=1.433) suggesting that the majority of the respondents replied less positively to the statements on this sub scale in comparison to the previous scales already discussed. Preliminary analysis

indicates that the data is not normally distributed with a significant Shapiro-Wilk statistic being reported (SW=.791, p<0.001).A summary of this sub-scale can be found in Table 6.16.

Table 6.16   Staff Organisation descriptive statistics and items

Staff Organisation					
Response Rate _n_ (%)		**Range**	**Mean**	**SD**	**No of Items**
123 (95.3%)		5-10	6.19	1.433	5
Item	**_n_**	**Strongly Agree**		**Strongly Disagree**	
6 Our nurse/patient allocation system works well for the nursing skill mix we currently have on the ward	123	96(78.04%)		27(22%)	
7 Our nurse/patient allocation system works well for the type of patients we have on this ward	124	89(71.77%)		35(28%)	
8 The skill mix on the ward is about right	124	102(82.25%)		22(18%)	
9 There are enough permanent nurses on this ward to give a good standard of care to all our patients	125	86(68.8%)		39(31%)	
10 The ward off duty works well	124	100(80.64%)		24(19.35%)	

A series of one-way Kruskal-Wallis H ANOVAs was conducted to compare the total scores of the sub-scale of Staff Organisation with the demographic characteristics of the respondents. Here there was one significant result. The Kruskal-Wallis H test showed that there was a statistically significant difference in Staff Organisation total scores between the different groupings of specialist qualifications; these were broken down into four groups: Dementia degree/certificate (mean rank=84.77), GN MSc (mean rank=49.40), GN degree/diploma/certificate (mean rank=51.66), and no specialist qualifications (mean rank=63.29), χ^2 (3)=8.469, p=0.03. Further analysis using Mann-Whitney U showed that there was a significant difference between the groups Dementia degree/cert and GN degree/diploma/certificate, (U=75.5, p=0.013) and those nurses with no specialist qualifications (U=278.5,p=0.045). This indicates that nurses with a GN MSc agreed more

strongly regarding the Staff Organisation sub-scale as they scored a lower mean value than those with a GN degree/diploma/certificate and those with no specialist qualifications.

6.7.4. Ward Layout

A total of 93.7% (*n*=121) of the respondents completed all six statements. Scores were skewed towards the lower end of the positive scale (*mean*=7.60, *SD*=1.68) out of a possible theoretical range of 6 to 12 reflective of slight positive views and opinions regarding the ward layout which effects the numbers of staff needed and the contact time available between the residents/patients and nurses. A summary of this sub-scale can be found in Table 6.17. Preliminary analysis indicates that the data is not normally distributed with a significant Shapiro-Wilk statistic being reported (*SW*=.845, *p*<0.001).

Table 6.17   Ward Layout descriptive statistics and items

Ward Layout					
Response Rate *n* (%)	**Range**	**Mean**	**SD**		**No of Items**
121 (93.7%)	6-12	7.60	1.676		6
Item	***n***	**Very Easy**		**Very Difficult**	
11 Patients being able to attract the nurses' attention	124	106 (85.48%)		18 (14.51%)	
12 Patient safety	124	84 (67.74%)		40 (32.25%)	
13 Good Usage of Nurses' Time	123	78 (63.41%)		45 (36.5 8%)	
14 Observation of all Patients	124	68 (54.83%)		56 (45.16%)	
15 Good Communication between nurses working on the Ward	125	105 (84%)		20 (16%)	
16 The Ward's Chosen way of Organising Nursing Care delivery (ie: functional, team or primary nursing)	122	101 (82.78%)		21(17.21%)	

A series of one-way Kruskal-Wallis H ANOVAs was conducted to compare the total scores of the Ward Layout sub-scale with the demographic characteristics of the respondents. These proved to be non-significant at the *p*<0.05 level with non-significant χ^2-values.

6.7.5. Quality of Ward Services

A total of 96.8% (*n*=125) of the respondents completed all four statements. The total theoretical score ranges between 4 and 8 and lower scores indicated greater satisfaction. In

this study, the mean score was 4.42 (*SD*=0.699) indicating that the majority believed that the quality of ward services provided, which effects the nurses' ability to provide care was satisfactory. A summary of this sub-scale can be found in Table 6.18. Preliminary analysis indicates that the data is not normally distributed with a significant Shapiro-Wilk statistic being reported (*SW*=.845, *p*<0.001).

Table 6.18 **Quality of Ward Services descriptive statistics and items**

Quality of Ward Services					
Response Rate *n* (%)	**Range**	**Mean**	**SD**	**No of Items**	
125 (96.8%)	4-6	4.42	0.699	4	
Item	***n***	**Very Good Influence**	**Very Bad Influence**		
17 Availability of Portering Services	125	96(76.8%)	29(23.2%)		
18 Quality of Portering Services	125	108 (86.4%)	17 (13.6%)		
19 Quality of Pharmacy Services	125	119(95.2%)	6 (4.8%)		
20 Quality of Sterile Supply Services	125	124 (99.2%)	1(.8%)		

A series of one-way Kruskal-Wallis H ANOVAs was conducted to compare the total scores of the Quality of Ward Services sub-scale with the demographic characteristics of the respondents. These proved to be non-significant at the *p*<0.05 level with non-significant χ^2-values.

6.7.6 Summary

In answer to the research question, What is the Relationship between Nurses' Beliefs about the Environment of Care and its impact on Dementia Care Nursing, the results were positively skewed with a mean score of 23.39 (*SD*=3.55) out of a possible 40 (lower scores are more positive). Positive scores were also evident within each of the four sub scales as presented in Appendix 29. The Staff Organisation and Ward Layout sub scales are slightly less positive than the Ward Facilities (Influence on Work) and Quality of Ward Services sub scales. These findings suggest that overall the nurses' beliefs about the environment of care and its impact on nurses' experiences of dementia care nursing, are positive.

6.8 Correlation Analysis (Pearson's r)

A correlation matrix was constructed via Pearson's r, involving the questionnaires and their sub-scales. Appendix 31, presents all of the correlations among the measures simply to

confirm that the expected large number of inter-correlations was observed. The results indicated that there was a large positive correlation between the Work Co-operation, Personal and Professional Development and Quality of Care sub-scales of the SNCW and the Total SNWC score (r=.89, p<0.01; r=.76, p<0.01; r=.80, p<0.01 respectively). There was also a medium positive correlation between the SNCW total score and its sub-scales Knowledge of Patients (r=.59, p<0.01) and Workload and Work Satisfaction (r=.71, p<0.01). All the sub-scales of the SNCW are correlated with each other; these relationships are positive, medium to strong. This would be intuitive as this scale is measuring the overall measure of nurses' views and opinions in relation to dementia care nursing.

The results indicated that there was a large positive correlation between the two sub-scales of the ADQ and the Total ADQ score (Hope: r=.84, p<0.01; Person-Centred Care: r=.78, p<0.01).There was also a medium positive correlation between the two sub-scales (r=.31, p<0.01). This questionnaire reflects the relationship between nurses' attitudes towards dementia and dementia care nursing. The Hope sub-scale is reflective of how hopeful the respondent is for the older person with dementia, whilst the Person-Centred Care sub-scale reflects how the respondents think and behave towards older persons with dementia.

In relation to the WOFS, PEW sub scale, the Total Score and its sub-scales Staff Organisation and Ward Layout are positively correlated with a strong correlation effect (r=.80, p<0.01; r=.80, p<0.01 respectively). Whilst the Total Score and the sub-scales of Ward Facilities and Quality of Ward Services are also positively correlated with a small to medium correlation effect (r=.64, p<0.01; r=.47, p<0.01, respectively). In addition, the sub-scales of this questionnaire are positively correlated with one another, with the exception of Ward Facilities and Quality of Ward Services sub-scales (r=.14, p>0.05). The correlations are all positive and range from a small to strong correlation effect. The lower score of the WOFS, PEW sub scale indicates a positive belief about the environment of care within which nurse provide care for the older person with dementia.

6.9 Hospital Aggregates

The findings from the survey are presented as aggregates from all three sites. Table 6.19 demonstrates that no differences were found between hospitals in relation to the SNCW, ADQ and WOFS (PEW) total scale scores or total sub-scales scores. Parametric ANOVAs were used for normally distributed data and non-parametric techniques namely Kruskal-Wallis H was used where the data was not normally distributed.

Table 6.19   Hospital Aggregates

Scale	Statistic	*p*-value
SNCW	$F=0.053$	0.948
Work Cooperation	$F^*=0.083$	0.959
Knowledge of Patients	$F^*=0.106$	0.949
Personal and Professional Development	$F^*=0.525$	0.769
Quality of Care	$F=0.071$	0.931
Workload and Work Satisfaction	$F^*=4.896$	0.086
ADQ	$F=1.745$	0.418
Hope	$F=1.459$	0.236
Person-Centered Care	$F^*=0.944$	0.624
WOFS (PEW)	$F^*=1.105$	0.576
Ward Facilities	$F^*=1.744$	0.418
Staff Organisation	$F^*=3.102$	0.212
Ward Layout	$F^*=0.513$	0.774
Quality of Ward Services	$F^*=2.001$	0.368

*Nonparametric test

6.10   Multiple Regression

A stepwise linear regression was conducted to explore the predictive power of demographic characteristics of the nurses surveyed for the ADQ, Table 6.20 gives a summary. This revealed that only country of education (Philippines/India and Ireland/UK) was significant ($F=41.697$, $p<0.001$).   This model explains 27.9% of the variance found in ADQ scores. Nurse's specialist qualification was added into the model as the tests of between subjects effects revealed that it was almost significant ($F=7.944$, $p<0.001$). In Fig 6.19 we can see that when both country of education and specialist qualification was added the model explained 30.8% of the variance.

Table 6.20   Multiple Regression – ADQ Results

Multiple Regression - ADQ

Model						Confidence Interval	
						95% Confidence Interval	
Model	Parameter	B	Std. Error	t	Sig.	Lower Bound	Upper Bound
1	Intercept	77.976	.989	78.837	.000	76.016	79.937
	Philippines/India	-8.123	1.258	-6.457	.000	-10.617	-5.630
	Ireland/UK	0[a]	.	.	.	.	.
2	Intercept	77.066	1.202	64.098	.000	74.681	79.450
	Philippines/India	-8.011	1.348	-5.941	.000	-10.686	-5.336
	Ireland/UK	0[a]	.	.	.	.	.
	Dem Degree	2.945	6.306	.467	.641	-9.562	15.452
	Dem Certificate	3.276	2.217	1.478	.143	-1.121	7.673
	GN MSc	-1.566	2.820	-.555	.580	-7.158	4.027
	GN Degree	-1.055	3.707	-.284	.777	-8.408	6.298
	GN Diploma	4.413	1.660	2.658	.009	1.119	7.706
	GN Certificate	-3.729	3.717	-1.003	.318	-11.101	3.643
	No specific qualifications	0[a]	.	.	.	.	.

a. This parameter is set to zero because it is redundant.
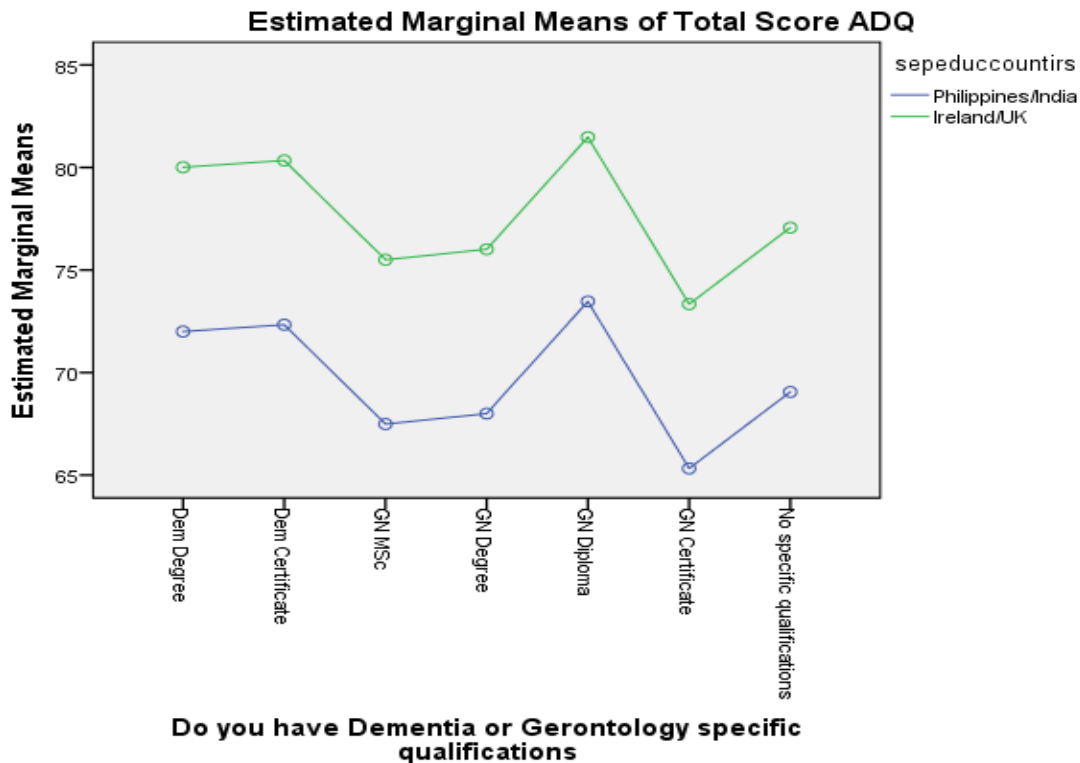
Fig 6.19   Estimated Marginal Means of Total Score ADQ

A stepwise regression was also conducted to explore if the total score of the SNCW could be predicted by the demographics characteristics. No variables were significant and hence no

model was produced. A stepwise regression was also conducted to explore if the total score of the WOFS (PEW) could be predicted by the demographics characteristics. No variables were significant and hence no model was produced.

6.11 Conclusion

Overall the nurses' views and opinions about dementia care nursing in non-dementia specific wards/units as identified and as operationalized by the SNCW were positive. In this study, the response rate was 94.5% and the mean total was (*mean*=117.97. *SD*=14.06) out of a possible 160. When the five subscales were explored for associations with the nurses' demographic characteristics, statistical differences were noted in relation to (i) Knowledge of Patients (ii) Personal and Professional Development and (iii) Work Load and Work Satisfaction. The statistical differences noted are as follows:

Knowledge of Patient - the most positive results correlated with respondents who had been qualified between 11-15 years; respondents who worked in the residential wards/units.

Personal and Professional Development - the most positive results correlated with respondents in management grades.

Work Load and Work Satisfaction - the most positive results correlated with respondents with MSc qualifications; respondents employed in the area for 6-10 years and; respondents educated in the Philippines.

Generally the relationship between nurses' attitudes towards dementia and dementia care nursing as operationalized by the ADQ were positive. In this study, the response rate was 96.1% and the mean total was (*mean* 73.73, *SD*=7.51) out of a possible 95. Yet, when the two sub scales were explored for associations with the nurses' demographic characteristics, a number of differences were exposed. For example, there were significant statistical differences noted in relation to (i) Hopefulness for the Person with Dementia, and (ii) Person Centred Approach to Care. The major differences were as follows:

Hopefulness - the most positive results correlated with respondents with specialist qualifications; management grades; employed in the area between 11 and 25 years and; educated in the Ireland and the UK.

Person-Centred Approach to Care - the most positive results correlated with respondents in management grades; respondents educated in Ireland.

Finally, exploration of the nurses' beliefs about the environment of care and its impact on dementia care nursing as operationalized by the WOFS (PEW) indicated mostly positive beliefs. In this study, the response rate was 93% and the mean total was (*mean* 23.89, *SD*=3.55) out of a possible 40. When the sub scales were explored for associations with the nurses' demographic characteristics a number of differences were discovered. For example, there were significant statistical differences noted in relation to (i) Ward Facilities, and (ii) Staff Organisation.

Ward Facilities - the most positive results correlated with respondents in the 20-29 years group.

Staff Organisation - the most positive results correlated with respondents with MSc qualifications.

The following chapter will present the results from phase two, the qualitative phase of the current study.

Chapter Seven – Results – Qualitative Phase Two

7.1   Introduction

This chapter presents the qualitative findings of phase two of this mixed methods study, generated from the five focus group interviews undertaken with registered general nurses (n=25). The purpose of the focus group interviews was to elaborate on quantitative responses from phase one which is compatible with the purpose of the sequential explanatory mixed methods research design used in the current study. Further explanation and enhancement of the data collected by way of questionnaires in phase one were brought about by conducting qualitative interviews in phase two. The chapter commences with a breakdown of the participants' demographics. This is followed by a summary of the four themes, as identified by thematic analysis and outlined in chapter five, these are:

- Environment of Care
- Nurses' Knowledge about Dementia
- Ethical Dilemmas
- Dementia: A Mis-understood Concept

7.2   Focus Group Demographics

Twenty-five nurses in total participated in the five focus groups. All of the focus group participants were female. The majority of the participants, 80% were in the 30-49 years age bracket and 64% were registered for 11-25 years. These figures are slightly higher when compared to phase one where 77.5% of the participants were in the 30-49 years age bracket and slightly lower than phase one where 76.3% were registered for between 11 and 25 years.

An equal number of participants within phase two practiced in residential units and rehabilitation, 32% respectively, followed by 28% from the acute setting. This is slightly different from phase one insofar as the percentage numbers from the individual units are concerned. For example, in phase one, the largest percentage of nurses, 37.2%, worked in residential care units, followed by 34.1% in rehabilitation and finally 14% within acute admissions in phase one.

Most of the participants in phase two were educated to degree level 68%, with 72% holding specialist qualifications to include 52% with specialist qualifications in gerontological nursing and 20% with specialist qualifications in dementia care. From phase one, 62.8% of participants held a nursing degree, with 28.7% holding a specialist qualification in gerontological nursing and 8.5%, in possession of a specialist qualifications in dementia care.

When it came to country of nurse education 56% of the participants had received their nurse education in Ireland and a further 20% had undertaken their nurse education in the Philippines, with 16% receiving their nurse education in India, while 8% were educated in the UK. This is different from phase one, whereby, 32.2% of the nurses had received their nurse education in the Philippines, 25% were educated in Ireland and 25% in India. Regarding staff grade 48% of the participants were staff nurses and 52% were clinical nurse managers compared to 78.9% staff nurse grade and 22% clinical nurse managers in phase one. The overall demographics from Phase Two are outlined in Table 7.1. The principal differences in the demographic characteristics of the participants from the two groups relate to country of education, nurse grade and numbers with specialist qualifications as illustrated in Table 7.2.

Table 7.1   Focus Group Demographics

Demographics	FG 1 (n=5) Staff Nurses Hospital C	FG 2 (n=8) CNMs Hospital C	FG 3 (n=4) Staff Nurses Hospital A	FG 4 (n=5) CNMs Hospital B	FG 5 (n=3) Staff Nurses Hospital B
Gender	Female 5/5	Female 8/8	Female 4/4	Female 5/5	Female 3/3
Age Group	0 30-39 yrs = 3/5 40-49 yrs = 2/5 0 0	0 30-39 yrs = 4/8 40-49 yrs = 2/8 50-59 yrs = 2/8 0	0 30-39 yrs = 1/4 40-49 yrs = 2/4 0 60-65 yrs = 1/4	0 30-39 yrs = 4/5 0 50-59 yrs – 1/5 0	20-29 yrs = 1/3 30-39 yrs = 2/3 0 0 0
How Long Registered	0 6-10 yrs = 2/5 11-15 yrs = 1/5 16-20yrs = 2/5 0 0 0	0 0 11-15 yrs = 2/8 16-20 yrs = 2/8 21-25 yrs = 1/8 26-30 yrs = 3/8 0	1-2 yrs = 1/4 0 0 16-20 yrs = 1/4 21-25yrs = 1/4 0 Other = 1/4	0 0 11-15 yrs = 1/5 16-20 yrs = 3/5 0 26-30 yrs = 1/5 0	1-2 yrs = 1/3 0 11-15 yrs = 2/3 0 0 0 0
Length Employed in Area	0 6-10 yrs = 3/5 11-15 yrs = 2/5 0 0	0 6-10 yrs = 2/8 11-15 yrs = 4/8 16-20 yrs = 1/8 21-25 yrs = 1/8	1-2 yrs = 1/4 6-10 yrs = 2/4 11-15 yrs = 1/4 0 0	0 6-10 yrs = 1/5 0 16-20 yrs = 4/5 0	1-2 yrs = 2/3 0 11-15 yrs = 1/3 0 0
Type of Ward/Unit • **Residential Units** • **Rehabilitation Units** • **Acute Units** • **Other**	 2/5 1/5 2/5 0	 3/8 2/8 1/8 2/8	 3/4 1/4 0 0	 0 3/5 2/5 0	 0 1/3 2/3 0
Nurse Qualifications • **Degree** • **Pre reg diploma** • **Certificate** **Specialist Nursing Qualifications (Post reg)** • **Diploma Dementia** • **Dip Gerontological** • **Cert Gerontological**	Degree 3/5 Diploma 2/5 Certificate 0 PG Dip Dem 3/5 PG Dip Ger 1/5 PG Cert Ger 0	Degree 4/8 Diploma 2/8 Certificate 2/8 PG Dip Dem 2/8 PG Dip Ger 3/8 PG Cert Ger 1/8	Degree 4/4 Diploma 0 Certificate 0 PG Dip Dem 0 PG Dip Ger 1/4 PG Cert 0	Degree 4/5 Diploma 1/5 Certificate 0 PG Dip Dem 0 PG Dip Ger 4/5 PG Cert 1/5	Degree 2/3 Diploma 1/3 Certificate 0 PG Dip Dem 0 PG Dip Ger 0 PG Cert 2/3
Country of Nursing Education	Ireland 2/5 Philippines 1/5 India 1/5 UK 1/5	Ireland 4/8 Philippines 3/8 India 1/8 0	Ireland 2/4 Philippines 1/4 India 1/4 0	Ireland 3/5 UK 1/5 India 1/5 0	Ireland 3/3 0 0 0

Table 7.2   Participant Demographics. Phase One and Phase Two

Country of Education	Phase One	Phase Two
Ireland	25%	56%
Philippines	32.2%	20%
India	25%	16%
UK	10.4%	8%

Staff Grade	Phase One	Phase Two
Staff Nurses	78.9%	48%
CNMs	22%	52%

Specialist Qualifications	Phase One	Phase Two
Specialist Qualifications	37.2%	72%

The following sections will present the findings from the focus group interviews commencing with table 7.3 which outlines the four identified themes.

Table 7.3   Focus Group Themes

Sub Categories, Categories and Themes

Sub Categories ⟶	Categories ⟶	Themes
Maintaining Safety, Privacy and Dignity For Persons with Dementia. Safety & Security Measures. Unfamiliar & Overstimulated Environment of Care. Orientation Cues. Creating a Familiar Environment of Care. _____	(i) Physical Environment of Care	**Theme One:** **Environment of Care**
Organisational Sources of Support. Policies & Procedures. Staffing Levels & Quality of Care. 'Specials' Enhanced Care.	(ii) Organisational Environment of Care	
Access to Specialist Dementia Education. Specialist Knowledge. Cultural Understandings of Dementia Care.	(i) Skills Acquisition (ii) Knowledge Base	**Theme Two:** **Nurses' Knowledge about Dementia**
Principles of Autonomy, Beneficience & Non-maleficence. Moral Imperative to Balance Care Needs. Debriefing and Support.	(i) Ethical Dilemmas Experienced in Dementia Care Nursing Practice (ii) Desire for Support	**Theme Three:** **Ethical Dilemmas**
Nurses' Views and Opinions about Dementia. Working as a Team.	Influences of Attitudes on Dementia Care Nursing Practice	**Theme Four:** **Dementia: A Misunderstood Concept**

The findings are presented with specific quotes organised according to the participants' code. For example, the first number refers to the number of the focus group and the second number indicates the seating arrangements. Thus (1.1) denotes focus group one, and seating position number one.

7.3   Environment of Care

This theme details the findings that relate to the nurses' beliefs about the environment of dementia care nursing within the research setting and the impact on their experiences of dementia care nursing. It elaborates on findings from phase one in relation to nurses' beliefs about the environment of care where issues related to the physical and organisational environment of care were explored.   During phase one, physical aspects of the care environment such as maintaining patient safety, observation of patients and organisational features including issues such as staffing levels and quality of care were investigated. Findings from phase one, revealed that the majority of the respondents held generally positive beliefs about these aspects of dementia care nursing.   These findings contrasted with the literature review and provided justification for further exploration of these issues in phase two as outlined in the Focus Group Interview Schedule (FGIS). Therefore, the environment of care was explored within the focus group interviews in terms of the physical layout of the wards/units and organisational characteristics such as organisational support relating to staffing levels which impact on quality of care were discussed and, are now presented.

7.3.1   Physical Environment of Care

7.3.1.1 Maintaining Safety, Privacy and Dignity for Persons with Dementia

A major component of dementia care nursing is maintaining safety for persons with dementia within the care environment. The participants in all five focus groups acknowledged that safety issues have to be considered alongside the need to promote dignity and privacy for persons with dementia. According to the participants, based on their experiences of caring for older persons with dementia, achieving this goal of care proved to be challenging and frustrating due to the physical design of the wards/units. Due to the physical design of the wards/units in the hospitals which were described as being divided into a number of bays, it was not possible for the nurses to maintain constant observation of all of the areas situated within the wards/units.   In a bid to support dignity, safety and privacy for persons with dementia, the participants discussed that they tried to ensure that constant observation aimed at promoting safety was undertaken discreetly, by assigning persons with dementia within view of the nurses' station. From the acute wards/units, the participants identified that this strategy was becoming more difficult to achieve due to the increasing number of persons with dementia being admitted to the acute area:

"you can't see through walls, we have three wards with walls you cannot see through them, you can't physically see everybody" (1.1)

"particularly on night shift, we don't know what is happening on one side to our patients" (3.1)

"in our acute unit, we make sure that if you have patients with dementia we initially put them in a ward closest to the nurses' station where there is always somebody and some of them would be mobile and they would be walking around the ward and make sure that someone is watching them" (1.2)

Despite the participants' best efforts to promote safety, persons with dementia do go missing from the wards/units. It was explained that while this occurs at regular intervals, it could not be said to take place on a daily or weekly basis. The participants reported that while some persons with dementia were eventually traced to other parts of the hospital, others were located out-with the hospital grounds. The participants indicated that such situations led to them experiencing inordinate levels of stress and frustration with the organisational system, combined with extreme fearfulness for the missing person. The participants reported that putting in place procedures to locate the missing person took up an inordinate amount of nursing time which interfered with the smooth running of the ward and the quality of time available for other patients with and without dementia in the ward/unit:

"How many times have we spent an hour down the other end of the hospital because someone is down there and you are trying to talk them back" (4.3)

"we had multiple incidents of patients not absconding, absconding implies that they were leaving with intent…………on a couple of occasions we had to call the garda, no harm came to anybody at any time but only for the grace of God" (5.3)

"some patients have gotten into town, or gone out to facilities that they would have been familiar with……….....your focus for the day is on that, so everything else for the day, for the 30 other patients and families, staff etc is pushed aside so you actually can't focus on the running of the ward, the effective management…..it is so frustrating, you feel so angry, you feel so let down and unsupported by the system" (2.7)

7.3.1.2 Safety and Security Measures

From the acute and rehabilitation wards/units across the three sites, the participants described that in an effort to promote safety, a locked door system with swipe card access was introduced by management. This was recognised by the participants as a form of restraint

which was at odds with respect for the dignity of the person. It was acknowledged that apart from being an inappropriate measure, this was not a fail proof system, it was explained that although the wards had locked doors accessible only by swipe card or by using the intercom, the system was often broken. It was identified by the participants that this led to the situation where patients had free access to leave the ward unobserved. They further explained that as the patients are generally dressed in their day clothes, this to a certain extent exacerbated the situation as even if the door was locked, other people such as visitors, would open the door for them and this made it easier for the patients to leave discreetly:

> *"I really do have concerns about the future of our department and dementia patients…..we had one patient lost who had a fall and there were serious outcomes from it and the family were very unhappy…based on that influence …..one of the measures brought about was a locked unit"* (4.3)

> *"It took a long time to get the facility to lock the door of the ward brought in….it was debated back and forth…… and it seems to always fall back on whether it is a form of restraint or not and therefore can't be used"* (5.3)

> *"Acute admissions ward had a closed system which I would say 75% of the time is broke"*(2.7)

The participants from the residential units explained, that in an effort to promote safety and maintain constant observation of persons with dementia and without, a computer based tracking system was installed by the management team along with a locked door system. Although from a risk/benefit ratio, the participants acknowledged that the theory behind the installation of the system was to promote safety and security, it was noted that it interfered with the residents' privacy and it was construed to be a form of restraint which promoted safety and security over and above the residents' dignity and autonomy:

> *"new system a wander alarm set up by WIFI so you can monitor those at risk of absconding or wandering, basically it is on our computer, you can see which room they are in and if they go out the door an alarm bell will go off and our security will ring to say…."*(1.3)

> *"it works to a certain extent, it is not brilliant, it goes off when, one of our lady's goes into the toilet but you get over that one, it is a work in progress"*(2.5)

> *"they put in a* tag system…………..*if a person goes near a door an alarm goes off, very irritating for everyone and residents get upset with the noise…..and of course it is a form of restraint"* (3.4)

A further challenge related to the physical environment of care, according to the participants is that it is an unfamiliar environment for persons with dementia.

7.3.1.3 Unfamiliar and Overstimulated Environment of Care

Another issue related to the environment of care which impacted on the nurses' experiences of dementia care nursing was the fact that it was acknowledged to be unfamiliar and strange for persons with dementia. The participants discussed that based on their experiences of dementia care nursing, the unfamiliar environment of care posed challenges for persons with dementia. It had the potential to cause persons with dementia to feel frightened and fearfulness can affect patients with and without dementia. It was recognised by the participants that persons with dementia are often disorientated and have no idea where they are, which results in accelerating their sense of fearfulness and agitation. The participants acknowledged in an empathetic manner, that fearfulness and sensory overload can potentially lead to the manifestation of responsive behaviours and the participants' response was to try and create a sense of security for persons with dementia:

> *"they are in a strange environment…..and it is really scary for patients without dementia, how much more for patients with dementia…we really try to make them feel secure and settle them in agitation, it is very difficult not only for patients with dementia but for other patients as well" (1.2)*

From the acute areas, it was recognised by the participants, that the combination of high speed and busyness created an overstimulated as well as an unfamiliar environment for persons with dementia. Other triggers included the unfamiliar hospital noises and odours. There was agreement from the participants that these aspects of the acute care environment posed the potential for triggering responsive behaviours for persons with dementia. Based on the participants' experiences, the acute thrust of the ward led to the nurses having to prioritise task focussed activities such as ensuring patients were ready for various procedures thus limiting nursing time to attend to the psychosocial aspects of care required by persons with dementia:

> *"if you have got someone whose acting out and very agitated, and aggressive, and pacing and frightened, they are frightened, they probably don't have a clue where they are or what's going on, I am sure they think we are going to harm them, that fear*

is there, lack of familiar surroundings, familiar smells, noises everything, it must be awful and the noises that goes on in a hospital" (2.3)

"some of the environmental aspects, high speed in acute wards, a lot of activity and patients that had dementia, seemed to be having a hard time, between patients having IVs and going for procedures and that, staff are run off their feet, not an environment for patients with dementia at all" (1.5)

"too much going on, too many people coming in and out, between visitors, doctors" (5.1)

7.3.1.4 Orientation Cues

The participants, from two of the three hospital sites, discussed that a further barrier for persons with dementia to overcome, was trying to negotiate their way in an unfamiliar environment without the benefit of visual prompts or orientation cues. The participants reported that appropriate orientation cues were not provided by the organisation, consequently, this situation could potentially result in persons with dementia getting lost, for example, on route to the toilet. This situation impacted on the nurses' experiences of dementia care nursing, as persons with dementia becoming lost and dis-orientated within a busy environment can potentially lead to an unsafe situation. The participants discussed their dissatisfaction and frustration at the lack of orientation cues, which they knew would benefit persons with dementia. The participants were aware that a dementia friendly environment should include such items as, clear signage, colour co-ordination and clocks for orientation purposes. It was also discussed that research demonstrates that using red plates instead of the hospital issue white plates can potentially improve nutritional intake for persons with dementia. It was related from both the rehabilitation and residential wards/units in one hospital site that signage was beginning to be seen as important. It was reported that orientation cues have been erected by the occupational therapists, but this initiative has still to be evaluated:

"I think signage is not helping patients, I think they feel more lost, like say the toilets, there are no clear signs" (2.4)

"there are a lot of environmental things that could be done but they aren't and we know this and we have known this for how long, colour co-ordination, signage, clocks, plates all this stuff" (4.4)

"the occupational therapist has recently put up a lot of signs, where the bathroom is,

where the dining room is…..they have only done that recently, so whether it will make a difference, I don't know" (3.2)

The participants believed that as well as providing orientation cues, the organisation needed to introduce a clinical nurse specialist role in dementia, in order to both drive the placing and organisation of environmental cues and to provide appropriate education as to the theory underpinning the changes:

"There is so much to be done, a lot of work to be done, we need a dementia nurse specialist to be brought on board and to drive these things and educate the reason behind it, it is not enough to make changes, people have to understand what they are about" (4.1)

*"There needs to be one person to drive dementia care, someone on the ground with experience of managing these patients with awareness of dementia friendly hospitals and all that" (*4.4)

Further discussion about the environment of care led to the importance of creating a familiar environment of care for persons with dementia.

7.3.1.5 Creating a Familiar Environment of Care

From one of the residential units, it was discussed that the major thrust of residential care is the creation of a homely living environment for residents with and without dementia. With this in mind, the participants stated that they would like to have a situation where they could create a sense of familiarity and homeliness for persons with dementia. This would involve the residents being able to have some of their favourite items from home such as a favourite chair. However, the participants commented on the frustrations of knowing the importance of creating a sense of familiarity but the difficulties encountered in making this a reality within a facility linked to acute hospital services:

*"like to be able to bring in their favourite chair or their dresser or their little bits, there is none of that, you know to bring in their own television, there is none of that, it is all cohorted for the patients in one room " (*2.8)

"when you are aware of all of this and you can't provide all this, it is so frustrating" (2.7)

This sub-theme reported the focus group findings associated with various aspects of the physical environment of care within the unique environment of non-dementia specific units contained in dedicated health care services for the older person. Although the findings promoted a deeper understanding of the impact of the care environment on nurses' experiences of dementia care nursing, there were points raised that are at variance from the phase one findings. For example, in phase one, respondents reported that patient safety and observation of patients were easy to maintain. In contrast, the qualitative findings highlighted that the use of technology was employed by management to promote safety and security. A further challenge for both persons with dementia and the nurses' experiences of dementia care nursing was the unfamiliar, overstimulated environment of care. The following aspects of the organisational environment will be presented in the following section: organisational support to include staffing levels and the effect on quality of care and the use of 'specials'.

7.3.2 Organisational Environment of Care

The organisational environment of care, takes account of organisational support along with issues related to staffing levels. From phase one, in relation to organisational support, findings demonstrated that respondents were generally satisfied that the organisational support they received permitted them to work at a comfortable pace, staffing levels were mostly satisfactory and quality of care was believed to be good. These findings were at variance with the literature review findings and led to the decision to explore these aspects of dementia care nursing further in phase two as outlined in the FGIS.

7.3.2.1 Organisational Sources of Support

The participants identified that important influences on their experience of dementia care nursing was the degree of perceived support that they received from their nursing colleagues and the corporate management team. There was general agreement reached between the participants that while they felt supported by their colleagues, this did not always extend to corporate management. Lack of perceived support, from this level of management was believed to be related to the fact that they were somewhat removed from the clinical nursing areas. Consequently, it was perceived that there was a general lack of understanding regarding the nurses' role within the age related units. The participants considered that this layer of management did not understand the intricacies of dementia care nursing and it was believed that they would benefit from more exposure to the clinical areas. The participants stated that they would really welcome a show of support and acknowledgement from the

corporate management group for the work that they do. It was thought by the participants, that to gain a true understanding of the challenges and stresses experienced by nurses in the provision of care for persons with and without dementia in non-dementia specific areas for the older person called for an assessment of the nursing role to be undertaken by the corporate management team:

> "*I don't think management, actually, unless they come down and they are on the floor, they don't actually know what it is like*" *(3.3)*

> "*I think there is too much detachment from the higher up management….. I think they would benefit from a bit more hands on. I think they are just looking at computers and numbers and they are not seeing the people in bed…………we have different priorities for our residential patients it is all about comfort and happiness*" (1.3)

> "*someone who has got to the top level, should come and sit down especially in the area where I am working, it is not happening so I dunno if someone came in as ….. said, they can join with our group for the say acute ward and then come and sit down and assess what we are doing, it would be better – join in – how much would it be useful - I would really appreciate because that is where we are lacking, I think if they gave more support to provide care for the patients - at least if they do come once in a while to come and assess how the stress of the staff or how they are working, you know that kind of a thing at least and try and support some time*" (1.4)

In contrast, the participants firmly acknowledged that they felt supported within their own units by their colleagues and direct line managers (clinical nurse managers), the two groups were both identified as generous sources of support. The participants described that when they experience particularly stressful situations due to staffing level problems or difficulties encountered with persons with dementia or their family members, whatever the cause of the stress, it was acknowledged by the clinical nurse managers. The following account illustrates this point:

> "*I think on our unit itself, we are supported and I think that we get a lot of acknowledgement if there is, are any difficult times, whether it is staffing or you know stressful situations with some of our residents or families or whatever. I think that it is always acknowledged after the fact, that there is appreciation, we know that it was a hard few weeks or a hard day*" (1.3)

Organisational support was also discussed in relation to hospital policies as outlined in the next section.

7.3.2.2 Policies and Procedures

In consideration of the environment of care within non-dementia specific wards/areas linked to acute hospital services, the participants spoke of the organisational influence of hospital driven policies and procedures particularly in relation to the residential care units. It was believed that these documents have a negative effect on the care purpose within age related services as the hospital policies and procedures are focused on "getting the job done" or the physical aspects of nursing care. The participants did not believe that they were appropriate for the delivery of dementia care nursing which is underpinned by the person-centred philosophy of care or "getting to know the person" and developing a biography of the person:

> *"you need to have procedures like this done and that done we are more patient centred, it is a hindrance for patients with dementia to be in a general hospital. In a general hospital, the priorities are different, they are focussing on like the work being done, not on whether Betty and Carmel have time to sit down and chat and really get to know their patients"* (1.3)

According to the participants, the delivery of quality dementia care nursing is only possible with appropriate staffing levels as discussed in the next section.

7.3.2.3 Staffing Levels and Quality of Care

In relation to staffing levels, there was agreement from the participants across the three sites that the perceived insufficient staffing levels within all of the wards/units resulted in challenges in providing the quality of dementia care nursing that they wanted to deliver and that they knew persons with dementia needed. It was believed that the care of the older person wards/units had higher staffing ratios than other wards/units but nurses stated they were still not in a position to provide holistic care due to regular nursing shortages. It was discussed that when nursing staff are on leave, they are not always replaced, leading to poor staffing levels. The participants reported that due to poor staffing levels they were challenged in attending to even basic nursing care such as hydration and nutrition, prevention of weight loss and/or the development of pressure ulcers. The following statements illustrate the participants' views on staffing levels:

> *"we do have a higher staffing ratio….but we are still not in a position to really, really provide holistic care"* (4.4)

> *"two people are out on long term sick leave, they are not replaced"* (4.2)

> *"6 patients, one nurse we are given. So for 26 patients on the unit, there are two carers (HCAs) on duty on the day, so that is it, in fact on one day of the week there is*

only one. One nurse will start the medication, feeding times, they need to be fed" *(4.2)*

"If you have four people who need to be fed, very hard, you might get one carer (HCA) that can help you so you feed one and then you are on to the next person….even hydrating them during the day, giving them fluids. People are not getting the care that they deserve – you have higher risks of skin breaking down, patients losing weight" (5.1)

The perceived poor staffing levels combined with care environments which the participants described as task orientated, where the medical and physical care needs of the person was the priority, led to the participants perceiving that providing dementia care nursing underpinned by the philosophies of person-centred care was very challenging. Participants reported that as a result of focusing completely on the physical aspects of care combined with poor staffing levels, resulted in persons with dementia's psychological needs such as exploring the cause of responsive behaviours being overlooked. The participants were clear that social interaction and relationship building to achieve meaningful connections is just as important as physical care. It was recognised that dementia care nursing should include practices such as reminiscing and orientating persons with dementia to the time difference between day and night. However, despite understanding the importance of psychological care, the reality was that attempting to provide this level of care proved to be difficult, due to insufficient organisational resources such as adequate staffing levels and basic tools such as calendars. The following accounts brings into sharp focus, the challenges faced by the participants:

"The most important thing that is driven is just medical, physical that whatever is wrong that is the way that they are treated"   (5.1)

"The acuity is really high so the focus is really on acute nursing care as opposed to managing challenging behaviour" (4.4)

"…we simply don't have enough time and staff to look after them. … introduce orientation, things to help them….. to remind them of the time, they don't have any sense of the time, you know during the day or at night some of them get confused between night and day, could use calendars but we don't have any on the wards and we don't have enough staff to sit down and have albums that they can relate to their past. Some of the patients feel at ease if they talk about their past. I don't think they have any awareness of the present …." (1.2)

"we don't have time and it is very stressful when we can't give time, a lot of our residents would be full nursing care, ….they can't do activities of living, they can't do

anything for themselves, it is like I say a different focus, like my stress is oh I didn't get a chance to sit down or to chat to that lady today" (1.3)

*"night staff, there is only 2 staff for 25 patients, one nurse and one carer.....maybe more 10, 15 with dementia……staffing is not what it should be"(*3.1)

From the rehabilitation wards/units in the three hospital sites, the participants discussed the wider consequences of poor staffing levels which included potentially leading to both an increased risk of persons with dementia falling and delayed discharges. Perceived, poor staffing levels also impacted on the person-centred practice of developing care plans to set appropriate rehabilitation goals with the patients. The participants highlighted that the purpose of rehabilitation is for persons to recover, as far as is possible, skills to enable them to be as independent as they can be in their activities of living. According to the participants the perceived poor staffing levels hindered this goal by slowing down the rehabilitation learning process, thus potentially delaying discharge. Leading from this comment another participant outlined the many challenges experienced by the nurses in provision of nursing care appropriate to the rehabilitation unit, such as continuing the physiotherapy walking programme. The participants also explained that added to the nurses' work load challenges, if a fall is sustained by a patient during the course of the hospital admission, time consuming incident forms outlining the circumstances of the persons' fall have to be completed and the situation could arise where the organisation could report back to the ward/unit that they held the record for the greatest number of falls. Consequently, leading to feelings of powerlessness and stress for the staff:

"In terms of person-centred care, we should be providing care plans for patients, we should be setting goals…….that doesn't happen, yes we set goals amongst the multi-disciplinary team but we are setting goals for the patients, but they are very rarely involved in that" (4.4)

"from the rehab perspective, I believe that we definitely do need to spend a lot more time with our patients, like especially helping them relearn the skills they are not able to do anymore. We need to spend a little bit extra with them which we actually don't, it could have an impact on the discharge plan, it could probably even help the patient learn and at the same time, learn it quicker rather than not having the time to do it and just kind of do what you have to do and move on, delaying the learning and kind of you know the discharge eventually so I think we would need, definitely a lot more staffing than we have at the moment" (2.4)

"when you are left with 2 or 3 nurses because they clearly won't provide any replacement for……. left with 2 nurses, one attendant …….because it is rehabilitation, they are encouraged to walk and then you have to walk with them to the toilet with 2 nurses and then you have still loads of things to do there…. At the end of the day, there will be 2 falls and somebody will come to you, oh you have the greatest number of falls, it is very discouraging because you try to do as much as you can …..we always send incident forms so then "oh you have the greatest falls" you have to or the CNM2 has to answer that and you have to explain anyway what happened, no matter how you try to do as much as you can, there is just a limit as to how you can be in 2 places at one time" (2.2)

"nurses manage 24/7……..everyone else can walk away and leave and they are the ones that are out there and they are the ones, if they fall or if they haven't got their medication on time or whatever happens – what were you doing, why weren't you there, why did they fall…..it all comes back to them" (4.4)

As a result of poor staffing levels and the challenges faced in provision of quality dementia care nursing, participants reported experiencing profound feelings of frustration, disappointment and emotional exhaustion:

"I leave here really frustrated like I know that I haven't given the care that I would like to have given………..physically you can't because there is not enough people" (5.1)

"I would say 90% of the day, we would leave feeling disappointed, disappointed in yourself, because you couldn't do an extra shower….." (5.3)

"I find that sometimes it's very emotionally draining, I go home and sometimes, I am emotionally exhausted, I am drained. Oh my God I have to face all of that again tomorrow, really, really tired" (5.1)

Another concern relating to staffing levels and nurses' experiences of dementia care nursing, is the use of 'specials'. The participants explained that sometimes as a result of persons with dementia displaying responsive behaviours, they have to request one to one 'special' observation.

7.3.2.4 'Specials'/ Enhanced Care

'Specialing' is taken to mean close observation undertaken to provide one to one observation or care when persons with dementia manifest responsive behaviours (Wilkes et al**,** 2010). According to the participants across the three sites, 'specials' are hospital wide health care assistants (HCAs) with no training in dementia care who undertake observation of persons

with dementia during an episode of responsive behaviour. The participants spoke of the unusual situation whereby persons with very complex nursing needs who need to be cared for in a specialist manner are allocated to the care of untrained staff. It was explained that due to the lack of an appropriate skill set, the 'special' may inadvertently escalate the situation. So rather than giving support to the nursing staff, the nurses' work load can be increased as they have to take time out of their schedule to manage or de-escalate the situation leading to a position described as a care or time burden. It was explained that if the nurse did not step in to manage the situation, potentially, it could escalate to the point where other patients within the ward/unit become upset. There was agreement that HCAs who are going to take on the role of a 'special' with persons with dementia should under-take a compulsory dementia specific educational course to ensure competency in the role. Added to the lack of training, the participants reported that in their experience, cultural diversity can also unintentionally exacerbate the situation. It was explained that many older adults who grew up in Ireland are not generally familiar with different cultures, consequently this fact could impact on the way that they respond to the allocated 'special':

"I always find it very strange that even although these patients are so complicated and need to be looked after and managed in such a specific way to avoid any kind of upset or to exacerbate their confusion or whatever symptoms that they are experiencing that they will send someone to care for someone with such a high level of needs that doesn't actually have training or even the most basic level of training" (5.3)

"The person who is specialling may not be able to communicate in a way to bring down the situation or de-escalate the situation and then ultimately the staff nurse....will have to step in and de-escalate the situation, so they are a care burden, a time burden…………you end up doubling the work that they are there to kind of take the burden…." (5.3)

"I would like anybody who is to be in the role of a one to one special care attendant to have done a dementia specific course and have some kind of certificate....and say, yes I have experience in what-ever and that they show that they are capable and have competency to look after a person with dementia" (2.7)

"If you don't step in, it can become a huge thing and then upsets everybody and all the other patients are very annoyed as well so it leads to double work for everybody as well because you are trying to calm down the other patients who are becoming upset with the situation" (5.1)

"Older adults, 70s, 80s, 90s they are not used to multi-nationals and individuals coming from different countries, as we have grown up with…….that also has a big impact on how they react" (4.5)

Across the three sites, the participants explained that requesting support by way of a 'special' is a detailed, time consuming, systematic procedure which involves completing a full nursing assessment signed off by a member of the medical team. It was pointed out that requests for 'specials' were only made following a thorough nursing assessment which demonstrated that the request was warranted. However, in the experiences of participants, despite fully complying with the hospital procedure relative to requesting a special, they could not depend on their request for support being fully granted. The participants explained that the situation could arise where more than one person with dementia in the ward/unit is charted for a 'special'. The participants identified, that this request was usually facilitated by management sending one 'special' to look after a number of persons with dementia. In the participants' experience, this is an untenable situation due to the fact that one 'special' cannot be expected to provide one to one support to more than one person with dementia at a time. Or sometimes a situation can arise when the organisation does not provide the special requested. This leads into an even more complex scenario resulting in a reduction of regular ward/unit staff being available to provide care for the other patients on the ward. Consequently, provision of essential care or factors that are considered to be basic human rights, such as assistance with toileting and nutritional requirements are challenging to fulfil:

> *"The CNM actually on the ward have to initiate it but they can't put the request through without medical sign off for one on one care" (4.5)*

> *"Like a ward where they need four specials, you are not going to get four specials, what happens on the ward is they cohort patients so now one special is now looking after two or three people" (4.5)*

> *"So you could have one that is wandering that won't sit down, you have one that is trying to get out of the bed and then you have one that might shout all night long and obviously one person can't be with the three people at the same time, so that is problematic" (5.1)*

> *"you have to take one of your floor attendants to attend to their needs, so then you have no floor attendant, so never mind like having to meet the basic needs of your patient load, already with the core staff you are now down a staff, not because of sick leave but because the support you have requested, and people are not requesting one to one supervision care attendants unless they are needed and warranted, so you are now down staff from your regular count to provide care and you are already busy ……now who is going to be bringing them to x-ray, who is going to bring them to where they need to be, who is going to do feeding patients, who is going to be helping toilet patients,……..so it is all the action and the reaction and nobody is looking at that" (2.7)*

It would appear from the discussion that the role of the 'special' and the request procedure involved, has the propensity to burden the nurses rather than provide valuable support.

This sub-theme reported the focus group findings associated with various aspects of the organisational environment of care to include staffing levels, quality of care and 'specials'. Provision of quality dementia care nursing proved to be challenging with what participants' perceived to be poor staffing levels. Issues related to staffing levels which impacted on the nurses' experiences dementia care also included the role of the' special'. It was perceived that this role did not always positively impact on the nurses' experiences of dementia care nursing. The chapter will now present findings related to the theme of Nurses' Knowledge about Dementia.

7.4   Nurses' Knowledge About Dementia

This theme outlines the findings relating to the participants' views and opinions regarding nurses' knowledge about dementia based on their experiences of caring for older persons with dementia in the unique environment of non-dementia specific wards/units. It elaborates on findings from phase one where aspects relating to nurses' knowledge about persons with dementia along with nurses' views and opinions about their personal and professional development were explored and found to be generally positive. To bring about a greater understanding of the reasons behind the quantitative answers, issues related to specialist education and specialist knowledge was explored qualitatively as outlined in the FIGS. Different understandings of dementia and dementia care emerged during the focus group discussions and family care versus professional care was explored and debated. The discussion points are presented in the following section.

7.4.1   Skills Acquisition

7.4.1.1 Access to Specialist Dementia Education

As would be expected from university teaching hospitals, the participants identified that there are substantive educational resources available, with which to develop or improve specialist knowledge in relation to dementia. That said, it was pointed out that dementia specific education is not a mandatory requirement within the age related departments of the hospitals. The participants were aware of various relevant post graduate courses along with the three day national dementia programme which is run in all three hospital sites. Yet, despite, the resources being available, the participants reported that in their experience a lack of

organisational support by way of appropriate study leave and funding was perceived to be a barrier to participation in relevant educational courses. These facts have led to the situation where the number of nurses with specialist qualifications has decreased over the last number of years in the age related units. The current situation is that participation in relevant courses is difficult and consequently, nurses perceive that they have to undertake courses in their own time:

> *"There are so many avenues available that you can take if you feel that you are not competent to look after somebody who has dementia"* (2.7)

> *"if we actually get off the unit to do it is the one"* (3.4)

> *"but it all comes back to the same thing, staff, releasing some of your staff, is there time for them to do these courses"* (4.3)

> *"Over the years, we have had a lower figure of nurses even in our department with gerontology courses and coming on the ground with gerontology experiences. A time when.....we all had the post graduate gerontology course, there is next to none at the moment. We have gone from very high ratios but that was a time when we were fully funded, you got every single day off that you needed – now they get five days, so you are asking someone to take on in their own life so that is certainly one thing that is a big issue"* (4.4)

The participants agreed that specialist education improves nursing practice and competence. Although in their experience, the resources recommended at specialist courses to integrate theory with practice may not be available in the practice area:

> *"after the course, I looked at things differently"* (3.3)

> *"research shows that there is a good response to red plates or pictures on the wall but then when you finish that course – they are doing all this research – the course has been developed by the hospital but yet when you go back to your ward, you are looking for the red plates that they are saying are so good but it is white plates – and yet there is so much research out there that shows they respond well but then it is not even brought in"* (5.2)

It is acknowledged that due to the complexities of dementia, providing nursing care for the person with dementia requires practitioners to be skilled and knowledgeable. Attaining appropriate levels of competence requires on-going participation in specialist education. It would appear that the participants' perceive that there is an on-going theory practice gap which leads on to the next section.

7.4.2 Knowledge Base

7.4.2.1 Specialist Knowledge

While it was acknowledged by the participants that specialist knowledge improves nursing practice and nursing experiences, there was some disparity across the focus groups as to perceptions of the level of specialist knowledge about dementia held by practicing nurses within the non-dementia specific age related units.   The participants acknowledged the importance that specialist knowledge can make to delivery of dementia care nursing and subsequently the well-being of persons with dementia. They also commented on the important linkage between theory and practice and, the point was made that it is not enough to complete a specialist course, the knowledge gained from the course has to be consolidated in the practice area. The participants acknowledged that theoretical knowledge also has to be underpinned with the personal ability to develop meaningful connections with persons with dementia along with a level of intuitive wisdom. In other words the integration of theory and practice promotes the art of dementia care nursing. It was also argued that care of the older person is not given the same speciality status or consideration that is awarded to other areas of nursing such as intensive care nursing. Consequently, due to a general lack of recognition of the importance of specialist knowledge, the person with dementia may not receive nursing care optimum to their condition:

> *"if the nurse is knowledgeable about care for people with dementia, it will be better, they will know what like there are some things that you need to do for people with dementia….so it is very important, you know it really impacts on a persons' well-being"(*1.2)

> *"if they understand they are more tender in their approach to dementia and they will act accordingly to make the person calm"(*1.4)

> *"You need to have a course done, you need to have to know how to deal with dementia and have knowledge about it and all the nurses may not specifically have that" (* 3.2)

> *"you can do a degree all you want, that degree you have to translate into practice"* (4.3)

> *"when they are very agitated or very distressed, I think you learn how to manage it – not through education, through knowing the patients, know what triggers them off and knowing what time they are going to kick off at, so it is not through education that you get that, it's your interaction with the patient and getting to know them rather than education or being formally…..given ways to manage, it is your personal interaction with them that helps you to manage with them" (*5.1)

From the residential care units it was acknowledged that specialist knowledge has increased over the years, the example given relates to medication assessment. As one participant explained, the accumulation of specialist knowledge, coupled with careful assessment to include screening for possible infection, rather than assuming that the increased confusion was due to the dementia pathology has resulted in more judicious practice in relation to prescription medication:

> *"they are screened for infections and everything like that before you attempt to change any drugs and you send referrals, there is lot of thought put into it, whereas a long time ago, you just sedated them if they were aggressive.   Your last resort now is to put them on extra medications, to make them relax and if you do put them on medication, you make sure they are monitored for adverse reactions"* (2.5)

While it is evident that there are pockets of specialist knowledge relating to skilful assessment and nursing practice, there are still instances where persons with dementia demonstrating confusion can be interpreted as increasing cognitive impairment rather than as a consequence of a physical condition. The following scenario from the practice area, illustrates the importance of specialist knowledge coupled with knowledgeable assessment. The situation outlined refers to persons with dementia transferring from both age related and general acute settings to an age related transition unit in preparation for hospital discharge. It was noted that on transfer the patients are deemed to be medically stable and any evidence of confusion was believed to be due to dementia/cognitive impairment. However, following assessment on admission to the transition unit, to include cognitive assessment, it was found that in many instances, the confusion was related to a urinary tract infection (UTI) which if not treated immediately could have led to a delirium:

> *"in the step down unit, we started doing em urinalysis on admission, we did the MMSE (Mini Mental State Examination) within 24 or 48 hours of admission and these were all patients who were coming from this hospital down to us medically very stable and em it was amazing the number of females over the age of 65 years that had Ecoli UTIs and it was – if we hadn't done it, we would have just dismissed them as having mild cognitive impairment, you know and I would say 60% of the patients coming down from the hospital after having been on acute medical wards with 24 hour nursing supervision and 60% would have had Ecoli UTIs, some would have turned into full blown delirium that we could just have put it down to mild cognitive impairment……knowing that we could trace it very quickly, it was just an accepted thing again back to the education and that"* (2.8)

Thus in the foregoing example, follow up assessment for the person with confusion indicated that the confusion was the result of a UTI rather than making the assumption that the confusion was a manifestation of the dementia pathology. Further issues discussed by the participants, suggested that within clinical practice, there remains a lack of clarity regarding the differential diagnosis of dementia and delirium. This point is illustrated by the following sentence made in relation to observations of nurses on age related acute wards within one of the research sites, when caring for persons with dementia who become acutely confused. There is a perception that nurses have a tendency to assume that the sudden development of confusion is linked to the dementia pathology there is no consideration, that it could be a delirium stemming from, for example, a physical problem such as dehydration or constipation:

> *"it must be a dementia, it couldn't be something else, like dehydration, constipation…….care and education…"* (2.8)

A further matter related to dementia care nursing that was considered was the patient age profile. It was noted by the participants that many patients admitted to hospital are amongst the older old (a term gaining common usage for those over the age of 80 years). The participants acknowledged that the older old, often present with complex histories to include co-morbidities along with diagnosed/undiagnosed co-incidental dementia. It was recognised that a thorough knowledgeable and sensitive assessment undertaken by a skilled practitioner is required to ensure appropriate timely care and to minimise complications for this vulnerable group of persons. It was acknowledged that for the older person with frailty, hospital admission has the potential to cause a rapid deterioration in their cognitive function resulting in a prolonged hospital admission:

> *"the old are getting older, their partners are getting older and they are remaining in hospital for longer, the levels of confusion are becoming an awful lot worse …..cognitive impairment coming in the doors of the hospital are affected over a couple of weeks"* (2.8)

Yet, in relation to assessment, the participants explained that cognitive assessment does not form a routine part of the admission criteria:

"the numbers of people with dementia is probably far greater because people are not being diagnosed" (5.3)

"if it is identified that they need cognitive screening, they do and some of it will be informal in the sense that nursing staff might say it is not a formal assessment but you know what, it looks as though things are not right" (4.5)

This means that potentially, persons with undiagnosed dementia are not being offered the help and support required.

7.4.2.2 Cultural Understandings of Dementia Care

The findings demonstrated that cultural understandings of dementia and their influence on dementia care impacted on the experiences of the nurses with Western and non-Western education. Participants who had completed their nurse education in Asian countries recounted that their nurse education and clinical experience was very medically driven compared to the Irish experience. So for example, dementia would not have featured as part of the medical/nursing care in hospital. Once the primary admitting problem was resolved, the older person with dementia was very quickly discharged home to the care of their family, as the cultural experience and expectation is that the older person is cared for by their family. One participant explained that in her home country there is not the same reliance on hospital or institutional care for the older person when compared to Ireland. The participant explained that dementia is not considered as a reason for hospital care, such patients would not be thought of as being sick. Other influencing factors on the participants' dementia care nursing experiences are that, life expectancy was identified as being shorter and according to the participants, dementia is not particularly prevalent in their home countries. Thus, nursing care of the older person with dementia was a new practice and learning experience when the nurses came to practice nursing in Ireland:

"so it was new learning definitely I would have heard about dementia but not to a great extent, it wouldn't have been seen, even though I worked in a medical ward where like a lot of our patients would have been older patients but like it was a very medically driven model of nursing over there, it is very system driven" (2.4)

"coming from a different country, that trained and learned nursing in a different country, definitely like in dementia because life expectancy is very low over there, ...it is not that prevalent like" (2.4)

> *"Ireland is more dependent on hospital care. In .....the children look after the parents. Families would not view people with* dementia *as being* sick *and they are cared for at home…it is rare to stay in hospital…."* (1.4)

Another participant related how her experience of nursing practice in Ireland is influenced by the fact that she is living away from her family and the cultural tradition of the family caring for the older person. The participant explained that due to cultural influences, she finds it hard to practice solely from a professional, evidence based perspective her filial experiences influence her nursing practice:

> *"I go to the emotional level, sometimes I forget that I have to stick to the nursing side of it………the people I look after, I see them as my family……I don't have anyone to accept my love and affection to so seeing them as my relatives as well, my family, I find it so hard."* (3.1)

These findings emphasise the importance of consideration of cultural understandings of dementia and their impact on nursing care and the significance of recognising and addressing this at the point of integration into nursing roles. It highlights the importance of on-going specialist dementia education, to ensure that nurses are providing dementia care nursing according to the person-centred philosophies of the organisation, along with the philosophies of the DOH (2014), HIQA (2015) and the NMBI (2015).

From the perspective of participants educated in Ireland, it was discussed that it used to be common practice in Ireland, for the older person with dementia to be cared for at home by their family. However, this situation has changed due to the fact that many of the women, who traditionally provided care at home, are now engaged in employment outside the home resulting in many persons with dementia now being cared for in professional settings or having increased professional input. It was generally assumed according to the participants, that up to recent times, dementia was considered to be part of the natural ageing process. However, with increased knowledge and education this assumption has changed and it is now recognised that dementia does not form part of the natural ageing process:

> *"women of the household were at home with an opportunity there for people to look after the persons who are dotty or now the person with dementia…. but now there is no-one at home to do minding, long term care facilities is the only answer"* (2.7)

> *"we now have a proper name for it……..when I was growing up….we would be told that someone who was very old and being nursed at home, oh sure they are a bit dotty, scatty you know, there was no proper terminology so education is huge"* (2.3)

Participants who had undertaken their nursing education in Asian countries explained that in their experiences, older persons with senility (sic), are cared for in the familiar home environment with family members, rather than being cared for in a professional residential setting. It was considered that due to the familiarity of home, while older persons may be forgetful, they do not display manifestations of dementia. It was conjectured that, care given by strangers may be the trigger for responsive behaviours. In one interview, there was discussion around the potential impact of alcohol and that this could be the cause or one cause of agitation in dementia. Comparisons were drawn relating to alcohol consumption in the various countries. The suggestion was made that as alcohol consumption is higher in Ireland compared to their home countries, this may be the cause of aggressive behaviour manifested by persons with dementia in Ireland. There also seemed to be a perception amongst a small number of participants' that a diagnosis of dementia is dependent on the manifestation of responsive behaviours. There appeared to be a belief amongst a small group of the participants that senility equates with confusion and forgetfulness and is conceptualised differently from dementia:

> *"It's better to have them in the home, they have a quality of life. Well yes there is where we are coming from, that the families who knows them and you know and by face, they probably would recognise them, won't recognise the name but there is no aggressive behaviour that is why it is difficult if it is cognitive impairment. We label it senility but it is not dementia. It is not diagnosed as dementia because there is no challenging behaviour"* (2.6)

> *"because it is our home setting, we look after our old so at least maybe, we are used to the family member and like if they are in a nursing home, you would be seeing different faces"* (2.1)

> *"I think that the weather has got something to do with it….it's a cold country so people would be more on the beer, or maybe the diet or something, we don't have aggressive behaviour back home"* (2.6)

In an effort to counter balance and clarify the issues related to the influence of environments and the points raised regarding alcohol and the person with dementia and understandings of

dementia, participants who had undertaken their nurse education in Ireland discussed both of these viewpoints. One participant related her experience of taking part in a dementia mapping course. The participant contrasted the difference between being able to identify triggers leading to responsive behaviours in the familiarity of the home setting or the more settled environment of the transition unit in the hospital in comparison to the difficulties of identifying the same triggers in a busy acute ward/unit in the hospital environment. It was pondered if it was partly the environmental factors that caused the aggressive behaviours rather than the alcohol:

> *"I wonder if the aggression that we are seeing is it partly environmental….*
> *I wonder if it is I suppose not the alcohol but is it something that we can zone in our home environment for the older person, like the sister coming in, we don't need the level of memory books and journaling and that you know in the old days with the repetition I dunno it was the familiarity to the end you know they were doing it"* (2.8)

Another participant who had undertaken her nurse education in Ireland, in response to the earlier comments regarding care in the family home versus the hospital environment stated that, of course, nurses know that the hospital environment is unsuitable for persons with dementia. However, she questioned, where can persons with dementia go, when they experience an acute illness or accident:

> **"….***we all know the acute admissions, the elective admissions, the rehab wards, the busy wards, they are so inappropriate for a person with dementia…. now we have an emotional battle with ourselves every day because you go in to look…. after the patients within your unit and……. the medical problem we have resolved but we have exacerbated her dementia to a point where she has challenging behaviours now and the whole environment is so inappropriate but where are we gonna go because the family now feel that Mrs Bloggs' dementia is exacerbated because you know the triggers have been there and she is acting differently now, they are fearful, very distressing, very frustrating because you have a battle with yourself"* (2.7)

This was responded to with lots of murmurs of agreement around the table

> *"and you are fighting a battle with yourself …….but where does the person with dementia go when they are acutely ill, we don't have the facilities here in Ireland, we just don't and that's final…..we do not have the facilities to look after somebody the way we would want to look after them because we know how we should look after them"* (2.7)

The importance of on-going education was brought to the fore, with one participant who had received her education in Asia, commenting that while she did not have any theoretical knowledge or clinical experience in relation to dementia care nursing when she initially came to practice in Ireland, through on-going education and experiential learning, her knowledge base has improved:

> *"during my first year here in Ireland, obviously dementia wasn't heard of and it wasn't a diagnosis in any part of the world and em when I was told that you know, this old lady didn't have a bowel motion for 3 days and became confused, and all this, I said to myself NO that couldn't be the reason. I kind of feel that it is not the reason why they are confused, I feel like em how could that contribute to confusion and then from learning it all and training even how you approach communication it has all improved"* (2.6)

From the theme of understanding dementia, the findings demonstrated that while pockets of specialist knowledge exist, particularly related to patient assessment, there are still gaps in nurses' knowledge to be found. A significant finding that emerged from the focus group interviews related to the influence of cultural understandings of dementia and dementia care nursing. The importance of on-going specialist education was highlighted to ensure that all nurses are practicing according to organisational philosophies of care. Yet, it was indicated that many nurses perceived that they encountered difficulties in receiving organisational support to participate in specialist dementia education. The chapter will now move on to the theme of Ethical Dilemmas.

7.5   Ethical Dilemmas

The findings presented in this section relate to the ethical dilemmas as experienced by the nurses in their practice of dementia care nursing in the identified setting. This section elaborates on findings from phase one, as highlighted in the FIGS, in relation to both the lack of opportunities to discuss the psychological stress of the job and lack of provision of constructive criticism (sic). Within this theme the participants reflected on the vulnerability of the person with dementia. This was discussed in relation to the principle of autonomy and linked to nurses' experiences of dementia care nursing. Further matters that were discussed related to nurses' duty of care, balancing care needs and advocacy issues. Another matter that came to light was that in view of the complexities of the ethical dilemmas experienced by the nurses in their daily practice, it was believed that the organisation should provide support by way of clinical supervision and education.

7.5.1   Ethical Dilemmas Experienced in Dementia Care Nursing Practice

7.5.1.1 Principles of Autonomy, Beneficence and Non-maleficence

The consequences of receiving a dementia diagnosis in relation to the decision making process or autonomy of persons with dementia was discussed by the participants, in relation to their experiences of dementia care nursing. It was perceived that persons receiving a dementia diagnosis and having a low score as assessed by the Mini Mental State Examination (MMSE) (Folstein et al, 1975) appeared to equate with both a loss of confidence and autonomous decision making. According to the participants, from their experiences of caring for older persons with dementia, to ensure that persons with dementia have their voice heard seems to be dependent upon (i) the level of advocacy initiated by professional staff and the family carers and (ii) the motivation of the professional staff and the family carers:

> *"it is the stalling to make a decision whether this person needs to go home or care package or whether to go to long term care when the decision is made to go LTC, the family stall, they go no no no………. the person in the hospital bed is forgotten about, they are forgotten about because they don't have a voice, their voice is gone at that point, If you are seen with your MMSE that's low and you don't think, at that point you have lost your voice so the family around depending on their motives, that person can be left sitting there for maybe a year, they say person-centred at one point but they are lost, they are bored, they are lost within themselves"(2.8)*

> *"the confidence for the patient to decide for himself is gone"* (2.2)

In the context of autonomy and decision making by persons with dementia, a scenario from clinical practice was discussed by the participants. The discussion outlined the situation when persons with dementia are deemed to have lost the cognitive ability to execute the decision making process and the implications for the provision of dementia care nursing. The participants discussed this ethical dilemma in relation to nurses' duty of care and respect for the dignity of the person when they refuse medical and nursing care as well as nutrition. A further discussion then ensued relating to quality of life issues to include the ethical principles of autonomy, beneficence (obligation to do good, to remove and prevent harm and weigh possible goods against the costs and possible harms of an action) and non-maleficence (principle of doing no harm) (Moule and Goodman, 2014) along with the nurses' duty of care:

> *"…he was told by his own team that he doesn't have the cognition, he cannot decide for himself that he can go home because because so he has been brought to another ward, he refused to have one month of medication, one month of no eating, so he was*

put back to our place, after 2 weeks time fully he was abstaining from his food and everything, so thankfully after 2 weeks he went back, he eats but medical and nursing he is refusing – warfarin and everything so far, in good form but the only thing is there is nowhere to send him anymore" (2.2)

"if that person doesn't have capacity, it is a very grey area……… but it is, are you going to let that person starve to death, they don't have the capacity to make that decision" (2.8)

"is it chemical restraint over physical restraint, it is still force feeding and the person still does not have the capacity, so are we still just flowering up and so what is the….." (2.8)

Issues related to providing sensitive nursing care to ensure respect and dignity are maintained for persons with dementia during episodes of restlessness and agitation, were considered within one focus group interview. The discussion included issues related to the commencement of sedation to settle persons with dementia when they become upset and restless. It was agreed that this can lead to nurses experiencing conflicted feelings. In terms of the benefits/risk ratio, while it was recognised that there are benefits such as ensuring the patients' safety, the drawbacks include issues such as a potential loss of mobility and continence. Finally, it was recognised that oftentimes due to the intricacies of the ethical dilemmas and the number of stakeholders involved, it is simply impossible to reach a clear solution:

"………..this lady would have been in a side room, throwing utensils, nobody would go into the room, they were terrified of her, the language for someone who never was like that prior to her developing dementia was unbelievable – the aggression, the absolute anger and she was commenced on a very low dose of haloperidol" (2.3)

"When she was off it she was mobile, she was at even greater risk to herself of damaging – say down the backstairs you know, but she was commenced on a low dose of haloperidol and whilst it has – she is a lot calmer in herself, all that agitation and aggression has gone, she seems quite content in herself, the effect it is has had on her, she is now totally immobile so has lost one thing to gain another" (2.3)

*"I suppose looking at her family and in particular her husband, he finds it very difficult now to understand how she can be doubly incontinent, it has progressed to that stage and she is unaware of that , ……very sad, which do you have, you couldn't have her the way she wa*s" (2.3)

"as a manager, I can see completely, like you are looking at the risks to the staff and the risks to herself and you know it's an ethical dilemma that I don't think you could ever conclude" (2.7)

In the participants' experience, they also recognised that they had to have the professional competence to balance care needs for all of the patients in the non-dementia specific wards/units. Balancing care needs and advocacy issues also extended to relatives and visitors to the wards/units. This leads into the next section.

7.5.1.2 Moral Imperative to Balance Care Needs

From the acute units, a picture of an unpredictable chaotic environment of care emerged which impacted on the care experience of nurses and patients alike, both persons with dementia and those without. The participants described the situation where some persons with dementia call out constantly, or a further source of noise came from bed alarms being activated to warn when the patient is in danger of falling. If these incidents occurred through the night, a decision could be reached to remove persons with dementia out of the ward to allow the other patients to sleep. This action was taken in acknowledgement of the fact that sleep deprivation has a fairly profound effect on the welfare of all of the patients and has the potential to interfere with recovery rates. It was also explained that sometimes the situation can occur when a person with dementia, in the process of walking around the ward can accidently interfere with a patient who is very ill thus leading into an unsafe situation for both parties. The following accounts illustrate the challenges experienced by the participants where safety issues for persons with dementia and those with no dementia have to be honoured and a balance of care has to be reached:

> *"So these are patients that would shout all night long, call out all night long, some of them would be on bed alarms because they are at high risk of fall, so the alarms are going off so it ends up then the other patients, they are getting very sleep deprived, so we end up having to move the patient from the room. Taking the bed out of the room and taking them down to the nurses' station so that the other patients can sleep"* (4.1)

> *"The other patients during the day who aren't with dementia end up missing meals, not drinking enough because they are so tired, so they are in a completely different cycle……they are refusing physio, they are refusing OT……it has an effect on everybody"* (4.1)

> *"if the patient with dementia is coming to especially an acute care setting, I think there is some hindrance to moving around to do their own business like for example in the next bed if the patient is sick maybe they don't like another patient going in and interfering with others so I think it is not appropriate for a dementia patient in an acute care setting …. I don't think it is even safe for the dementia patient but rather both sides"* (1.4)

The challenges of balancing care for persons with dementia and those without were also reported from the residential care environments. The residential units cater for both persons who have continuing care needs and persons who avail of a short period of respite care. The participants described that due to the dementia pathology, manifestations of different behaviours can be displayed by persons with dementia which can be frightening for the persons with continuing care needs and those persons who avail of a short period of respite care. The participants described that persons with dementia have both physical and psychological needs that can take up a considerable amount of nursing time which can impact on balancing nursing time available for the other persons within the unit. It was reported that this situation may lead to jealousies amongst the other persons in the unit receiving care who may perceive that they are not receiving the same amount of nursing time. Participants were also aware that they had to ensure that a suitable mix or balance of persons both with and without dementia was allocated within the rooms in the unit:

"Sometimes, people can get jealous, why are you always with that person" (3.3)

"I think they both suffer really because patients with dementia need a lot more care, a lot more attention, different behaviours and if someone has no issue about that and if they are very quiet, they can miss out because your focus is more on trying, making the care of the patient with dementia more comfortable and they can find it quite frightening especially, we do have respite beds and when they come in, if they don't have any insight into it, it can be quite frightening and we try to get the balance of rooms suitable for them to be together, it can be hard" (1.3)

Achieving a balance of care between persons with dementia and those without in non-dementia specific care environments is evidently difficult to achieve and impacts heavily on nurses' experiences of dementia care nursing. Persons with dementia are recognised as requiring more in the way of nursing care time to ensure that their complex physical and psychological needs are met which can result in persons without dementia not benefitting from the same amount of care time.

Nurses' experiences of dementia care nursing care within a non-dementia specific care setting are also influenced by other patients, relatives and visitors to the units. It was agreed by the participants that the views and opinions of other patients without dementia, relatives and visitors can often be quite negative towards dementia. According to the participants, other patients and their relatives/visitors within the ward/unit can become angry and dismissive of

the person with dementia while others take on a pitying attitude. It was suggested that some patients and visitors complain and request that the person with dementia should be moved off to another area. In some instances, other patients in the ward when they witness the person with dementia manifesting responsive behaviours which they perceive as aggression towards the staff can mistakenly take on the role of staff advocate. Consequently, these issues require sensitive intervention and advocacy by the nursing team. These comments highlight the intricate balancing act of providing care for the person with dementia and others:

> *"...when a patient sees another patient acting, you know, acting out or with challenging behaviours, they can get quite frustrated, angry, quite dismissive of them "get that patient away from me" "don't let him come near me" really angry mm fearful and some pity (*consensus from others, murmurs of yea yea*) patients pity other patients, very much so and fear that God forbid that that will happen to me mmm and God love the staff having to put up with that"* (2.7)

> *"You have the family kind of complaining….some of them are saying can that patient not be moved off and why do they have to be in this room"* (5.1)

> *"they feel very ahh sorry for the staff especially if the see someone being physically or"they feel very ahh sorry for the staff especially if the see someone being physically or verbally aggressive towards and get quite irate at the patient and can be verbally aggressive towards the person with dementia and challenging behaviours and they are only seeing it as they are acting on the nurses behalf or carers behalf"* (2.7)

A poignant experience from clinical practice emphasised the distress that can occur within a non-dementia specific ward, for all parties concerned when a person with dementia becomes disinhibited. Lack of understanding of the manifestations of the dementia pathology can cause unintended distress to the other patients in the ward especially when it involves the removal of clothing:

> *"You would see some people actually reduced to tears because their dignity can be affected and it is not a lack of care or lack of, I am just thinking of one ward, a while ago where there was a gentleman who just wouldn't leave his clothing on, he kept removing it all of the time ………he had a one on one - but he just wouldn't leave his clothes on and his dignity, everything was – dreadful to witness it and I can only imagine what it felt like for a patient in for investigation, looking at that, I am sure they thought we were neglecting them ……….one person was visibly brought to tears and was very very upset couldn't understand that somebody could not know what they are doing (*consensus of opinion murmurs of yea, yea*) of course they understand. You know and you couldn't get it through to them actually, that person doesn't really realise what they are doing – that is very tough"* (2.3)

The findings demonstrate that for both nurses and persons with dementia, experiences of dementia care nursing are influenced by the views and opinions of other patients and visitors to the wards/units. At times, the attitudes of other patients and visitors towards persons with dementia can be quite negative which results in the creation of difficult dynamics within the care environment calling for sensitive advocacy by the nursing team. These comments lead into the next section which explores the topic of debriefing and support.

7.5.2 Desire for Support

7.5.2.1 Debriefing and Support

It was suggested by the participants that due to the many complex ethical issues experienced by nurses in practice, the organisation should provide organisational support by way of clinical supervision or a peer support group and education. It was agreed that this would facilitate nurses with opportunities to reflect and discuss the many ethical issues that they experience in their daily practice and would also provide on-going support. It was related by one participant that one of the geriatricians provided her with the opportunity to discuss ethical dilemmas that she was faced with particular to dementia care nursing. While she appreciated this opportunity because of his expertise and knowledge about ethics, this was on an *ad hoc* basis and she would welcome the availability of clinical supervision:

> *"so we have sick patients or some type of issue or an emergency ethical dilemma that can come up, sometimes, what we don't do is have a discussion about it after, you know brainstorm how people actually felt about it....."* (1.5)
> *"Ethical dilemmas that we face into should be debriefed. We don't have discussions or brainstorms, open discussions over issues should be encouraged, open to learning. Management should encourage discussions, we could learn within the team"* (1.5)

> *"there aren't any forums for discussion of ethical dilemmas, my colleagues here that I can discuss it with but that's it"* (2.3)

> *"I have come up against it as well in the past, there is nowhere to go with these things, I did with the consultant …….but at least I can, the time to listen, this is just wrong do you know, he can say from his level of expertise with ethics, but there is nowhere and there is no point in talking to your manager because……….education programme has the ethics and legal aspects…listen I don't think that really is ethically…."* (2.8)

The theme of ethical dilemmas brought about a fuller understanding of various issues experienced by nurses in the daily practice of dementia care nursing to include nurses' duty of care, balancing care needs and advocacy issues. It was suggested by the participants that

that they would welcome organisational support by way of clinical supervision and specialist education to promote ethical competence in decision-making. The final identified theme 'Dementia – A Misunderstood Concept is now presented.

7.6   Dementia - A Misunderstood Concept

Within this section issues related to nurses' views and opinions about attitudes towards dementia are presented. From phase one, it was noted that overall the respondents held positive attitudes towards dementia care nursing and person-centred care but they were less hopeful for persons with dementia. As such, issues related to the nurses' attitudes towards dementia and person-centred approaches to care were explored within the focus group interviews as outlined in the FIGS. The influence of both positive and negative attitudes espoused by nurses and the influence of the MDT in relation to dementia care nursing are explored and discussed in the following section.

7.6.1   Influences of Attitudes on Dementia Care Nursing Practice

7.6.1.1 Nurses' Views and Opinions about Dementia

During the focus group discussions about attitudes towards dementia, it was agreed that in the past there was a societal stigma attached to dementia which influenced the care that the older person with dementia could expect to receive. However, based on the participants' experiences, it is now believed that negative attitudes are gradually being eroded. The participants acknowledged that nursing practice is influenced by societal attitudes and as a result of more positive attitudes, more recognition is now being given to the importance of specialist dementia units and specialist dementia education:

> *"becoming more socially acceptable, was previously regarded as a stigma not an illness and was not treated as a medical. Now we are more open to setting up units and training for nurses"* (1.1)

> *"Education does help to change attitudes" (1.5)*

In a positive manner, the importance of nurses engaging with persons with dementia to facilitate PCC by way of making a meaningful connection was acknowledged by the participants. On the other hand, the participants also reported that negative attitudes still exist amongst some nursing staff and this has the propensity to impact poorly on the quality of dementia care nursing. An example was provided whereby some staff would consider that

nurses who engage with persons with dementia by providing a PCC approach to incorporate, psychological support such as sharing moments was evidence of these nurses not really working. It was also acknowledged by the participants that persons with dementia can be sensitive to a negative atmosphere. A negative atmosphere was described as a lack of interaction or communication between nursing staff and persons with dementia. It was suggested that this can impact heavily on persons with dementia and lead to them experiencing feelings of distress. In the nurses' experiences, if distress is interpreted as disruptive it can result in sedation being mooted by some nurses as a form of management:

"They may not remember you from one day to the next, I think they definitely at some level, they meet with you at some degree, you can connect with them" (5.1)

"They can be restless and you have to be there……just to sit with them sometimes…and like others….we are not really working…..holding their hand…they think that…comfortable and not doing any work" (3.1)

"I think it is there, it is their attitude…… and you can see the result in the patient, ...if they are in the room and they don't care, the patients are bored and agitated because there is no communication…impacts heavily on the person with dementia, patient picks up on the vibes………..negative attitudes can cause harm" (1.1)

"an opportunity to provide distraction therapy or to access distraction therapy instead of having to use a medication….it isn't solving the problem, I understand there is a role for medication and nobody should be left for long periods of agitation, of course there is going to be a benefit from medication but it should be used in a responsible manner" (5.3)

"when patients are agitated, get them something, get the doctor down, just get them something, sedate them" (5.1)

7.6.1.2 Working as a Team

The importance of a supportive nursing team in the provision of dementia care nursing was referred to by the participants. It was acknowledged that there can be personal challenges experienced in dementia care practice such as communication difficulties, both in understanding and being understood. It was explained that when the interaction/communication between the nurse and the person with dementia is not progressing well, a possible resolution to this situation is to seek support from other members of the nursing team to take over nursing care. This action facilitates reflection on the

encounter but it requires understanding of the situation and a positive and supportive attitude towards dementia care nursing:

> *"we work as a team or whatever, if you are actively working with a patient and you know looking after a patient and things are not going well, you can see that the patient is getting agitated or whatever…..you know you walk away and see if someone else can come on board and you know and deflect the situation or whatever, come back and approach the person again, …….what you are doing isn't the right approach, you are either too rushed or you are saying the wrong word or whatever, you just back off"* (1.5)

Dementia care nursing takes place within the MDT and therefore nurses' experiences and nursing practice is influenced by the attitudes of the team members particularly in relation to the notion of successful ageing and discharge planning. According to the participants if a person has a dementia diagnosis, there is reluctance by some members of the team to think about successful ageing with dementia and the possibility of discharging the person to an independent living facility. Consequently, the decision can result in a longer hospital admission while the person awaits residential care placement. This can potentially be contrary to the person with dementia wishes, as discussed in (section 7.5.1):

> *"I think there is still labelling, I think it still exists with our multi-disciplinary teams as in if someone has a cognitive impairment, then straight off, oh now, home, independence, successful ageing still we are trying to get that into peoples' heads, that to make people aware that people can successfully age with a cognitive impairment, instead of people thinking – cognitive impairment, dependency levels Oh God….. but I think sometimes people approach, if they hear dementia, they are very much oh we will have to rethink the home situation or discharge plan mm it is definitely in its infancy, the whole successful ageing with a cognitive impairment"* 2.7

The findings from the theme of a misunderstood concept demonstrated a mixture of positive and negative attitudes. The discussion highlighted the potential harm that negative attitudes about dementia can have on dementia care nursing and it was agreed that education has an important role to play in developing positive attitudes.

7.7   Summary

7.7.1   Environment of Care

7.7.1.1 Physical Environment of Care

Within the non-dementia specific wards/units contained in the dedicated health care services for the older person linked to the three identified hospital sites, in the nurses' experiences, the physical environment proved to be challenging. The physical design of all of the wards/units inhibited observation of all of the patients and maintaining safety and security for persons with dementia was experienced by the nurses as demanding. Persons' with dementia were known to go missing from the wards/units which caused considerable concern for the nurses regarding safety issues for the missing person. In the nurses' experiences, it also created balance of care dilemmas as implementing a search strategy took up considerable time and nursing resources which impacted negatively on the care available for the other patients on the ward. In an effort to increase security, management installed security doors which the nurses' recognised as a form of restraint that was at odds with respect and dignity for persons with dementia. The unfamiliarity and overstimulated environment of care also posed difficulties for persons with dementia and consequently dementia care nursing. Orientation cues were recognised by the nurses as a way of alleviating this problem but were not universally available. Creating a familiar environment was also identified as important for persons with dementia but in the nurses' experiences, this was difficult to implement due to the acute care ethos.

7.7.1.2 Organisational Environment of Care

According to the nurses, while they felt supported by their colleagues, this did not extend to corporate management. The nurses' expressed that they would welcome a show of support from management. They perceived that a more visible presence would increase managements' understanding of dementia care nursing in the non-dementia specific wards/units in the research sites. Additionally, perceived staffing shortages, impacted negatively on the quality of care that the nurses could deliver. Difficulties in providing essential nursing care, far less the person-centred care that they aspired to was a cause of concern. Further staffing concerns were related to the use of 'specials'. In the nurses' experiences, the management strategy of deploying untrained 'specials' to enhance care for persons with dementia who become restless was unrealistic and often resulted in nurses having to step in to contain an already difficult situation.

7.7.2   Nurses' Knowledge About Dementia

It was acknowledged that dementia care nursing requires specialist skills and knowledge. While it was known that there are a number of specialist educational courses available, access to participate in these course was perceived to be problematic. Participation in specialist education was difficult due to both staffing shortages which inhibited release from duty and lack of funding. From the findings, it became apparent that while there are pockets of specialist knowledge, it was also evident that there are gaps in knowledge. A significant finding related to cultural understandings of dementia and dementia care. Dementia care nursing was a new experience for nurses who had received their education in the Philippines and India. However, it was discussed that access to specialist education and clinical experience proved to be advantageous in developing the appropriate level of knowledge.

7.7.3 Ethical Dilemmas

A number of ethical dilemmas experienced in the delivery of dementia care nursing were discussed. These included the principles of autonomy, beneficence and non-maleficence to ensure promotion of dignity for the person with dementia in relation to autonomy and decision making, particularly following the loss of decision making capacity. Duty of care, balancing care needs and advocacy issues were also brought to the fore. Findings demonstrated that in the nurses' experiences, balancing nursing care in a non-dementia specific ward/unit can be difficult due to the complex nursing needs of persons with dementia which require sufficient time to ensure that nursing needs are met. In light of the ethical dilemmas experienced by the nurses, it was suggested that clinical supervision and relevant education would provide support and potentially improve their practice and understanding of ethical decision making.

7.7.4 Dementia: A Mis-understood Concept

According to the nurses' views and opinions about dementia, nurses' attitudes both positive and negative, significantly impact on dementia care nursing. Positive attitudes result in meaningful interactions underpinned by person-centred care philosophies of care. On the other hand, negative attitudes result in a lack of communication and interaction which potentially can result in persons with dementia experiencing feelings of distress. It was suggested that if distress is interpreted as disruptive, it can lead to suggesting management by way of sedation. The findings from phase one and phase two will be integrated and discussed in the following chapter.

Chapter Eight – Discussion

8.1   Introduction

The purpose of this chapter is to provide a discussion of the findings from both phases of the current study. The findings from the two phases are integrated as outlined in chapter five and highlighted accordingly throughout this chapter. The findings will be discussed, explored and compared with the relevant national and international literature. The strengths of the mixed methods design will be clearly illustrated as the two sets of data serve to corroborate, strengthen or refute the findings. The discussions reflecting the objectives of the study are divided into several components:

Objective One: the nurses' views and opinions about dementia care nursing based on their experiences of caring for older persons with dementia in non-dementia specific wards/units that include acute, rehabilitation and residential, contained in dedicated health care services for the older person linked to acute hospital services are explored and described.

Objective Two: investigates and discusses attitudes held by nurses towards dementia and dementia care nursing based on their experiences of caring for older persons with dementia in the identified setting.

Objective Three: nurses' beliefs about the environment of care to include the organisational and physical environment and the impact on nurses' experiences of dementia care nursing, in the identified setting are examined and described.

As described in chapter three, the Socio-technical System Theory (STS) (Trist, 1981) was used to provide a conceptual framework for the discussions. The STS (Trist, 1981) was considered to be a good fit as a conceptual framework as it provided a means within which to categorise and develop an understanding of the complex interactions between the social components and the technical components interacting within the environment as identified in the current study. As related to the current study, the overall technical components within the organisational environment includes, the physical environment of care and organisational support which encompasses: corporate management, hospital policies and procedures (applicable to nursing staff) appropriate nursing staffing levels, nursing education and training, in other words the components available to support nurses. Social components includes: the nursing staff, their work culture and, their skills and knowledge related to

dementia along with their attitudes towards dementia. The rationale for using the STS for this study is that according to the STS, optimal work performance is dependent upon equilibrium or joint optimisation between the social and technical components interacting within the environment. Ultimately, according to the central tenet of the STS, the degree of equilibrium between the social and technical components influences the nurses' experiences of dementia care nursing. Effective organisational performance is dependent upon joint optimisation between the social and technical components interacting within the environment (Trist, 1981). Effective organisational performance as related to the current study, is dementia care nursing.

8.2   Nurses' Views and Opinions about Dementia Care Nursing

In this section, key findings pertaining to nurses' views and opinions about dementia care nursing based on their experiences of caring for older persons with dementia are discussed. The nurses' views and opinions were measured quantitatively by the SNCW (Hallberg et al, 1994) and the SNCW sub-sections guides the presentation of the findings in this section.

8.2.1   Organisational Sources of Support and Work Load

The overall findings as measured by the SNCW, from the quantitative phase demonstrated that generally nurses held positive views and opinions about dementia care nursing (section 6.5). Demographic characteristics were non-significant, thus no differences were evident with the different groupings of respondents. It is suggested by Hallberg et al (1994) that variables that impact on dementia care nursing, include the quality and quantity of informal and formal support at work and work load issues. From the quantitative findings as measured by the SNCW sub-section Work Co-operation, it was noted that the majority of nurses (74.35%) agreed that both the quality and quantity of informal and formal support at work was positive (section 6.5.2). Although it emerged that only 27.3% of nurses agreed that there were enough opportunities to discuss the psychological stress of the job. From the SNCW Work Load sub-section, findings revealed that while the majority of nurses (68.4%) agreed overall that they were satisfied with the work load, less than half (47.2%) agreed that they received constructive criticism (sic) about their work (section 6.5.6). These results indicate that while overall findings in regard to Work Cooperation and Work Load were found to be positive, nurses believed that matters related to organisational support or psychological support and evaluation of nursing practice were less positive. Organisational support is considered to be a

technical component within the STS as the role of organisational support is to support the social component or the nursing staff.

Qualitatively, in relation to informal sources of support, it was generally accepted that dementia care nursing can be complex and challenging for a variety of reasons. However, it was corroborated both quantitatively and qualitatively that many nurses found that they could rely on their colleagues as a source of support (sections 6.5.2 and 7.3.2). Colleagues' support, which is a social component within the STS, was especially valued when difficulties arose in practice between the nurse and person with dementia. It was reported that a common challenge that can arise in the delivery of dementia care nursing, is that due to communication difficulties such as receptive and expressive dysphasia, both the nurse and persons with dementia can experience problems in understanding and being understood. From the nurses' experiences, when this happens, the situation can be a source of frustration for both parties (section 7.6.1). Significantly, when circumstances like this arise, support from other members of the nursing team was noted to be vital, in order to allow the nurse to step away and reflect on the situation and ponder on the most appropriate way to deflect the situation (section 7.6.1).

On the other hand, the majority of nurses did not believe that the quality and quantity of formal/organisational support at work which is a technical component within the STS, was quite so positive, ie 47.2% of respondents agreed that they received constructive (helpful) criticism about their work (section 6.5.6). These findings were corroborated qualitatively and many of the nurses agreed that while they found their colleagues supportive, this did not extend to the organisation/corporate management team (section 7.3.2). There was a perception amongst some of the nurses that the corporate management team did not have an understanding of the complexities of dementia care nursing and the challenges confronted by the nurses in practice. This was understood to stem from this level of management being removed from the clinical areas. It was believed that a regular visible presence in the clinical areas by this level of management would both increase their understanding of the challenges faced by the nurses and would be perceived by the nurses as receiving support and encouragement for the work that they do (section 7.3.2).

The reported findings highlight issues related to sources of organisational support as identified by nurses in the current study. These findings are critical as according to Hallberg

et al (1994), if the organisation does not provide support by way of constructive feedback nurses, are left to rely on one another for support which may consequently lead to feelings of isolation and dis-interest (Hallberg et al, 1994). It is argued, that lack of organisational support, may lead to nurses believing that their work is worthless and they must have no worth themselves which can result in the quality of dementia care nursing being compromised (Hallberg et al, 1994; Cowdell, 2010a; Pinkert et al, 2017). A perceived lack of appreciation of nursing work can lead to nurses' believing that they are 'lone fighters' (Pinkert et al, 2017), who frequently have to resolve problems associated with dementia care by themselves (Fukuda et al, 2015). The findings related to organisational sources of support are particularly important in relation to nurses' experiences of dementia care nursing, as due to the dementia pathology, persons with dementia are not always able to give their views on the nursing care that they receive (Hallberg et al, 1994). Accordingly, this means that nurses rely on other professionals to provide them with recognition of their work, feedback and evaluation of nursing work provided (Hallberg et al, 1994). From the qualitative discussions relating to organisational support, matters concerning ethical dilemmas encountered by nurses emerged and these will now be presented.

8.2.2   Ethical Dilemmas Encountered by Nurses

Ethical nursing practice is a vital element of quality dementia care nursing (Daly and Fahey-McCarthy, 2014). Qualitatively, the findings indicated that nurses experienced a range of ethical issues that were perceived as dilemmas in practice, for example, nurses' duty of care, balancing care needs and advocacy matters to ensure that all patients are cared for in a safe, ethical and effective way. Issues pertinent to nurses' duty of care associated with persons with dementia refusing nursing and medical treatment and nutrition were discussed and it was agreed that this is a very grey area of practice. This was especially the case when persons with dementia were deemed to have lost their decision making capacity (section 7.5.1). As one nurse commented "*are you going to let that person starve to death, they don't have the capacity to make that decision".* It was acknowledged that nurses need to be ethically competent to be able to interpret persons with dementia wishes and to act in accordance with their best interests, if they are not known (section 7.5.1). Within the STS theory, nurses' ethical competence is considered to be a social component as it relates to nurses' knowledge.

A further ethical dilemma related to administering sedation to persons with dementia who become severely agitated (section 7.5.1). It was recognised that introducing sedation can

effectively settle agitation but there was concerns voiced that there can be a significant cost to the person, such as unwanted side effects for instance immobility, incontinence, excessive drowsiness or the risk of falls. As one nurse stated *"it's an ethical dilemma that I don't think you could ever conclude"* (section 7.5.1). In other words nurses have to have the skills to be able to consider and weigh up the benefit/risk ratio for the person with dementia.

Further reported challenges included balancing the needs of persons with dementia with those of others in the ward/unit (section 7.5.1). Situations such as persons with dementia, unintentionally interfering with other patients in the ward/unit leading to an unsafe situation for both parties were explored and discussed. Or the situation can also arise when due to persons with dementia accidently disturbing other patients, especially at night time, a decision can be reached to remove the person with dementia from the ward to the corridor, in their bed, to allow other patients to sleep (section 7.5.1). Ethical dilemmas encountered by nurses also extended to other patients and visitors within the environment of care. It was reported that other patients and relatives can often become upset or can be unsympathetic as a result of persons with dementia displaying behaviours which may include loss of inhibitions or shouting excessively. Or the situation can arise whereby other patients or relatives can mistakenly take on the role of advocating for the nurses, when they witness a person with dementia becoming agitated and aggressive towards a member of staff (section 7.5.1). Reactions from other patients and visitors to the ward/unit reported by some nurses ranged from pity to anger to being dismissive and a frequent request was to have persons with dementia removed from the ward. These are complex situations calling upon nurses to act as advocates for their patients (section 7.5.1).

Balancing care needs is recognised as an ethical problem that practitioners wrestle with on a daily basis (Brooker, 2004; Daly and Fahey-McCarthy, 2014). Additionally, according to Bolmsjö et al (2006), nurses are called upon to act as advocates for the older person with dementia more frequently than within other care environments. The nurses' advocacy role was highlighted in a study conducted by Nolan (2006) where it was found that due to the potential for persons with dementia to be stigmatised or labelled by others in the care environment, nurses can be called upon to act as advocates for persons with dementia. The reality of practice, as described by Bolmsjö et al (2006), means that ethical problems can arise for nurses when they find themselves in situations where they can choose between different options to act and where it is not possible to satisfy all parties' interests in an ideal

manner This concurs with Fetherstonhaugh et al (2013), who are of the opinion that conflicts can occur in ensuring that the autonomy of the person with dementia is upheld while at the same time safe guarding their wellbeing. For nurses to have the ability to confidently explore ethical dilemmas that they encounter in practice requires ethical competence.

Ethical competence is described as possessing the appropriate skills, knowledge and language needed to ensure confidence in exploring ethical dilemmas in practice (Daly and Fahey-McCarthy, 2014). To enable nurses to reflect on and defend ethical dilemmas in practice requires a grasp of ethics and an understanding of the theories underpinning ethical decision making (Daly and Fahey-McCarthy, 2014). However, many of the nurses, in my study, reported that they lacked confidence in ethical decision making and they were of the opinion that the organisation should provide them with support by way of clinical supervision or a peer support group and specialist education related to ethics. They considered that this level of support would enable them to reflect on their practice and share each other's experiences of the ethical dilemmas that they encounter in daily practice. Nurses' identifying the desire for clinical supervision and specialist education is a key finding, of significant importance which is unique to the current study.

The generated findings, related to the various ethical dilemmas encountered in practice are specific to the study setting of non-dementia specific wards/units contained in dedicated health care services for the older person. However, they are consistent with findings reported from nursing studies conducted in general hospital acute ward settings. Nurses reportedly experience feelings of frustration when they are faced with the decision to administer sedation as a management strategy due to the potentially negative side effects such as an increased risk of falling or excessive drowsiness (Eriksson and Saveman, 2002; Nilsson et al, 2016). Further dilemmas expressed by nurses in Eriksson and Saveman's (2002) study were that, when persons with dementia inadvertently disrupted the ward, as a management strategy, they were sometimes taken out of the ward to the corridor to allow other patients to sleep. The nurses did not want to take this action but as a result of being unable to resolve conflicts and to ensure that the ward could run as smoothly as possibly, they felt that there was no other alternative option to take (Eriksson and Saveman, 2002). In a similar manner Clissett et al (2013a) found from an observational and interview study conducted within acute hospital wards that persons with dementia were often placed in side-rooms to ensure the safety of other patients on the ward. According to Eriksson and Saveman (2002) and Clissett

et al (2013a) the needs of the other patients are often prioritised over the needs of persons with dementia leading to an imbalance of care. As Fukuda et al (2015) states, attempting to balance care needs between persons with dementia and those without is a considerable source of conflict for nurses. However, the findings related to the nurses' suggestion that clinical supervision and specialist education would provide them with the means to reflect on and discuss ethical issues that they encounter on a regular basis is unique to the current study.

Clinical supervision is described by Hallberg et al (1994) as a means of providing nurses with room for reflection on emotional reactions and a way of deepening the understanding of the patient within the nursing care relationship. It also provides nurses with opportunities to reflect on and share the knowledge gained in everyday practice which is mostly tacit (Hallberg et al, 1994). These comments are supported by Nilsson et al (2016), who make the recommendation that to ensure that nurses are supported in their goal of providing quality dementia care nursing they must be provided, with opportunities to both reflect on and discuss the care that they provide. Although this recommendation substantiates the importance of clinical supervision, it is different from my study, insofar as it is the researchers, not the participants who recognise the importance of this particular aspect of organisational support. The points raised by Hallberg et al (1994) and Nilsson et al (2016) support the important role that clinical supervision can provide in supporting nurses in becoming competent in ethical decision making. It reinforces the findings from the current study where nurses' perceive that clinical supervision has the potential to support them in their goal of delivering quality dementia care nursing.

From the perspective of the STS, the qualitative findings suggest that there is an imbalance between the social component which in this case, refers to nurses' knowledge and competence in ethical decision making and, the technical component or organisational support. Nurses reported that they felt constrained in ethical decision-making with regard to dementia care nursing, by a lack of specific knowledge. Competence in ethical decision-making is dependent upon possessing the appropriate competencies. Competencies are developed through organisational support such as clinical supervision and specialist education. The findings strongly illustrate the importance of providing organisational support for nurses, such as clinical supervision, to enhance dementia care nursing practice and to ensure joint optimisation between the social and technical components according to the tenets of the STS. The findings suggest both quantitatively and qualitatively that nurses' ability to

achieve optimal work performance or dementia care nursing, is constrained by inadequate organisational support, such as access to specialist education, suggesting that an imbalance exists between the social and technical components interacting with the environment.

8.2.3   Knowledge of Patients, Specialist Qualifications and Educational Resources

Optimal nursing management with the older person with dementia is dependent upon skilled, knowledgeable practitioners (Moyle et al, 2010; Traynor et al, 2011). In relation to nurses' views and opinions about knowledge of patients to include medical and social understandings, the majority of nurses (72%) in this study indicated quantitatively that they believed that they had sufficient knowledge about persons with dementia in their care (section 6.5.3). These findings correlated significantly with nurses who worked in the residential units and those who were qualified between 11-15 years. The majority of those qualified between 11-15 years' practiced in the residential wards/units and significantly within this group, the highest level of specialist (dementia or gerontological nursing) qualifications were recorded (35.4%). These findings suggest that specialist qualifications and nursing experience which is a social component within the STS, equate with nurses believing that they have the specific competencies to provide nursing care for persons with dementia. Significantly, the findings from phase one of this study demonstrated that only 37.2% of nurses held specialist qualifications either in gerontological nursing or dementia specific education with just over a quarter of the staff nurses (28.71%), the group that provide hands on care, held a specialist qualification. From phase two, the demographic findings illustrated that 72% of the participants held specialist qualifications. Of the 13 CNMs, 11 held specialist qualifications, of the 12 staff nurses, 7 held specialist qualifications.

Overall, in the Irish context, the number of nurses with specialist qualifications in dementia remain low as reported in (section 2.5.1), where findings from de Siún et al's (2010) Dementia Needs Analysis report established that 83% of registered nurses (n=632) had not participated in specialist dementia education. Despite these findings, de Siún and Manning (2014) found that just over half (52%) of the hospitals audited had provided specific training for nurses over the previous 12 months. These findings are contrary to the recommendations contained in the Irish National Dementia Strategy (DOH, 2014). According to the DOH (2014) all staff caring for persons with dementia should be supported by on-going training and education. This would ensure that all staff have the necessary skills and competencies to deliver high quality, person-centred care and support for persons with dementia (DOH,

2014). It would appear from the findings from the current study that the DOH (2014) recommendations remain at an aspirational level.

Qualitatively, nurses recognised that in order to deliver skilled dementia care nursing, extensive specialist knowledge in dementia is necessary (section 7.4.1). The process by which nurses acquire professional competence in dementia care nursing is through professional training and education (section 7.4.1). Access to specialist education is dependent on organisational support and is regarded as a technical component within the STS theory as its function is to support the work force. While it was identified (section 7.4.1) that a number of specialist educational courses are available which indicates organisational support, a perceived lack of organisational support inhibited nurses' possibilities of taking part in these programmes. The challenges faced in participation in specialist programmes included inadequate study leave and lack of funding and consequently, according to the nurses this has resulted in a decrease in the numbers of nurses obtaining specialist qualifications over recent years. The decrease in organisational support has occurred over recent years and according to some nurses, this situation has developed as a consequence of the austerity years in Ireland (2009-2016). Up to the time of the economic down-turn or years of austerity, nurses undertaking specialist education were granted study leave commensurate with the needs of the specialist course and, full funding was provided (section 7.4.1).

A further source of frustration that emerged from the discussions was that even if nurses did get the chance to participate in specialist programmes, the resources recommended to, create a dementia friendly environment, such as contrasting colour schemes, clear signage, clocks and calendars, may not be available in their particular unit/ward (section 7.3.1). Consequently, nurses experienced constraints in consolidating theory with practice. The physical environment of care is viewed as a technical component within the STS as it is regarded as a source of support in the accomplishment of organisational goals. The presented findings highlight the critical relationship between specialist dementia education and nursing competence in the delivery of quality dementia care nursing and reinforce the DOH (2014) recommendations that all staff should be supported by on-going dementia education. The findings also highlight the imbalance between the social and technical components of the STS. As noted earlier, dementia care nursing is dependent upon skilled, knowledgeable practitioners (Moyle et al, 2010; Traynor et al, 2011). Developing specialist skills and

knowledge is reliant on the organisation facilitating access to educational programmes. The findings suggest that many nurses experience organisational constraints in participating in specialist dementia educational programmes. Quantitatively, it was found that CNMs expressed more positive views about personal and professional development compared to staff nurses (6.5.4). The CNMs are also the group with the highest levels of specialist qualifications.

The findings generated from the unique setting of the current study, non-dementia specific wards/units contained in dedicated health care services for the older person, are comparable with international nursing studies conducted within general hospital acute wards. It has been found within the acute general environment of care, that many nurses do not believe that they have the specific nursing competence to provide quality care for persons with dementia (Eriksson and Saveman, 2002; Atkin et al, 2005; Pinkert et al, 2017). These findings are generally attributed to an organisational lack of educational support (Atkin et al, 2005; Arnold and Mitchell, 2008). Additionally, nurses would welcome specialist dementia education and it should be provided on an on-going basis (Atkin et al, 2005; Fessey, 2007; Cowdell, 2010a). However, it has been found that even when training is provided, staffing shortages inhibit those who can attend educational courses (Borbasi et al, 2006; de Siún and Manning, 2010; Baillie et al, 2016) and the strategies recommended to improve care such as time and resources are not available (Borbasi et al, 2006; de Siún and Manning, 2010).

Qualitatively, issues relating to nurses' knowledge concerning nursing assessment and cultural experiences of dementia care nursing were explored and these will now be presented. According to Nilsson et al (2012) and de Siún et al (2014) skilled nursing assessment with persons with dementia encompasses evaluation of both cognitive and physical function. From the qualitative discussions, it became clear that many of the nurses from the residential units had a comprehensive understanding of the importance of conducting an assessment of both physical and cognitive function when an increase in confusion was experienced by persons with dementia. It was stated that a full assessment should lead to an identification of the cause of the confusion and if medication is prescribed, careful monitoring for any signs of adverse side effects are implemented (section 7.4.2). On the other hand, from the acute/admissions units/wards, it was perceived (section 7.4.2) that there remains a lack of clarity regarding the differential diagnosis of dementia and delirium. If persons with dementia developed an acute confusion, it was suggested that nurses had a tendency to believe that the

acute confusion was linked to the dementia pathology rather than stemming from a physical problem such as an infection. This is important, as according to Bunn et al (2015) when physical problems are attributed incorrectly to dementia, as a consequence, the person with dementia may not receive timely care. Similarly, Clissett et al (2013a) caution when the meaning of a behaviour, such as increasing restlessness, is incorrectly believed to originate from the dementia pathology rather than from a physical problem and, is not explored, needs are left unmet which can potentially lead to an exacerbation of behaviours and the development of new needs.

The importance of skilled and knowledgeable assessment was also discussed in relation to the increasing numbers of older old (persons >80 years of age) hospital admissions (section 7.4.2). The hospital admission rates of older old persons with dementia are noted to be increasing (Timmons et al, 2016). For older old persons with dementia and co-morbidities, hospital admission has the potential to cause a rapid deterioration in their cognitive function (Timmons et al, 2016). It was agreed that a thorough assessment undertaken by a skilled practitioner is necessary in order to minimise deterioration and ensure best possible care is delivered (section 7.4.2). Although findings reported by Briggs et al (2016a) from a medical perspective, point to the challenges faced in undertaking an assessment of persons with advanced dementia or who may be experiencing a delirium. For example, direct history taking may be inaccurate or inconsistent and physical examination may be challenging (Briggs et al, 2016a). These findings also impact on the experiences of nurses conducting assessments with persons with dementia, where the same difficulties present. According to Briggs et al (2016a) these issues are further exacerbated by a lack of staff training to include nursing staff. As noted earlier, skilled nursing assessment with persons with dementia is dependent upon specialist dementia knowledge.   Therefore, organisational support to facilitate access to dementia education for nurses is an important priority which would lead to improved confidence in dementia care nursing to include knowledgeable assessment. This would also ensure joint optimisation between the technical and social components ie organisational support and nurses' skills and knowledge.

8.2.4   Nurses' Cultural Experiences of Dementia Care Nursing

Qualitatively, nurses' views and opinions about dementia care nursing based on their experiences of nursing were discussed by nurses who had undertaken their nursing education in different parts of the world. As the participants were a culturally diverse group, it could be

conceptualised that due to their varied historical and social backgrounds, they may bring divergent experiences to their nursing practice (Morgan, 2014). The practice of dementia care nursing was reported to be a new experience for nurses who had undertaken their nurse education in different parts of Asia (section 7.4.2). It was discussed by some of the nurses that they had limited nursing experience of caring for older persons and older persons with dementia in the hospital environment prior to commencing practice in Ireland. It was explained that this stemmed from the fact that the cultural tradition in their countries of education is that adult children undertake the care of the older person at home and it is customary, that as soon as the older person recovers from their medical or surgical hospital treatment, they are discharged home to the care of their relatives.

These findings are consistent with Kang et al (2011) and Fukuda et al's (2015) Korean and Japanese studies where the family, as part of the cultural tradition, are acknowledged as the caregivers and older adults are honoured and treated with great respect. During hospital admission of older persons with and without dementia, the family provide assistance with activities of living thus freeing up nurses to attend to more technical nursing duties (Kang et al, 2011; Fukuda et al, 2015). However, this is a situation that is currently undergoing transition due to a number of different reasons; such as an increase in the nuclear family, a greater number of women working outside the home, and industrialisation which incurs people moving from the countryside to urban areas in search of employment. Consequently, there are an increasing number of older adults living alone (Kang et al, 2011). These facts may contribute to different nursing experiences of care of the older person with and without dementia for more recent or current migrating nurses from Asian countries.

It was also discussed that limited exposure to persons with dementia was linked to lower life expectancy in the country of education along with dementia not being considered to be a medical condition, meaning that nursing and medical assistance is not sought by the family (section 7.4.2). These comments are supported from an anthropological perspective where it has been found that dementia remains hidden in Asian countries (Hashmi, 2009; Cipriani and Borin, 2015). Culturally, dementia is believed to be a normal part of the ageing process, it is not considered to be a medical condition and medical assistance is not sought (Hashmi, 2009; Cipriani and Borin, 2015). From the perspective of nurses who had received their education in Ireland, it was discussed that it used to be common practice for older persons with dementia to be cared for in the family home and it was suggested that up to recent times,

dementia was commonly thought to be part of the ageing process (section 7.4.2). However, it was agreed from the Irish educated nurses' perspective, that with increased knowledge and education this assumption has changed and it is now generally acknowledged that dementia is not an inevitable part of the ageing process. It is important to understand nurses' beliefs about dementia (Innes, 2009). If differing conceptualisations of care or understandings of dementia are held by nurses, potential problems may be encountered in delivering the ethos of care that an organisation is promoting (Innes, 2009). This point is illustrated somewhat by one participant who recounted that she did not have any knowledge about dementia when she initially commenced her nursing practice in Ireland "*during my first year in Ireland, obviously dementia wasn't heard of and it wasn't a diagnosis in any part of the world......* " However, she stated that her knowledge and understanding of the dementia pathology, including physical and psychological aspects of the disease, has increased exponentially through engaging in specialist dementia education "*from learning it all and training even how you approach communication it has all improved*" (section 7.4.2). The findings presented relating to nurses' views and opinions about dementia care nursing based on cultural experiences of dementia care nursing, highlights the important place of specialist education to ensure that: dementia is conceptualised correctly and, that the organisational ethos of care is practiced consistently by all nurses. The final discussion point in this section explores nurses' views and opinions about quality of care for persons with dementia.

8.2.5 Quality of Care

From the data obtained quantitatively in relation to Quality of Care (section 6.5.5) it emerged that the majority of the respondents (77.27%) agreed that the overall quality of care was satisfactory and that persons with dementia nearly always received good quality nursing care. However, qualitatively it was noted that cognitive screening does not form part of the routine nursing assessment process and as a result, it was suggested that there are a number of persons with undiagnosed dementia within the wards/units (section 7.4.2). This finding concurs with Afzal et al (2010) and Cahill et al (2012) where it was noted that a large percentage of patients did not have cognitive assessments completed. Consequently, the perception in this study was that persons with dementia are not always being offered the support or the quality of nursing care that they need (section 7.5.1). This is a critical finding as it is suggested that a diagnosis of dementia should underscore and direct the organisation and management of all of the other nursing and medical issues encountered (Afzal et al, 2010; Timmons et al, 2016; Bunn et al, 2017).

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A further perceived barrier identified by some nurses in delivery of quality dementia care nursing, related to the challenges imposed in implementing hospital wide policies and procedures. From the STS perspective, hospital policies are a technical component as they support the work system. It was asserted that the priorities in the hospital driven policies and procedures are focussed on the physical aspects of care, whereas within age related services, the priority for nursing care is delivering care underpinned by a person-centred philosophy of care (section 7.3.2). This point is also discussed in Edvardsson et al's (2008) review of person-centred care of persons with dementia. It is suggested by these researchers that for policies and procedures to be meaningful for persons with dementia, they have to be guided by a person-centred philosophy of care. These points tie in closely with the findings from the current study and serve to highlight as McCormack and McCance (2017), contend that the implementation of a person-centred approach to care is only possible with overall organisational support. Thus, to ensure that the organisation meets both professional and governmental standards, hospital policies have to be compatible with a person-centred philosophy of care. The findings from the unique setting of the current study are consistent with those reported by Nilsson et al (2012) who conducted a cross sectional survey study, exploring staff attitudes towards older patients with cognitive impairment, one of the tools used was the SNCW (Hallberg et al, 1994). The study took place in a Swedish university teaching hospital within twelve medically orientated wards. Of the participants (n=391) 55.2% were registered nurses. It was reported by the participants that the patients' cognitive status was rarely assessed. Yet, despite the lack of cognitive assessment and appropriate hospital protocols, the majority of the participants reported that older persons with dementia received the best possible care and treatment. According to Nilsson et al (2012) this contradiction perhaps demonstrates a limited awareness of the unique needs of persons with dementia. It is suggested that perhaps the same conclusion could be reached from the quantitative results of the current study. However, as qualitatively, the nurses identified the psychological needs of persons with dementia, such as the importance of meaningful interaction (section 7.6), it is a very tentative suggestion.

In summary, the aim of this section was to explore and describe nurses' views and opinions about dementia care nursing based on their experiences of caring for older persons with dementia in the unique setting of the current study. A critical finding concerned nurses' experiences of ethical issues which were perceived as ethical dilemmas in practice. It was perceived, that many nurses lacked confidence and certainty in ethical decision-making, due

to an insufficient understanding of ethics. To overcome these difficulties and to develop competence in ethical decision-making, it was uniquely suggested by some nurses, that the organisation should provide support by way of clinical supervision or a peer support group and specialist education related to ethics. It was understood that organisational support to facilitate nurses to participate in clinical supervision and specialist education would improve nurses' competence in ethical decision-making and ultimately support quality dementia care nursing. This concurs with the work of Hallberg et al (1994) and Nilsson et al (2016), reported earlier in this chapter, regarding the benefits of clinical supervision to augment dementia care nursing.

Significantly, quantitatively, it was found that specialist dementia or gerontological nursing qualifications and years of nursing experiences equated with nurses' having a greater understanding of dementia care nursing. Qualitatively, it emerged that some nurses may believe that dementia is a normal part of the ageing process. This is an important point, as already alluded to, if nurses hold inconsistent understandings of the dementia pathology, potentially the delivery of dementia care nursing may not be congruent with the philosophy of the care organisation. This finding highlights the importance of the organisational role in promoting specialist dementia education to ensure standardisation of nursing care delivered to persons with dementia. Given the implications of these findings for dementia care nursing, suggest that this may be an area of nursing that would benefit from further research inquiry within the context of dedicated health care services for the older person which are linked to acute hospital services.

The findings from the nurses' views and opinions about dementia care nursing provide compelling evidence that the technical and social components interacting within the environment are not jointly optimised. The weakness emanates from the technical component. According to the principles of the STS theory, it is the technical components that provide the structure that supports workers (nurses) to achieve optimal work performance or quality dementia care nursing. It would, therefore, appear that nurses perceive that they are not being appropriately supported by the organisation and the required resources are not consistently provided. The current study was conducted within the unique setting of non-dementia specific wards/units contained in dedicated health care services for the older person linked to acute general hospital services, however, many of the findings are corroborated by findings reported from general hospital acute wards/units, nationally and internationally. As

noted (section 1.3) dedicated health care services for the older person within acute hospitals emerged with the aim of providing a high level of nursing and medical care for older persons with and without dementia (Government of Ireland, 1968). More recently, specialist geriatric units were recognised as contributing to more effective care for the older person (Baztán et al, 2009; HSE, 2012; Briggs et al, 2016b). Given that dedicated health care services for the older person are recognised as areas of expertise in older person care, it was somewhat unexpected to discover that many of the findings from the current study were corroborated from general hospital acute wards/units, nationally and internationally.

8.3   Nurses' Attitudes' Towards Dementia and Dementia Care Nursing

In this section, key findings relating to nurses' attitudes towards dementia based on their experiences of caring for the older person with dementia are discussed and explored. Attitude is an important element of dementia care nursing as it is pivotal to the quality of nursing care delivered (Lintern et al, 2000; Kang et al, 2011; Pinkert et al, 2017). The association between nurses' demographic characteristics and nurses attitudes are also presented. From the STS perspective, nurses' attitude is conceptualised as a social component as it influences responses to a stimulus which in this study, is dementia. According to Breckler (1984), attitude is defined as a response to a stimulus which includes affect, behavioural and cognitive components.

Findings from the quantitative phase of the current study, as measured by the ADQ (Lintern et al, 2000) (section 6.6.1) demonstrated that generally, nurses held overall positive attitudes towards dementia and they believed that they practiced a person-centred approach to care. However, views were more mixed in relation to hopefulness for persons with dementia (section 6.6.2). Demographic findings from the current study found that clinical nurse managers (CNMs); nurses with specialist qualifications; nurses with over 11 years of service; and nurses educated in Ireland and the UK held the most positive general approach and hope attitudes towards dementia. When it came to person-centred care (PCC), CNMs and nurses educated in Ireland and the UK espoused the strongest belief in person-centred care.

These are key findings as it is attitude that particularly determines the quality of dementia care nursing (Lintern, 2001). A person-centred approach to care is reflective of how the respondents are likely to behave and think about persons with dementia (Lintern, 2001). Additionally, hope especially predicts staff behaviours, eg engagement in social interaction

with persons with dementia, involvement in purposeful activity and stimulation, and the quality of physical care interactions such as providing information and giving choice (Lintern, 2001). Hopefulness for the person with dementia mirrors respondents' feelings about both the current and future condition of older persons with dementia (Lintern, 2001). The quantitative findings were corroborated qualitatively and a mixed picture emerged from the focus group discussions. Some nurses spoke positively about the importance of underpinning their nursing care with a person-centred philosophy of care to incorporate hopefulness for persons with dementia and, described the value of ensuring meaningful connections with persons with dementia and the benefits of providing psychological support. It was acknowledged that engagement in social interaction should include practices such as reminiscing and social interaction.

However, despite understanding the importance of person-centred care and demonstrating a level of hopefulness, the reality as perceived by some nurses was that attempting to provide this level of care was challenging due to the task focused environment of care and insufficient organisational resources such as adequate staffing levels (section 7.3.2). These qualitative findings suggest that from the STS perspective, there could be an imbalance between the nurses' goal of delivery of person-centred care and the organisational system of support. As Brooker and Latham (2016) and McCance and McCormack (2017) argue, the delivery of person-centred care is reliant upon organisational support such as an appropriate environment of care and adequate staffing levels.

On the other hand, it was suggested by some nurses in the current study that negative attitudes exist to a certain extent within the nursing team. As an illustration of this point, it was explained that if persons with dementia became restless, rather than promoting a person-centred approach to care such as making a meaningful connection *"they can be restless, you have to be there"* to hold their hand *(*section 7.6.1) others perceived that this was evidence of *"not doing any work"* (section 7.6.1). Similarly the role of medication was discussed. From a positive stance, it was recognised that persons with dementia should not have to experience long periods of agitation and it was contended that medication should only be introduced after all other avenues of management such as distraction therapies have been exhausted. However, it was believed that some nursing staff still advocate for the use of medication as a first line management strategy (section 7.6.1). Similar findings are reported from Pinkert et al's (2017) study from the general hospital acute care environment, where some participants

in an effort to preserve the routine of the ward/unit and the task orientated approach to care advocated the use of medication management rather than building trusting relationships to ensure the well-being and safety of persons with dementia. Interestingly, Briggs et al (2016b) reported that no differences were found between the proportion of anti-psychotic medications across non-dementia specific wards in the older person setting compared to non-specialist wards. It would appear that this is an area of dementia care nursing that would benefit from further investigation.

Further qualitative discussions, served to highlight the harmful influence that negative attitudes held by nurses can have on persons with dementia. It was understood by many of the nurses that persons with dementia make sense of their environment emotionally thus, they pick up on negative staff attitudes (section 7.6.1). It was commented that negative attitudes held by some nursing staff can manifest in them having no interest in making a meaningful connection with persons with dementia, resulting in persons with dementia feeling disregarded or ignored. As persons with dementia pick up emotionally on negative attitudes, negative attitudes held by some nurses can potentially lead to persons with dementia demonstrating expressions of agitation and restlessness (section 7.6.1).

Although these findings emerged from the non-dementia specific wards/units as identified within the current study, Edvardsson et al (2011) presented similar findings from a psycho-geriatric dementia assessment ward situated in one Swedish university hospital. From this observational study, it was found that staff set the emotional tone within the care setting. If the nursing staff promoted a joyful, relaxed atmosphere along with meaningful communication, very few occasions of anxious behaviours were exhibited by persons with dementia. On the contrary, when persons with dementia were observed to be ignored or marginalised by staff, they were seen to become restless and agitated (Edvardsson et al, 2011). It was found that feelings of anxiety can quickly transfer between patients, which can collectively exacerbate the situation (Edvardsson et al, 2011). These findings concur with McCloskey (2004), who contends that persons with dementia are highly sensitive to the emotional tone of people around them and they can have a tendency to mirror their affective behaviours. The findings from the current study illuminated the significance of gaining an understanding of nurses' attitudes towards dementia care nursing. Findings demonstrated that positive attitudes held by nurses which strongly equate with specialist qualifications and years of nursing experience, promotes a person-centred approach to nursing care while

negative attitudes can potentially result in a poorer quality experience of dementia care nursing for persons with dementia, from the perspective of nurses.

8.3.1   Nurses' Demographic Characteristics Associated with Nurses' Attitudes

The demographic findings identified in my study were found to be somewhat consistent with other studies where the ADQ (Lintern et al, 2000) was used to measure staff attitudes towards dementia (de Siún and Manning, 2010; Kang et al, 2011; Surr et al, 2016). This is despite the studies taking place in different countries (Ireland, Korea and England, respectively) and within different health care settings including medical and surgical wards within general hospitals.

Demographic findings from my study demonstrated that in concurrence with the de Siún and Manning's (2010) Irish Dementia Education Needs Analysis Report, from the general approach and person-centred scores of the ADQ the respondents had generally positive attitudes towards dementia, while, scores for hopefulness were more mid-range. Thus, suggesting that while the majority of the respondents embraced a person-centred philosophy of care, fewer respondents had a high degree of hopefulness for persons with dementia. Consistent with the current study, participants with higher attitude scores correlated with nurses who had received specialist education. In contrast to the current study, there were no significant differences in scores between the three nursing grades which included clinical nurses, nurse managers and others (de Siún and Manning, 2010). For those nurses who had participated in dementia education, it was found that there was no significant difference between the general approach or the hope subscale but there was a significant positive difference in scores on the person-centred sub-scale (de Siún and Manning, 2010). Thus, it would seem that training influenced the nurses' person-centred philosophy of care but did not influence the degree of hopefulness that they felt for persons with dementia. This concurs, to some extent, with an English study conducted by Surr et al (2017). The aim of the study was to evaluate the effectiveness of specialist training within one NHS trust, with participants (n=41) which included nurses (n=35) (Surr et al, 2017). It was found that specialist training improved person-centred attitudes towards dementia. However, in contrast to de Siún and Manning (2010) specialist training also increased a sense of hopefulness for persons with dementia. In concurrence with the current study, positive attitudes correlated with a senior position and clinical experience greater than 11 years. In the Surr et al (2017) study 39% of

the nurse participants were senior nurses with over 20 years experiences of working in the acute sector.

These findings are also supported by Kang et al (2011) where it was reported that specialist education, years of nursing experience along with working in the medical wards correlated with nurses' holding more positive attitudes towards dementia. It was reported that nurses who work in the medical wards were more likely to have a gerontological nursing qualification and they had longer years' work experience than those nurses practicing in the surgical wards. It was suggested by Kang et al (2011) that experienced nurses have a greater understanding of dementia care nursing which results in a more positive attitude. Additionally, according to Kang el al (2011) specialist qualifications permit a better understanding in relation to the treatment and management of responsive behaviours which promotes a more positive attitude.

In summary, the aim of this section was to explore attitudes held by nurses towards dementia and nurses' views and opinions about dementia care nursing based on their experiences of caring for older persons with dementia in the unique setting of the current study. The aim has been met and new knowledge has been provided which is exclusive to the research setting. A significant quantitative finding from the current study concerned nurses' demographic characteristics. As presented earlier in this section, from the ADQ, demographic findings demonstrated that: CNMs, nurses with specialist qualifications and nurses with over 11 years' service combined with nurses educated in Ireland and the UK had the most positive overall attitudes towards dementia. From (section 6.3) it was noted that 58% of Irish educated nurses were in management positions and the odds ratio of having a specialist qualification for an Irish/UK educated nurse was found to be 2.55 times than that of an Indian/Philippine educated nurse. Therefore, it would appear that specialist qualifications and, years of experience equate with management grades and with those educated in Ireland. When the findings related to nurses' attitudes was followed up qualitatively, it emerged that nurses educated in India and the Philippines, prior to taking up nursing practice in Ireland had limited exposure to gerontological nursing and dementia care nursing and were the least likely to have specialist qualifications. In other words, gerontological nursing was a new area of practice for them and they were unlikely to have specialist qualifications. However, it was perceived that specialist education and clinical practice led to an improved knowledge base. To ensure that all nurses adhere to the organisational ethos of provision of person-centred

dementia care nursing, points to the crucial importance of providing on-going specialist educational support. The reported findings emphasise that positive attitudes towards dementia, are cultivated through nurses' participation in specialist dementia education. From the STS perspective, constraints encountered by nurses in accessing specialist dementia education, reflect an imbalance of joint optimisation between the social component (nurses' attitudes) and the technical component (organisational support) needed to achieve equilibrium. This is a critical finding, as Trist (1981), argues the interaction of the social and technical components within the environment creates the condition for effective organisational performance. If optimisation of only one aspect occurs, the consequence of this may result in unpredictable performance or dis-equilibrium (Trist, 1981).

8.4   Nurses' Beliefs' About the Environment of Care

In this section, key findings pertaining to nurses' beliefs about the environment of care are explored. The current study identified that the environment of care is pivotal to nurses' experiences of dementia care nursing and the findings presented encompass both the organisational and physical components. From the STS perspective, the environment of care is conceptualised as a technical component or the sub-system that theoretically supports the accomplishment of organisational goals which in this case is dementia care nursing. As Edvardsson et al (2011) advises, a fundamental aspect of provision of care for persons with dementia within the environment of care is to create an atmosphere of safety and security, otherwise the person can feel unsafe, lost and displaced. According to Adams et al (1995), the physical layout of the environment of care influences ease of observation of patients and consequently their safety. Key findings from the quantitative findings established that overall, the majority of nurses (60%) held generally positive beliefs about the environment of care including, ward facilities, quality of ward services, staff organisation and ward layout (section 6.7). The availability of ward support services affect nurses' ability to provide nursing care (Adams et al, 1995) and it was found that both ward facilities and quality of ward services were viewed positively by nurses in the current study. However, inconsistencies between the quantitative and qualitative findings were identified in relation to staff organisation and ward layout and these will be discussed in the following sections. Key findings also include nurses' experiences of 'specials'/ untrained staff who provide support for nursing staff with the care of persons with dementia. Issues related to nurses' reports of experiences of emotional and physical exhaustion related to dementia care nursing are also reported.

8.4.1 Staff Organisation and Nurses' Experiences of Dementia Care Nursing

Key quantitative results found that the majority of nurses (70%) expressed satisfaction with staff organisation, statements included agreement that there are enough permanent nurses on the ward to provide a good standard of care, the ward off-duty works well and the skill mix is about right (section 6.7.3). However, these findings do not appear to be corroborated qualitatively. From phase two, it was suggested that the goal of dementia care nursing was to provide high quality person-centred care to incorporate both physical and psychological care (section 7.3.2). However, due to perceived inadequate staffing levels, this goal proved to be challenging. Poor staffing levels, in the nurses' experiences, affected all of the non-dementia specific wards/units.

Significantly, from the rehabilitation units, it was suggested that poor staffing levels were believed to inhibit the nursing practice of supporting persons with dementia in promotion of mobility exercises and activities of living "*helping them relearn the skills that they are not able to do anymore*" and it was suggested that this could potentially lead to delayed discharge rates (section 7.3.2). The suggestion that poor staffing levels can delay discharge rates is a significant finding from the current study and as such highlights the critical importance of ensuring nursing staffing levels commensurate with organisational as well as nursing goals ie in this instance, the support of efficient, and realistic discharge rates.

Perceived, poor staffing levels also impacted on nurses' experiences of provision of nutritional requirements. Persons with dementia often require assistance with nutritional needs (Heaven et al, 2013). Some nurses from the acute/admission and residential wards/units, reported that as a consequence of perceived poor staffing levels, ensuring that all patients' nutritional and hydration needs were met proved to be challenging. For example, it was reported that if four patients, required assistance with nutrition and there was only one nurse available, perhaps two, it was very challenging to meet the patients' individual needs. This is a significant finding as de-hydration and malnutrition can lead to the development of weight loss and pressure ulcers (section 7.3.2). Similar findings were reported in a qualitative study conducted by Heaven et al (2013) to explore ward based nutritional assistance within age related wards/units situated within four UK hospitals and there was a particular focus on persons with dementia. Heaven et al (2013) argue that malnutrition amongst older hospitalised patients is a well-known problem which potentially can lead to the development of pressure ulcers, infection and a longer stay in hospital. Constraints in provision of

assistance with patients' nutritional needs were generally associated with limited time and staffing and, these factors were perceived to be out of the control of ward staff (Heaven et al, 2013).

Further points that were raised, in the qualitative phase of the current study, were that in the nurses' experiences, poor staffing levels also impacted negatively on the delivery of person-centred care including relationship building between nurses and persons with dementia. This is a significant finding as it is through meaningful connections with persons with dementia that nurses develop an understanding of the meaning behind behaviours, as one nurse explained "*it is interaction with them that helps you to manage with them*" (section 7.4.2). The qualitative discussions appear to contrast with the quantitative findings however, despite the uniqueness of the research setting they corroborate with studies conducted within general hospital acute settings. From the general hospital acute setting, Borbasi et al (2006) reported a system under pressure and due to poor staffing levels participants were unable to provide even basic nursing care. With regard to person-centred care, Pinkert et al (2017) found that contextual constraints such as poor staffing levels, inhibited participants in their attempts to engage in psychosocial activities with persons with dementia such as looking at photograph albums.

Qualitatively, it also emerged that there is a perception that poor staffing levels has the potential to impact negatively on emotional and physical aspects of nurses' experiences of dementia care nursing. Some of the nurses in the current study expressed feelings of frustration and disappointment that they were not able to provide the care that they would like to give "*I leave here really frustrated, "like I know that I haven't given the care that I would like to have given*" (section 7.3.2). They also described feelings of being emotionally drained and exhausted "*it's very emotionally draining…emotionally exhausting*" (section 7.3.2). Reported feelings of emotional exhaustion and frustration are significant as, according to Eriksson and Saveman (2002) and Nilsson et al (2016), these emotions can lead to burnout and a deadened conscience which can potentially lead to a poor quality of care. These comments which emerged qualitatively, are specific to the current study and the identified non-dementia specific practice areas, however, they are corroborated from the international literature, from general hospital acute settings. According to Eriksson and Saveman (2002) and Byers and France (2008) nurses experience feelings of failure, powerlessness and inadequacy when they are unable to give the care that they consider that they ought to be able

to give. In concurrence with the reviewed literature, the qualitative data from the current study highlights the detrimental effects, poor staffing levels may have on nurses' overall experiences of dementia care nursing.

In relation to the differences noted between the quantitative data and the qualitative data relating to staffing levels, it is suggested that perhaps the quantitative findings related to the overall numbers of permanent nurses allocated to the ward, while the qualitative data was referring to the numbers of nurses on duty on the ward during a particular shift. The overall ward/unit nursing staffing figures generally allude to the total number of nursing staff members assigned to the practice area, they do not account for nursing staff members on leave. From the qualitative data, when nursing staffing levels were discussed, some nurses explained that nursing staff on leave impacted on their daily staffing levels, so if three nurses were allocated to the ward and one was on leave, the nursing staffing level was then down one member of staff for that particular shift. Qualitatively, some of the nurses stated that they could not depend on a replacement member of staff for the person who was on leave which consequently led to depleted staffing levels (section 7.3.2). From the perspective of the STS theory, the findings suggest that there is an imbalance between the social and technical components and subsequently, according to the tenets of the STS theory, if joint optimisation is not achieved the possibility of optimal organisational performance or quality dementia care nursing is constrained. The delivery of quality dementia care nursing is reliant on adequate staffing levels which is a technical component. In the absence of adequate nursing staffing levels, nurses or the social component are restricted in their ability to achieve their goal of delivering quality dementia care nursing.

8.4.2 'Specials'/Enhanced Care

A further influence on nurses' experiences of dementia care nursing and aspects related to staffing issues which emerged qualitatively was the organisations' utilisation of 'specials'. Concern and frustration was expressed by some nurses in relation to the practice of using untrained members of staff 'specials' to care for persons with dementia manifesting unmet needs (section 7.3.2). It was believed that in order for 'specials' to proficiently undertake the care of persons with dementia, specialist dementia knowledge was required. The unrealistic management expectation that untrained staff could undertake the care of persons with very complex needs was described as strange. The reality of this practice meant that potentially, due to the lack of a specialist skill set, the 'special' could inadvertently escalate an already

unpredictable situation, leading to poor outcomes for persons with dementia and resulting in other patients in the ward becoming upset. So rather than providing support for nursing staff and persons with dementia, the situation was identified by some nurses, as creating "*a care burden, a time burden*" as it often led to nurses having to step in to de-escalate the situation, thus adding to their already busy schedule or "*doubling the work*" (section 7.3.2). These experiences are specific to the research setting however, similar opinions were reported in two Australian qualitative studies conducted within general acute wards/units situated in two hospitals (Moyle et al, 2010; Wilkes et al, 2010). It was highlighted within these studies that when 'specials' are not trained, there is the potential to further aggravate the situation (Moyle et al, 2010; Wilkes et al, 2010). Additionally 'specialling' was noted to be an unpopular activity generally undertaken by untrained nursing assistants (Moyle et al, 2010; Wilkes et al, 2010). It was reported that the participants in both of these studies, agreed that specialist education and training is vital for the persons undertaking the role of a 'special' (Moyle et al, 2010; Wilkes et al, 2010).

A unique finding specific to the study setting, concerned issues that can confront nurses when making a request from management for a 'special' (section 7.3.2). It was discussed that despite complying with hospital procedures which consist of completing a time consuming nursing assessment, signed off by a medical doctor the request was not always granted. The reason given by management for not granting the request was generally ascribed to not having available staff. Other factors relating to the use of 'specials' included that if requests were made for four specials from the same ward/unit, one 'special' would be allocated to look after the four persons with dementia who required support. According to some of the nurses, this was an untenable situation as the manifestations of the dementia pathology are so diverse and individualised, that the expectation that one 'special' could provide the support needed for more than one person at a time was unrealistic. The role of the 'special' exerts a considerable influence on nurses' experiences of dementia care nursing. According to the qualitative findings, the success of this role in providing vital nursing support is dependent upon the staff undertaking the role being supported educationally by the organisation.

8.4.3   Physical Environment of the Ward/Ward Layout

Findings from the quantitative phase revealed that the majority of nurses (66.66%) were generally satisfied with the ward layout (section 6.7.4). The sub-section of the WOFS, PEW, Ward Layout included items referring to patient safety and observation, along with

organisational features related to contact time possible between nurses and nursing care delivery methods. All items were positively scored and nurses' demographic characteristics were found to be non-significant thus, no differences were found between the different groupings of respondents. However, these findings were inconsistent with the qualitative data. From the qualitative phase, it was reported that maintenance of safety and security was experienced as challenging for nurses in terms of ensuring visibility of all persons with dementia (section 7.3.1). A major source of concern was the fact that persons with dementia were at risk of going missing from the wards/units (section 7.3.1). When persons with dementia did go missing, it created inordinate levels of anxiety for nurses, as they put in place procedures to locate the missing person and at the same time ensure a balance of care for the other patients in the ward/unit. In an effort to promote safety, technological solutions including electronic doors were introduced by management in all areas (section 7.3.1). This was recognised as a form of restraint which nurses believed placed safety measures over and above the promotion of dignity, privacy and autonomy for persons with dementia. Added to this, electronic measures such as alarms going off led to frustration for persons with dementia, other patients and the nursing staff (section 7.3.1). These findings were generated from the current study setting.

Nonetheless, the qualitative findings are consistent with nursing studies conducted in the general hospital acute environment. As a consequence of the physical design of the care environment, maintaining safety and security for persons with dementia was found to be very challenging (Borbasi et al, 2006; Pinkert et al, 2017). While, Eriksson and Saveman (2002) reported that, the doors of the wards were sometimes closed to promote the safety of the persons with dementia. This measure ultimately acted as a constraint which led to frustration for both patients and nurses. In consensus with the current study, Moyle et al (2010) is of the opinion that the undue focus on safety measures such as technological interventions, places safety issues over and above meeting the physical, social and emotional needs of persons with dementia. According to Dewing (2003), seeking to respond to the person with dementia's immediate needs, rather than containment should be implemented. The results from the literature resonate with the qualitative phase of the current study although they were conducted within different care environments ie general hospitals. However, despite the convergence of findings between the reported literature review findings and the qualitative phase of the current study, contrasting views were reported in the quantitative phase (section 7.3.1). The participants in phase one and phase two were drawn from the same wards/units

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within the same hospitals but as the questionnaires were anonymous, there was no way of knowing if the same participants contributed to both phases. Additionally, from the quantitative phase, nurses' demographic characteristics were found to be insignificant, consequently it is difficult to ascertain the reasons for the differences in the quantitative and qualitative results.

8.4.4 Unfamiliar Environment of Care and Environmental Stressors

From the qualitative phase of the current study, discussions about the nurses' beliefs about the environment of care and its impact on nurses' experiences of dementia care nursing were explored. Discussions included the, effects of the unfamiliar environment of care and environmental stressors on persons with dementia and the consequent impact on dementia care nursing. Nurses were aware that due to the dementia pathology, persons with dementia have a reduced capacity to manage environmental stressors. It was acknowledged that factors such as high speed and busyness contributed to environmental stressors, "*not an environment for patients with dementia at all*" (section 7.3.2). Environmental stressors were recognised as having the potential to trigger responsive behaviours and it was also acknowledged that the unfamiliar care environment can pose 'way finding' difficulties for persons with dementia (section 7.3.2).

It was evident, qualitatively that nurses were aware of the need to modify the environment to avoid these issues and the value of creating a dementia friendly environment to incorporate orientation cues such as contrasting colour schemes, clear signage, clocks and calendars to promote 'way finding' and a sense of familiarity was advocated (section 7.3.2). Promoting a sense of familiarity for persons with dementia within all of the wards/units especially the residential units, was also acknowledged as a way to minimise the manifestation of behaviours associated with the dementia pathology. However, although nurses were aware of the importance of creating a sense of homeliness for persons with dementia, they expressed frustration as a result of the perceived challenges faced in achieving this goal. In relation to the residential units linked to the acute hospital, the reality was that lack of space prevented the possibility of persons with dementia having familiar items from home, such as a favourite chair or dresser. The qualitative findings which emerged from the acute, rehabilitation and residential wards/units contained in dedicated health care services for the older person illustrated that, similar challenges in promoting a sense of familiarity for persons with dementia impacted on nurses' experiences of dementia care nursing in all of these

settings. Perceived insufficient organisational support, related to the physical environment of care, constrained the nurses in having the flexibility needed to provide a sense of familiarity for persons with dementia.

The findings are consistent with research studies conducted within general hospital acute settings, where it was acknowledged by nurses that environmental stressors such as multiple stimuli can be viewed as a potential trigger for increasing confusion for persons with dementia and consequently impacts on nurses' experiences of dementia care nursing (Eriksson and Saveman, 2002; Borbasi et al, 2006). Additionally, de Siún et al (2014) found that many hospitals have a lack of orientation cues despite the known benefits for persons with dementia. It is purported that the presence of familiar objects can support a sense of identity and continuation of self (Brooke and Semylen, 2017) and homeliness (Edvardsson et al 2005; Clissett et al, 2013b). However, despite the recognition of the importance of creating a sense of familiarity for persons with dementia, it was found by Borbasi et al, (2006) and Pinkert et al (2017) in their studies conducted within general hospital acute settings, that the hospital environment imposes contextual constraints such as limited physical ward/unit space which impedes the possibility of nurses ensuring the personalisation of bed spaces. In concurrence with the current study, Pinkert et al (2017) make the point that the care that nurses are capable of delivering is very much dependent upon the physical environment and organisational support.

In summary, the aim of this section was to obtain descriptions of nurses' beliefs about the environment of care and its impact on nurses' experiences of caring for older persons with dementia based on their experiences of caring for older persons with dementia in the unique setting of the current study. New knowledge specific to the research setting has been revealed, such as the suggestion that that poor staffing levels within the rehabilitation wards/units can potentially lead to delayed discharge rates. However, inconsistencies were found between the quantitative and qualitative results concerning staffing levels with the quantitative results reporting general satisfaction with staffing levels. When the findings were followed up qualitatively, many nurses from all of the wards/units, described that due to poor staffing levels, they were unable to provide the quality of care that they wanted to give. Due to the inconsistencies between the quantitative and qualitative findings, further work needs to be initiated to gain a deeper understanding of the impact of nursing staffing levels for persons

with dementia within the environment of non-dementia specific wards/units within age related services.

A further critical finding related to staffing levels emerged qualitatively in relation to the role of untrained health care assistants or 'specials' to support nurses with care of persons with dementia. Nurses outlined the time consuming nature of fulfilling the hospital procedures for making a request for a 'special' which was not always granted. Or the situation could arise when one 'special' was allocated to provide support for a number of persons with dementia which according to the nurses was untenable. Due to the integral function of the 'special' in providing support for nursing staff, the role of the 'special' exerts considerable influence over nurses' experiences of dementia care nursing. According to the nurses, organisational support is needed to ensure that persons who undertake the role of 'specialing' are provided with adequate education to provide the understanding needed to take on this complex function. From the STS perspective dementia care nursing is highly dependent upon adequate staffing levels, according to Clissett et al (2013a) persons with dementia require more organisational resources such as higher staffing levels to ensure quality of care. Constraints encountered by nurses in relation to staffing levels, reflect an imbalance of joint optimisation between the social component and the technical component. This is an important finding, as according to the philosophies of the STS, the social requirements of the people carrying out the work have to be supported by the technical requirements to keep the work system viable (Whetton and Georgiou, 2010).

8.5   STS Perspective

From the findings presented, it is evident from the nurses' views and opinions about dementia care nursing, based on their experiences of caring for older persons with dementia that they encountered a complex array of challenges. The STS, with its emphasis on the interaction between the social and technical components within the organisational environment, successfully provided a framework and, an effective means of capturing the influence that the environment, to include the physical and organisational has on nurses' experiences of dementia care nursing. It provided a conceptual framework within which to categorise and develop an understanding of the complex interactions as perceived by the participant nurses between the social components (participant nurses) and the technical components (overall organisational structure) necessary to keep the work system (dementia care nursing) viable within the environment of care. Organising the social and technical elements interacting

within the environment of care successfully illuminated, the degree of equilibrium achieved. Ultimately, the degree of equilibrium as perceived by the participant nurses between the social and technical systems interacting within the environment of dementia care nursing will influence the nurses' experiences of dementia care nursing.

The technical aspects refer to those components that support the nurses in their nursing practice such as the physical environment of care and the organisational environment of care such as, education and training and staffing levels. The social aspects refer to the work force (nurses) nurses' skills and knowledge and their attitudes. It is apparent from the study findings that there is an imbalance between the social and technical components interacting within the environment, originating from the technical components. The study findings demonstrated that many nurses did not believe that they received adequate organisational support to include: the opportunity to discuss the psychological stress of the job; an evaluation of their work was lacking; it was perceived that there were insufficient opportunities to develop their specialist skills and knowledge in relation to dementia; perceived poor levels of staffing did not support the complexities of providing dementia care nursing and, the physical environment of care did not adequately support the safety and security of persons with dementia. From the STS perspective, the main tenet is a dual focus for joint optimisation between the social and technical components interacting within the environment (Trist, 1981). Optimal work performance requires joint interaction between the social and technical components or the work force and the technical aspects that support the work system (Trist, 1981). If optimisation of only one aspect occurs, the consequences may result in an unpredictable organisational performance (Trist, 1981). Therefore, according to the STS theory, nurses' experiences of dementia care nursing are unpredictable as, there is an imbalance between the interaction of the social and technical components within the environment. Appendix 32 provides an illustration of the technical and social components, as perceived by the study participants and based on STS theory. The diagram clearly demonstrates the imbalance of the two components interacting within the environment.

8.6   Summary

Using a mixed methods research design culminated in capturing more fully the complexities of dementia care nursing based on nurses' experiences of caring for older persons with dementia in non-dementia specific wards/units in dedicated health care services for the older person. The same level of understanding could not have been captured using a mono method.

Further explanation and enhancement of the data collected by way of questionnaires in phase one were brought about by conducting focus group interviews in phase two. Using a mixed methods sequential explanatory design allowed nurses' voices to be heard directly in relation to their nursing experiences. A number of significant issues associated with the provision of dementia care nursing were identified and included: specialist qualifications in relation to skills, knowledge and nurses' attitudes; the influence of staffing levels on dementia care nursing and, the physical environment of care.

Dementia care nursing is contingent upon nurses having the appropriate specialist skills and knowledge (Traynor et al, 2011; NMBI, 2015). In the current study, specialist dementia and gerontological nursing qualifications correlated significantly with skills and knowledge and a more positive attitude towards dementia. These findings are corroborated in the national and international literature.   However, it must be considered that in comparing the findings that emerged from the unique setting of non-dementia specific wards/units contained in dedicated health care services for older person linked to acute Irish hospitals, a number of differences must be taken into account between dementia care nursing in the research setting compared to dementia care nursing in general acute care wards contained in acute general hospital settings, nationally and internationally.   Dedicated health care services for the older person within acute general hospitals is defined as an area which specialises in services exclusive to the person over the age of 65 years (Government of Ireland, 1968). Non-dementia specific dedicated health care services for the older person within general hospitals are better placed to provide care to meet the needs of persons predominantly over the age of 75 years, with and without dementia (National Council for the Aged, 1985; Baztán et al, 2009; HSE, 2012; Briggs et al, 2016b).   The distinctive features of non-dementia specific specialist geriatric units include adequate staffing levels and specialist training (HSE, 2012).   Therefore, a surprising finding from the current study was that the outcomes were comparable to studies undertaken nationally and internationally in general acute wards within general acute hospitals.

In the current study, nurses with the most confidence in their knowledge about persons with dementia had the highest level of specialist qualifications (35.4%). On the other hand, nurses with the least confidence about their knowledge of persons with dementia had the lowest level of specialist qualifications (11%). A further influence on dementia care nursing is that of attitude, attitudes determine the quality of dementia care nursing (Lintern, 2001).

Significantly, the current study found that positive attitudes correlated strongly with nurses with specialist qualifications and this concurred with national and international literature (de Siún and Manning; Kang et al, 2011; Surr et al, 2016). Notably, findings indicated that only 37.2% of the respondents in this study had specialist qualifications. Yet, there was a perception that difficulties can be encountered for some staff being released from practice which inhibited the chance to participate in specialist training and education.

Specialist knowledge also impacts on nurses' competence in ethical decision making. The complex needs of older persons with dementia are better served by nursing staff, who have confidence in their ethical decision making skills (Bolmsjö et al, 2006). Ethical dilemmas were encountered by nurses in their daily practice. Due to a lack of specialist knowledge many nurses did not believe that they were sufficiently competent in ethical decision making and they expressed a desire to engage in specific educational courses and participate in clinical supervision. In concurrence with the literature (Hallberg et al, 1994; Nilsson et al, 2016), the nurses believed that this would provide them with the opportunity to reflect on their practice and discuss dilemmas faced in practice which often remain tacit. In the nurses' experience of dementia care nursing, the role of untrained members of staff or 'specials' to enhance care of the person with dementia forms an integral aspect of care. It was agreed that staff undertaking this role should receive specific training to ensure that they have the specific required competencies. The study highlights the importance of specialist training and education. The requirement for effective education of all healthcare staff to provide high quality, person-centred care for persons with dementia is now embedded in policy (DOH, 2014) but it would appear that it is yet to be fully implemented.

Quality dementia care nursing is dependent upon adequate staffing levels (Pinkert et al, 2017). However, difficulties in sourcing nursing staff to work in care of the older person departments were highlighted by the Government of Ireland as far back as 1968 (Government of Ireland, 1968). This problem has continued over the years and currently, there is an acknowledged international shortage of nurses (International Council of Nurses, 2018). Poor staffing levels as perceived by nurses' impacts heavily on the quality of care that they are capable of delivering. Against this background, it was suggested that not only was provision of essential nursing care challenging to achieve but provision of person-centred care as

advocated by governmental and professional bodies (DOH, 2014; HIQA, 2015; NMBI, 2015) was noted to be particularly difficult to implement.

The physical design of the environment of care should promote safety and independence (Adams et al, 1995; McCance and McCormack, 2017). However, the physical design of all of the wards/units in the three research sites, were perceived qualitatively, to place persons with dementia at harm as constant observation could not be implemented. Safety measures undertaken by management involved installing computer based technology by way of locked doors. This was perceived by the nurses, to be a method of restraint which was the antithesis of delivering person-centred care. Efforts to deliver best quality dementia care nursing was also constrained by environmental factors such as, the fast paced noisy environment of care within all of the wards/units which were noted to have the potential of increasing the disorientation of persons with dementia. The task-orientated focus of hospital care created tensions between prioritising acute care and providing person-centred dementia care nursing with a resulting lack of focus on persons with dementia. The findings highlight the discrepancies between the person-centred philosophy of care advocated by (DOH, 2014; HIQA, 2015; NMBI, 2015) and the reality of practice as perceived by the nurses.

The research study has led to a fuller understanding of the experiences of nurses in the unique environment of non-dementia specific wards/units that include acute, rehabilitation and residential contained in health care services for the older person linked to acute hospital services. The study adds to the evidence base of nursing knowledge about dementia care nursing. The final chapter which follows will place the study results into context and, discuss limitations, conclusions and potential for future research.

Chapter Nine – Conclusion

9.1 Introduction

The purpose of this chapter is to present the implications and recommendations that have emerged from the current study. The intention of the study was to explore nurses' views and opinions about dementia care nursing based on their experiences of caring for older persons with dementia in the unique setting of non-dementia specific wards/units that include acute, rehabilitation and residential contained in dedicated health care services for older person linked to acute hospital services. A number of significant findings were identified that impacted on nurses' experiences of dementia care nursing to include that, provision of quality dementia care nursing is dependent upon nurses having specialist qualifications, skills and knowledge and access to on-going education; organisational support by way of appropriate staffing levels to support person-centred dementia care nursing as advocated by both professional and governmental bodies is critical and the physical environment of care should enable nurses to promote and support safety and familiarity for persons with dementia. Using a mixed method sequential explanatory research design offered the opportunity to explore, in phase two the findings from phase one thus, promoting a deeper understanding of the quantitative results. This research study provides a fuller understanding of these issues from the unique perspective of participant nurses' experiences of dementia care nursing in the identified setting. Implications and recommendations will be presented and these will be followed by the acknowledged limitations of the study and finally a personal reflection will be presented.

9.2 Specialist Education

The role of the nurse is pivotal to the delivery of best quality care for older persons and older persons with dementia (HSE, 2012; NMBI, 2015). Best quality care is dependent upon competent, skilled and knowledgeable nurses and skills and knowledge are developed both clinically and theoretically. Specialist education and knowledge underpins the quality of care that persons with dementia can expect to receive. Skilled dementia care nursing to include medical and social understandings correlated significantly with specialist qualifications (gerontological nursing or dementia specific education) (section 6.5.3). Specialist qualifications were also found to lead to more positive attitudes to include person-centred care and hopefulness for persons with dementia (section 6.6.1). With regard to nurses' ethical

competence and advocacy skills related to dementia care nursing, significantly, it was proposed that nurses would welcome the opportunity to participate in clinical supervision sessions and specialist education related to ethics (section 7.5.2). It was perceived that clinical supervision and education would lead to greater confidence in ethical decision making (7.5.2). Despite the critical importance of specialist knowledge to underpin dementia care nursing, findings demonstrated that less than half (37.2%) of participant nurses held specialist qualifications in gerontological nursing or dementia specific education. Given that there is a clear correlation between specialist qualifications and knowledge about persons with dementia and positive attitudes towards dementia care nursing, suggests that provision of training and education are key areas in the provision of effective, person-centred dementia care nursing. Theoretical knowledge is gained through participation in specialist educational programmes and the nurses identified a number of specialist programmes both locally and nationally. It was firmly acknowledged that education is invaluable in improving care and competence (section 7.4). Education should be easy to access, on-going and should be led by the organisation. Yet, it was perceived that a lack of organisational support to include both poor staffing levels which inhibited staff release and inadequate funding opportunities, constrained nurses' participation in specialist educational programmes (7.4).

Disquiet was expressed in relation to the organisational use of untrained health care assistants or 'specials' to support the nurses with the care of persons with dementia experiencing periods of agitation and restlessness. Care of persons with dementia was acknowledged as highly complex work, requiring an appropriate level of specialist skills and knowledge. Theoretically, the use of 'specials' should support nursing staff in the delivery of dementia care nursing but in practice due to lack of training, it was suggested that 'specials' can often add to nurses' work load as they are called upon to de-escalate situations where 'specials' have inadvertently escalated an already unpredictable situation (section 7.3.2).

9.2.1 Recommendations – Specialist Dementia Education

❖ Initiate a system of standardised organisational support to facilitate attendance at on-going accredited specialist dementia programmes to ensure that all nurses practicing in areas where dementia care nursing takes place have the appropriate competencies to include ethical competence to underpin their practice. This will ensure that dementia care nursing is delivered using a standardised approach and commensurate with best practice guidelines and evidence based approaches. This is in line with

recommendations from the Irish National Dementia Strategy (DOH, 2014). This should be mandatory.

❖ Study time should be provided to nursing staff who wish to attend dementia conferences, both nationally and internationally. Attendance at conferences would expose attendees to current national and international research findings and knowledge about dementia.

❖ Clinical nurse specialists in dementia care posts should be established in clinical areas, as a source of support, to provide education and advice to nurses.

❖ Participation in a dementia champion programme should be promoted along with support to undertake the role of dementia champion. The role of a dementia champion is to provide advocacy for persons with dementia, progress competent practice in dementia care and ensure promotion of person-centred dementia care hospital policies and procedures (DCU, 2015).

❖ Clinical supervision should be established to enable nurses to actively reflect on their emotional reactions and share their clinical knowledge. Clinical supervision would also promote a deeper understanding of the person with dementia within the nursing care relationship.

❖ The role of the 'special' in dementia care is recognised as highly complex work and in practice exerts a substantial influence on nurses' experiences of dementia care nursing. Staff assuming the role of 'specials' should undertake accredited specialist dementia specific education to facilitate the acquisition of competencies to undertake person-centred care of persons with dementia and, to address responsive behaviours. This should be mandatory.

9.3   Environment of Care – Organisational Support

The current study highlighted that a perceived lack of organisational support from corporate management, to include lack of management visibility and psychological support (section 6.5.2) along with a lack of critical evaluation (section 6.5.6) in the nurses' experiences, led to the belief that the challenges that they faced in provision of dementia care nursing in a non-dementia specific environment, was neither recognised or understood (section 7.3.2). These are important points, as according to McCormack and McCance (2017) nurse leaders play a vital role in fostering a culture and creating conditions that enable a person-centred approach to care. Added to this, lack of recognition or understanding of the complexity of the dementia care nursing role can lead to quality of care being compromised as nurses can feel that their

role is of no value (Hallberg et al, 1994; Cowdell, 2010a; Pinkert et al, 2017). Poor organisational support also influenced staffing levels which were also found to impact strongly on nurses' experiences of dementia care nursing. Concerns about the effect of perceived poor staffing levels were commonplace and it was suggested that poor staffing levels affected all of the non-dementia specific wards/units (section 7.3.2). For example, maintaining physiotherapy led walking programmes, within the rehabilitation wards/units is a time consuming activity that requires strong staffing levels. A unique suggestion was that as a consequence of poor staffing levels which impacted on the level of support available for persons with dementia, potentially a delay in discharge may occur (section 7.3.2). From the residential and acute wards/units it was suggested that poor staffing levels impacted on essential nursing care such as support with nutrition (section 7.3.2). Poor staffing levels also impacted on nurses' ability to provide person-centred care. Nurses aspired to deliver person-centred dementia care nursing to include relationship building and social interaction with persons with dementia (6.6.3). However, this level of care was often hampered by lack of time, as a result of poor staffing levels consequently leading to feelings of disappointment and frustration for the nurses. The nurses also expressed feelings of both physical and emotional exhaustion (section 7.3.2) as a result of poor staffing levels which subsequently according to Eriksson and Saveman (2002) and Nilsson et al (2016), can lead to burnout which can potentially have a negative effect on the delivery of dementia care nursing. A unique discussion point from the current study was the difficulties encountered by nurses in processing a request for a 'special' (section 7.3.2). Despite the time-consuming nature of following management procedures, the request was not always granted.

9.3.1   Recommendations – Organisational Support

❖ Corporate management should ensure a regular, visible presence on the wards/units to familiarise themselves first-hand, with the role of the nurse in provision of dementia care nursing within non-dementia specific wards/units situated within age related services, to include the acute, rehabilitation and residential wards/units. This is especially important as corporate management have an important role to play in creating and maintaining the conditions that support quality dementia care nursing.

❖ Work force planning should ensure that adequate staffing levels (guided by an appropriate instrument) are provided to guarantee that staffing levels support the provision and balance of nursing care for all patients in the non-dementia specific wards/units, to include quality dementia care nursing. Regular clinical audits to

monitor staffing levels should be undertaken by the Nursing Practice Development Unit (NPDU) for the purpose of evaluation.

❖ An evaluation of the process of requesting a 'special' by nursing staff, should be initiated. This would provide evidence as to the numbers being requested, why the request is being made and how the allocation of a 'special' is managed by the organisation.

9.3.2 Physical Environment of Care

Although the majority of nurses reported general satisfaction with the physical layout of the wards/units (section 6.7) problems were identified with supporting safe walking and facilitation of visual access to persons with dementia (section 7.3.1). In an effort to promote safety, management installed technological measures such as locked doors which nurses recognised as a form of restraint which is the antithesis of person-centred care (section 7.3.1). It was also suggested that the unfamiliar environment of care impacted negatively on persons with dementia and had the potential to trigger responsive behaviours. Nurses acknowledged that a dementia friendly environment includes such items as orientation cues and familiarising the environment could potentially lead to a reduction of responsive behaviours. However, lack of orientation cues along with poverty of space inhibited the possibility of creating a dementia friendly environment of care (section 7.3.1). There was a suggestion that the organisation should appoint a clinical nurse specialist in dementia care to lead out on these potential changes and provide education as to why environmental changes can potentially improve care for persons with dementia (section 7.3.1).

9.3.3 Recommendations – Physical Environment of Care

❖ Create appropriately designed dementia friendly environments based on international guidelines to include issues related to maintenance of safety. An appropriate environment should ensure that persons with dementia are cared for in a dignified and respectful manner, minimising the priority of safety over respect. This could be achieved by liaising with environmental experts.

❖ In light of the importance of a sense of familiarity for persons with dementia, consideration has to be given to creating adequate space to create personalised areas. Appropriate orientation cues (words accompanied by pictures) need to be erected.

❖ In consideration of the multi stimuli in the environment of care, thought also has to be given to creating quiet spaces thus minimising the risk of triggering responsive behaviours.

❖ Link person/persons such as dementia specific clinical nurse specialists should be appointed to ensure that the reasons for the environmental changes are understood by all members of the nursing staff.

9.4   Clinical Practice

Significantly, in the experiences of nurses, it was perceived that the implementation of the hospital driven policies and procedures promoted physical aspects of care over and above a person-centred approach to care thus rendering them to be inappropriate to guide dementia care nursing practice (section 7.3.2). It was also highlighted that patients' cognitive status was not routinely assessed and that information regarding patients' cognitive status was often not documented in their records, leading to the situation where the numbers of persons with dementia in the environment of care was unknown (section 7.4.2). Consequently, not all persons with dementia were being offered the support that they need (section 7.4.2). Positive attitudes as measured by the ADQ (Lintern et al, 2000) indicated that, nurses with specialist qualifications held the most positive attitudes about dementia (6.6.1). However, only 37.5% of nurses held specialist qualifications. As a result of lack of specialist education and potentially, where negative attitudes may exist, there is a possibility that less than optimal dementia care nursing may take place. Especially when persons with dementia experience manifestations of the dementia pathology (section 7.6.1)

9.4.1   Recommendations – Clinical Practice

❖ Identifying cognitive status on admission would assist in ensuring that persons with dementia receive care appropriate to their needs and, provide more accurate statistics of persons with dementia within the identified setting.

❖ Cognitive assessment, by nurses, should be mandatory on admission to the age related units and repeated on a regular basis as dictated by the needs of the individual. Ideally, the initial assessment should be conducted as part of the nursing admission criteria.

❖ Consequently, nurses need to be educationally prepared to undertake cognitive assessment using an appropriate measurement tool

- ❖ Development of appropriate nursing practice guidelines to guide dementia care nursing practice, under-pinned by a person-centred philosophy of care, should be undertaken by the NPDU with support from experts in dementia care and liaison with Care of Older Person Nursing staff.
- ❖ Audit of the use of anti-psychotics needs to be undertaken to establish prescription rates and reasons for prescription. This is in line with recommendations from the Irish National Dementia Strategy (DOH, 2014). This is especially important due to the significant negative side effects for persons with dementia such as a nearly three-fold increased risk of mortality (Jackson et al, 2017) increased drowsiness and increased risk of falling.

9.5 Implications for Further Research

This study contributes an understanding of dementia care nursing from the unique perspective of nurses' experiences of caring for older persons with dementia within non-dementia specific wards/units that included acute, rehabilitation and residential, contained in dedicated health care services for the older person linked to acute general hospital services. Most of the existing research on dementia care nursing has been conducted within acute general wards situated in acute general hospitals as identified within the literature review (chapter two). Despite the fact that the current study uniquely focused on the experiences of nurses within the identified setting, there was a similarity to findings reported from acute general wards within acute general hospitals, particularly in relation to the perceived lack of organisational support. Discrepancies were noted between the quantitative and qualitative findings, relating to the physical environment of care. While the majority of phase one respondents indicated general satisfaction with the physical layout, participants in phase two in concurrence with the reviewed literature, identified a number of problems. To assist in bringing about an understanding of these inconsistences requires further exploration. A unique finding from the current study related to cultural understandings of dementia and dementia care nursing. To ensure that all nurses share a similar understanding of dementia and dementia care nursing emphasises the importance of recognition that cultural differences do exist. Taking all of the above points into consideration, I believe that these findings have important implications for future research involving gerontological and dementia care nursing.

9.5.1 Recommendations for Further Research

❖ With regard to organisational support for dementia care nursing and gerontological nursing within age related services linked to acute general hospital settings. It is recommended that future research should be conducted to explore hospital management understandings of dementia care nursing and gerontological nursing within a designated age related service linked to acute general hospital services.

❖ With regard to the physical environment of care. It is recommended that further research should be conducted to explore nurses' experiences of ensuring a sense of safety and security for older persons with dementia, within a designated age related service linked to acute general hospital services.

❖ The prevalence of migrant nurses continues to increase in the Irish Health Care System, in particular within the speciality of gerontological nursing. Future research needs to closely examine the extent of cultural differences in relation to understandings of dementia and attitudes towards dementia. An awareness of these issues should assist in developing appropriate educational strategies to bring about a standardised approach to dementia care nursing practice that is delivered using a person-centred philosophy of care as advocated by both NMBI (2015) and the National Dementia Strategy (DOH, 2014).

❖ The role of the 'special' has a significant influence on nurses' experiences of provision of dementia care nursing. Further research needs to explore the role of the 'special' in assisting nursing staff with care of persons with dementia to include the perspective of both nursing staff and the persons who assume the role.

❖ With regard to ethical competence, future research needs to be conducted to explore nurses' views and opinions regarding their beliefs about the most effective approach to clinical supervision and specialist education related to ethics. This would assist in providing the most beneficial strategies and approaches to underpin this initiative.

9.6 Limitations of the Study

There were a number of limitations in conducting the current study and the outcomes of the study should be interpreted with regard for them. The sampling methods involved using non-probability convenience and purposive methods. Consequently, there was a risk of selection bias and the possibility of generalising results is limited. Added to this, the survey data was self-reporting which entails the risk of bias and responses may have reflected social desirability. As such, they may not reflect what the respondents do in practice instead they may highlight what respondents' say that they do. This is highlighted by some of the

quantitative responses which conflicted with both the literature and focus group findings, for example, in relation to the appropriateness of the environment of care (section 6.7.6). Similarly, participants volunteered for the focus group interviews and they may have been more interested in dementia care nursing than those who did not respond. Conversely, participants volunteering to take part in the focus group interviews may have had a negative attitude to dementia care nursing. These considerations may lead to questioning the representativeness of the people who did participate in relation to the population (Haber, 2002) and therefore caution is required in analysing and interpreting the results.

A further limitation was that the data set was generated from the unique environment of non-dementia specific wards/units contained in dedicated health care services for the older person contained in three hospital sites in one Irish city. The results cannot, therefore, be generalised to other countries due to both the unique research site and the differing health care delivery systems. However, given the similarities found between the current study results and findings from the acute general hospital care environment from a number of different countries strengthens the view that the findings do add to the international body of nursing knowledge.

Further issues related to limitations of the study are associated with the use of gatekeepers and the possibility of gatekeeper bias. Such bias can occur when a gatekeeper may hinder access rather than enable it (Punch and Oancea, 2014). The role of the gatekeeper is explored in (section 5.2.1). Participation rates for both phases of the study reflected a good response, so it would appear that the gatekeepers' role enabled participants to access and become involved in the study.

Quantitatively it was noted from the ADQ (Lintern et al, 2000) (section 6.6.1) that nurses educated in India and the Philippines scored considerably lower than their colleagues educated in the UK and Ireland. Lower scores, according to the ADQ scoring criteria, equate with less positive attitudes towards dementia (Lintern et al, 2000). It is acknowledged that study limitations included that the participants' nursing history, reasons for migrating to Ireland or working with older people were not discussed. Ultimately, as none of these issues were explored, cultural differences can only be speculated on and may be related to cultural mores such as social and historical experiences rather than issues stemming from nursing experiences.

A further potential limitation to the current study was that aggregating the responses and participants from the three sites, could have skewed the results. To address this potential limitation, analysis of the individual total scores and total sub-scores of the three questionnaires as generated by the three separate hospitals was conducted. No significant differences were found amongst the total scores or the total sub-scores (section 6.9). Thus, aggregating the responses did not adversely affect the results.

The current study explored nurses' views and opinions of dementia care nursing based on their experiences of caring for older persons with dementia. It is acknowledged that persons with dementia experience progressive decline in their cognitive abilities along with a concurrent decrease in their abilities to perform activities of living (DOH, 2014). This means that nurses' experience caring for older persons with dementia with a wide variation of functional capacity and cognitive abilities. As the study did not distinguish between functional capacity and cognitive abilities, it is unknown if there were negative nursing responses towards persons with higher dependency levels.

The current study is nursing specific and nurses are recognised as pivotal team players working with and liaising with the multi-disciplinary team (section 1.1.4). The role of the nurse is recognised as being central to delivery of best quality care for persons with dementia (NMBI, 2015). So while it is acknowledged that dementia care requires an MDT approach it is the role and approach of the nurse within the identified setting that is the focus of the current study.

9.7   Personal Reflection

There is no doubt that my lengthy engagement in the area of gerontological nursing influenced this study, from the choice of topic, to the selection of non-dementia specific wards/unit for the older person with dementia along with the fact that care of the older person with a co-incidental dementia has become a major part of the nursing role. I remain enthusiastic about the topic and I continue to be passionate about care of the older person and in particular dementia care nursing. However, at times as I struggled with the complexities of time management, I often pondered if my enthusiasm was going to be sufficient to sustain my on-going study. Conducting a mixed methods study is without a doubt a very time consuming undertaking, so again despite my commitment and my belief that it was the most robust way to explore dementia care nursing, it often appeared to be an almost insurmountable enterprise.

However, I persevered and my study has brought with it invaluable experience both academically and professionally. I now have a firm grasp of the skills necessary to undertake research activity, particularly in the area of the mixed methods approach. This skill set will assist me in identifying suitable areas for further research and enhance my role within a team of researchers. The study has also increased my understanding of the complexities and challenges involved in provision of dementia care nursing.

9.8   Conclusion

This study contributes an understanding of dementia care nursing from the perspective of nurses' experiences of caring for older persons with dementia within the unique setting of non-dementia specific wards/units contained in dedicated health care services for the older person linked to acute hospital services. The study offers insights into the array of complexities experienced by nurses in their daily practice of dementia care nursing. Key issues identified that according, to the experiences of nurses, elements of organisational support critical to the delivery of dementia care nursing should include, placing an emphasis on access to on-going specialist training and education, a review of staffing levels and, the creation of inclusive environments of care that promote safety and security for older persons with dementia, The study provides valuable new knowledge concerning; cultural differences related to nurses' understandings of dementia and, the substantial influence that the role of the 'special' plays on the experiences of nurses' provision of dementia care nursing. A further unique suggestion was that many nurses would welcome the opportunity to participate in clinical supervision and specialist education to enhance their competence in ethical decision making. The findings of the study have firmly established that organisational support is critical to the delivery of dementia care nursing. As Kitwood (1997) argues, organisational understandings of person-centred care require the valuing of staff and provision of support to enable them to carry out their work efficiently. This view is supported by Ryan and Nolan (2016) who believe that it is only possible for staff to create an enriched work environment if staff themselves, are familiar with this experience. The numbers of older persons with dementia accompanied by multi-morbidities is increasing. To ensure that nurses are in a position to meet the organisational goal of quality person-centred dementia care nursing requires an organisational mind shift. An adequately supported nursing team will increase the likelihood that older persons with dementia receive the quality of care that is their right to expect. Quality care is a human right not a gift to be bestowed by benevolent others.

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Appendices

Appendix One
Literature Search Flow Diagram

Identification

948 records identified through database searches

6 additional records identified through other sources

954 records identified

406 duplicates removed

Screening

548 records screened for eligibility

500 records excluded

Eligibility

48 full text articles assessed according to inclusion criteria

22 excluded did not meet criteria

Included

26 studies reviewed and included in the review

Appendix Two

Recommendations for a Dementia Friendly Ward within Acute Hospital Services

Recommendation	Aim
Space for Meaningful Activities	- Availability of a day room. - To include books, games and reminiscence activities. - Supportive lighting and inclusion of natural light.
Outdoor spaces	- Availability of a garden. - Areas to walk with resting points. - Seating areas.
Orientation Cues	- Legibility of signage that includes pictures and text. - Toilet doors painted a single distinctive colour and toilet seats and hand rails in a colour that contrasts with the walls and floor. - Clocks and calendars. - Use of colours and artwork to identify bays and individual bed areas.
Safety and Security	- Uncluttered areas and discreet security responses. - Removal of nurses' stations to increase the visibility of staff. - Good observation to all bed bays. - Non-slip, uniform coloured floors and level door thresholds. - Painting scheme that disguises doors to all staff areas. - Handrails placed appropriately. - Fully accessible toilets with a range of supports.
Familiarity	- Dining areas utilising traditional cutlery and crockery. - Additional space provided for each bed space to permit placing of personal items and photographs. - Provide a softer and less institutional setting with bright, colourful furniture and spaces.

(Brooke and Semylen, 2017; Cox and Eastham, 2017; Grey et al, 2017).

Care Environment
Socio – Technical System Components

Social Components

Nursing Staff

Nurses Work Group Relations

Nurses' Skills and Knowledge

Nurses' Attitude

Nurses' Professional Development

Technical Components

Physical Environment of Care

Organisational Support (OS)
Corporate Management

(OS) Hospital Policies and Procedures (Applicable to Nursing Staff

(OS) Such as appropriate staffing levels

(OS) Educational support for nursing staff

(OS) Psychological and work evaluation support

Social and Technical System Components Interaction
Adopted from (Happ 1993; Brooks and Anderson,

Adapted from (Happ, 1993) and (Brooke and Anderson, 2005).

Appendix Three – Socio-technical System

Appendix 4 - Study Setting

All three hospital sites that provided the setting for this study are university teaching hospitals. Two of the hospitals are acute general hospitals and one is an affiliated site. They are unusual in that they provide acute, rehabilitation and residential services for older persons with and without dementia within their dedicated health care services for the older person departments. This level of health care services for the older person within general hospitals is comparatively uncommon. Indeed, findings from the Irish audit of dementia care, revealed that less than one-fifth of older persons with dementia were admitted to a specialist geriatric medicine ward (Briggs et al, 2016b). According to Grey et al (2017) there are approximately 50 acute general hospitals in Ireland and acute care is defined as a breadth of clinical health care services, incorporating emergency medicine. Although Grey et al (2017) point out that some of these hospitals also incorporate non acute services such as age related day hospitals as part of their overall service, they do not provide figures. Details of the three hospitals are now presented.

Hospital A has a 219 bed capacity and is closely affiliated to hospital B. Age related services offer a range of health and social services for adults of 65 years and older to include, residential care, respite care and rehabilitation services under the auspices of the geriatricians in hospital B and the general governance structure of both hospitals. Residential care provides non-dementia specific care (two units, each with 24 beds) and rehabilitation services (one unit with 25 beds). There are also two respite beds. Age related services aim to provide an environment that promotes person-centred care values that includes respect for individuality, privacy and independence. Services within the age related unit include medicine, nursing, physiotherapy, speech and language, audiology, occupational therapy, nutrition and dietetics, pharmacy, social work and out-patient therapy services. There is one dementia clinical nurse specialist who covers the entire hospital.

Hospital B is a large university acute general teaching hospital (600 bed capacity) and provides non-dementia specific acute services (two units) and rehabilitation services (one unit) and a day hospital within the age related department within the main hospital under the direction of a number of geriatricians and the general governance structure of the hospital. As noted above, it is closely affiliated to hospital A and rehabilitation and residential services are also provided within hospital A as outlined above. Clinical services include acute geriatric medicine, rehabilitation, day hospital, memory assessment clinic, stroke unit, TIA clinic,

integrated care of older persons team, falls clinic, fracture liaison services and an atrial fibrillation clinic. The multi-disciplinary team within the age related unit include medicine, nursing, psychiatry, physiotherapy, speech and language, occupational therapy, nutrition and dietetics, pharmacy, social work and out-patient therapy services. There is one dementia clinical nurse specialist within the age related out-patient services.

Hospital C is a large university acute general teaching hospital (bed capacity 1,000) with a sizeable age related department. It has a full range of services for the physical and mental requirements of older people on site. It provides non-dementia specific acute services (two units) rehabilitation services (three units) and residential services (three units) to include respite care within the main hospital under the direction of a number of geriatricians and the general governance structure of the hospital. It also has a day hospital. It has a further satellite unit (two residential units) in a neighbouring community hospital under the remit of the dedicated health care services for the older person department and the governance structure pertinent to hospital C. Further services include an out-patients department, a memory clinic, a falls and blackout unit, an osteoporosis treatment and fracture prevention unit and stroke services. The multi-disciplinary team includes, medicine, nursing, psychiatry, physiotherapy, speech and language, occupational therapy, nutrition and dietetics, pharmacy, social work and out-patient therapy services.

The National Three day Dementia Programme is run on a regular basis within all three hospital sites but it is not mandatory. Care is led in all three hospitals by geriatricians and a highly skilled multi-disciplinary team to include nursing staff under the governance structures of the individual hospitals as outlined. They should therefore, be in a prime position to deliver skilled medical and nursing care as envisioned by the Government of Ireland (1968). All of the units are non-dementia specific.

Rationale for Including Acute, Rehabilitation and Residential Sites
Within the dedicated health care services for the older person, there is a great deal of cohesion between the acute, rehabilitation and residential wards/units. Persons with and without dementia may use all three services. For example, persons with and without dementia, from acute and residential may use the rehabilitation facilities. Persons with and without dementia may transfer permanently from the acute wards/units to the residential

units. Additionally, nurses move seamlessly between the acute, rehabilitation and residential sites.

General Statistics

It is estimated that there are 29-42% of older persons with a co-incidental dementia receiving hospital care in the Irish setting (de Siún and Manning, 2014) (section 1.4.1). Although this is believed to be an under-estimate as a large percentage of persons either do not have a cognitive assessment or do not have information in their admission documents to indicate that they have a dementia. Within rehabilitation services (section 1.4.3), over half or 63.8% of the service users are over the age of 80 years and 6.2% are known to have dementia. The majority of rehabilitation facilities are provided by the HSE.

The HSE are also responsible for the majority of residential services (section 1.4.2) for the older person experiencing serious chronic illness who require on-going medical care. It is estimated that 47% of residents have a known dementia (Pierce and Pierse, 2017). The residents are generally over the age of 80 years with (20.8%) between 80 and 84 years increasing to 50.2% over the age of 85 years. Consequently as the three university teaching hospitals which provide the setting for this study are under the auspices of the HSE, the majority of the service users in all sectors of dedicated health care services for the older person are likely to be over the age of 80 years with co-morbidities and a co-incidental dementia.

Appendix 5: Director of Nursing Letter

School of Nursing and Midwifery
Trinity College Dublin
D'Olier Street
DUBLIN

Dear Director of Nursing

Within hospitals which provide dedicated health care services for the older person, nurses are encountering an escalation in the number of both acutely and chronically ill older people with coincidental dementia. Due to the demographic changes in our population and the increasing prevalence of dementia an exploration of the variables that contribute to dementia nursing care is warranted.

As you provide dedicated health care provision for older adults within your hospital, I am formally requesting permission to recruit nursing participants from within this unit. This will involve completing anonymous questionnaires in phase one of the study and participating in focus group interviews in phase two.

I confirm that confidentiality will be maintained throughout the study and that neither the participants or the organisation will be identified. Furthermore, I confirm that the organisation will not be identified in any publications without prior approval. A copy of the research dissertation will be made available to the hospital on completion of this study.

I enclose for your attention:

- ➢ Questionnaire booklet
- ➢ Letters to participants to include:
    - o Letter of invitation to complete the questionnaires which outlines the procedure of consent (phase one)
    - o Letter of Invitation to participate in Focus Group interviews (phase two)
- ➢ Participant information leaflets
    - o Phase One and Phase Two
- ➢ Letters to the gatekeeper
    - o Phase One and Phase Two
- ➢ Consent form (Phase Two)

I have obtained ethical approval from SJH/AMNCH Research Ethics Committee which I am also enclosing for your attention.

I hope that you agree with me that this is potentially a valuable study and that you will allow me access to the nurses practicing with the appropriate units.

I am undertaking this research project in pursuit of the award of a PhD with the School of Nursing and Midwifery, Trinity College Dublin.

I have enclosed a stamped addressed envelope for your attention.

Yours sincerely
Anna C Ayton, RGN, MSc, BNS

Appendix 6: Demographic Questionnaire

<table>
<tr><td>Section 1 – Demographic Questionnaire

This section addresses questions about you and your nursing qualifications
All questions can be answered by ticking the appropriate box ☑
apart from country of nursing education and where you may have to answer "other please state".</td></tr>
</table>

1.   What is your age bracket?

20-29years	30-39 years	40-49 years	50-59 years	60-65years

2.   What is your gender?

Female	Male

3.   Please State the Country Where Your Nursing Education took Place?

4.   How long have you been a registered general nurse?

1-2years	3-5years	6-10years	11-15years	16-20years	21-25years	26-30 years	Other Please State

5.   What are your nurse qualifications?

MSc	Degree	Diploma	Certificate	Other Please State
		Pre registration		
		Post registration		

6.   Do you have dementia (**Dem**) or gerontology (**GN**) specific qualifications?

	MSc	Degree	Diploma	Certificate	Other Please State
Dem					
GN					

7.   What is your nursing grade? Clinical Nurse Manager (CNM)

Staff Nurse	CNM 1	CNM 2	Other Please State

8.   What type of care of the older person ward/area do you work in?

Acute/Admission	Rehabilitation	Continuing Care	Other Please State

9.   How long have you worked in this area?

1-2years	3-5years	6-10 years	11-15 years	16-20 years	21.-25 years	26-30 years	Other Please state

10.   How long have you worked within the hospital?

1-2 years	3-5 years	6-10 years	11-15 years	16-20 years	21.-25 years	26-30 years	Other Please state

Appendix 7: SNCW

Section 2 –Satisfaction with Nursing Care and Work Assessment Scale (Hallberg *et al*, 1994)
This section asks you questions concerning your views and opinions about the provision of nursing care for the person with dementia
Please indicate to what extent you agree or disagree with the following statements by ticking the appropriate box ☑

1.   My duties at work are stimulating

Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree

2.   My duties at work are varied

Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree

3.   I am able to organise my working conditions so that I can work at a pace which is comfortable for me

Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree

4.   I often find that I do not complete everything that I should in my job

Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree

5.   My opinions are considered when changes are made at work

Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree

6.   I worry that my own job situation will change because of changes to the organization

Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree

7.   I am satisfied with the independence I have in my job

Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree

8.   I am satisfied with the responsibility I have in my job

Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree

9.   Our work organization is good

Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree

10.   Our staff work well together

Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree

11. There is a friendly atmosphere at work

Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree

12. I often feel that I know too little about the patients/residents disease and treatment

Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree

13. I often feel that I know too little about the patients/residents personal background, habits and wishes

Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree

14. There are enough opportunities at work to discuss the psychological stress of the job

Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree

15. The patients/residents at work nearly always receive good care

Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree

16. The patients/residents are given enough information about their disease

Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree

17. The patients/residents are given enough information before examination and treatment

Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree

18. Newly admitted patients/residents are given enough information about the routine in the place where I work

Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree

19. Relatives are given enough information about care and treatment

Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree

20. It is important to try and enter into the way patients/residents experience what happens to them

Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree

21. It is too much to expect that I can involve myself with every patient/resident

Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree

22. It is difficult to manage the job if you get too involved with the patients/residents

Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree

23.   I seldom have time to try and understand what the patients/residents think about
       our care

Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree

24.   It is boring to work with the same patients/residents every day

Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree

25.   I enjoy my current work situation

Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree

26.   I feel I am developing as a person from my work here

Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree

27.   I feel that I am developing professionally from my work here

Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree

28.   I often receive encouragement from others for the work I do

Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree

29.   I often receive constructive (ie helpful) criticism about the work I do

Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree

30.   My colleagues value what I do at work

Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree

31.   My colleagues often ask me for information I can give about particular patients

Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree

32.   We often discuss ways of improving the care we give (eg alternative care methods
       setting care goals, changing the work routine)

Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree

Section 3 - Approaches to Dementia Questionnaire
(Lintern *et al,* 2000)
This section asks you questions concerning attitudes towards dementia

Please indicate to what extent you agree or disagree with the following statements by ticking the appropriate box ☑

1.   It is important to have a very strict routine when working with dementia sufferers

Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree

2.   People with dementia are very much like children

Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree

3.   There is no hope for people with dementia

Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree

4.   People with dementia are unable to make decisions for themselves

Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree

5.   It is important for people with dementia to have stimulating and enjoyable activities to occupy their time

Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree

6.   Dementia sufferers are sick and need to be looked after

Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree

7.   It is important for people with dementia to be given as much choice as possible in their daily lives

Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree

8.   Nothing can be done for people with dementia, except for keeping them clean and comfortable

Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree

9.   People with dementia are more likely to be contented when treated with understanding and reassurance

Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree

10.   Once dementia develops in a person, it is inevitable that they will go down hill

Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree

11. People with dementia need to feel respected, just like anybody else

Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree

12. Good dementia care involves caring for a person's psychological needs as well as their physical needs

Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree

13. It is important not to become too attached to patients/residents

Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree

14. It does not matter what you say to people with dementia because they forget anyway

Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree

15. People with dementia often have good reason for behaving as they do

Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree

16. Spending time with people with dementia can be very enjoyable

Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree

17. It is important to respond to people with dementia with empathy and understanding

Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree

18. There are a lot of things that people with dementia can do

Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree

19. People with dementia are just ordinary people who need special understanding to fulfil their needs

Strongly Agree	Agree	Neither Agree or Disagree	Disagree	Strongly Disagree

Appendix 9: Strengths & Weaknesses -Attitudes to Dementia Questionnaires

Questionnaire	No of Items	Sample Items	Administration and Scoring Instructions	Reliability	Notes
(Swedish) Strain in Nursing Care Assessment Scale (SNC). Hallberg and Norberg (1995) Aim – To measure nursing staff attitudes towards people with dementia and their reactions to them	36	In daily care, people with dementia often – are manipulative	Included with the instrument	Cronbach's alpha Attitude sub scale 0.747 Strain sub scale 0.961	Questionable use of language, such as the sample item
(English) Approaches to Dementia Questionnaire (ADQ) Lintern et al (2000) Aim – To measure care staff' attitudes towards people with dementia to include hopefulness and person- centred care	19	It is important to have a very strict routine when working with dementia sufferers	Included with the instrument	Cronbach's alpha Total score=0.85 Hope= 0.76 Person centred=0.85. Reliability Total score=0.76 Hope=0.70 Person centred=0.69	Questionable use of language such as dementia sufferers
(Norwegian) Nurses' Attitudes Towards People with Dementia: The Semantic Differential Technique. Norbergh, et al, (2006) Aim – to measure nurses' attitudes towards people with dementia	57 bipolar adjec-tives	Valuable-valueless. Knowledgeable-ignorant	Included with the instrument	Cronbach's alpha 0.954	Adjectives very subjective
(American) Dementia Attitudes Scale (DAS) O'Connor and McFadden (2010) Aim – To measure attitudes towards dementia	20	I feel uncomfortable around people with ADRD	Described in article outlining its development	Cronbach's alpha 0.83	Confusing use of AD RD (Alzheimer's disease and related disorders). Very limited evidence of its use in research studies

After careful consideration the Lintern et al (2000) Approaches to Dementia Questionnaire (ADQ) was used in the current study. The questions were considered to be appropriate to measure attitudes from a nursing point of view, particularly as they included questions referring to a person-centred approach to care.

Appendix Ten:

Permission to use the Approaches to Dementia questionnaire

>> _____

>> From: Professor Bob Woods, [b.woods@bangor.ac.uk]

>> Sent: 02 August 2010 10:54

>> To: Anna Christina Ayton

>> Subject: Re: Appraoches to Dementia Questionnaire

>>

>> Dear Anna,

>>

>> You are most welcome to use the ADQ - do you have a copy of it already?

>> The DSIDC at St James are already using it, I believe.

>>

>> Please keep me informed of any results obtained with it,

>>

>>

>> Best wishes,

>>

>>

>> Bob

Appendix 11 – Strengths and Weakness of Environmental Tools

Questionnaire	No of Items	Sample Item	Admin-istration and Scoring	Validity and Reliability	Notes	Strengths	Weakness
(English) Ward Organisational Features Scale (WOFS) Adams et al (1995) Aim: To explain the influence of the ward environment on nursing care	6 sub scales Physical Environ-ment of the Ward sub scale (used in current study) 20 Items	How easy is it to achieve: patients being able to attract the nurses' attention	Included with questionnaire	Cronbach's alpha = 0.801	Used in several English studies and one Norwegian study. Develop-ment very clearly described by Adams et al (1995)	Relatively easy to use	May be slight confusion between questions in subscale, Staff Organisation – Q1 and Q2. At first sight they are remarkably similar
(English) Design in Caring Environments Parker et al (2004) Aim: Design better care environments for older people	28	Are there adequate numbers of well equipped WCs	Included with questionnaire	Cronbach's alpha = 0.85	Many items not applicable to current study	Relatively easy to use	Time consuming to complete

After careful consideration the Adams et al (1995) tool was used in the current study. The questions were more appropriate from a nursing perspective as can be seen in the examples given above.

<div style="border:1px solid black">

Section 4 - Ward Organisational Features Scale
Physical Environment of the Ward
(Adams *et al*, 1995)
Please tick the appropriate box ☑

</div>

Influence on Work

1.   Facilities for Relatives

Very Good Influence	Very Bad Influence

2.   Facilities for Patients

Very Good Influence	Very Bad Influence

3.   Facilities for Staff

Very Good Influence	Very Bad Influence

4.   Availability of Equipment

Very Good Influence	Very Bad Influence

5.   Quality of Ward Maintenance Services

Very Good Influence	Very Bad Influence

Staff Organisation

1.   Our nurse/patient allocation system works well for the nursing staff skill mix
        we currently have on the ward/unit

Strongly Agree	Strongly Disagree

2.   Our nurse/patient allocation system works well for the type of patients we
        have on this ward

Strongly Agree	Strongly Disagree

3.   The skill mix on the ward is about right

Strongly Agree	Strongly Disagree

4.   There are enough permanent nurses on this ward to give a good standard of
        care to all our patients

Strongly Agree	Strongly Disagree

5.   The ward off duty roster works well

Strongly Agree	Strongly Disagree

Ward Layout. How easy is it to achieve each of the following
1.   Patients being able to attract the nurses' attention

Very Easy	Very Difficult

2.   Patient Safety

Very Easy	Very Difficult

3.   Good usage of nurses' time

Very Easy	Very Difficult

4.   Observation of all patients

Very Easy	Very Difficult

5.   Good communication between nurses working on the ward

Very Easy	Very Difficult

6.   The ward's chosen way of organising nursing care delivery (ie functional, team or primary nursing)

Very Easy	Very Difficult

Quality of Ward Services
1.   Availability of portering services

Very Good Influence	Very Bad Influence

2.   Quality of portering services

Very Good Influence	Very Bad Influence

3.   Quality of pharmacy services

Very Good Influence	Very Bad Influence

4.   Quality of sterile services

Very Good Influence	Very Bad Influence

Thank you for taking the time to complete the questionnaires, your comments are very important to me. If there is anything about the questionnaires that you would like to discuss further, please do not hesitate to contact me on 01 416 2266 or anna.ayton@tcd.ie or aayton@stjames.ie

Appendix 13: Permission to use the ward organisational features scale

From: Adams, Ann <A.E.Adams@warwick.ac.uk>
Sent: 10 October 2010 20:34
To: Anna Ayton
Subject: RE: ward organizational features scales

Dear Anna,

Thank you for getting in touch with me. Please do go ahead and use WOFs. I hope they do the job you need and will be very interested to hear how your study goes.

best wishes,

Ann Adams.

Dr. Ann Adams,
Principal Research Fellow
Health Sciences Research Institute
Warwick Medical School
Coventry
CV4 7AL
tel: 02476 573956
fax: 02476 528375
a.e.adams@warwick.ac.uk

Appendix 14 – Pilot Letter Thanks

Dear Nurse

Thank you for participating in the pilot study, I appreciate your support. Please note that as you have taken part in the pilot study, you cannot participate in the main study. If you have any comments to make regarding the study, please feel free to contact me on 01 416 2266.

Anna

Appendix 15 : Invitation Letter (Phase One) Procedure of Consent

School of Nursing and Midwifery
Trinity College Dublin
D'Olier Street
DUBLIN

Dear Colleague

A Mixed Methods Study to Explore Nurses' Views and Opinions About Dementia Care Nursing

I would like to invite you to take part in a research study being undertaken to explore nurses' views and opinions about dementia care nursing.

The purpose of this two phase mixed methods study is to explore the views and opinions of nurses about dementia care nursing and the influence of nurses' attitudes and the environment of care, in dedicated health care services for the older person in three university teaching hospitals.

As a nurse practicing in a dedicated health care facility for the older person, your opinions are very important to me. You are invited to take part in phase one of the study by completing a questionnaire booklet containing four questionnaires which will take approximately thirty minutes of your time. The questionnaires propose to measure nurses' views and opinions about nursing care for the person with dementia, nurses' attitudes towards dementia and nurses' beliefs about the environment of care along with demographical information. On completion of the questionnaire booklet, please place it in the self sealing envelope and post it into the designated sealed box at the nurses' station.

Your completion of the questionnaire will be taken as consent given. However, you do need to ensure that your completion indicates that you are satisfied with the following points:
- You have received a participant information leaflet and it contained adequate information about the study
- You had an opportunity to ask questions and discuss the study
- Participation is entirely voluntary
- Confidentiality and anonymity are guaranteed by the researcher as outlined in the participant information leaflet
- Information generated from the study will be published, however, no personal details will be used

The time span between delivery by the gatekeeper and collection of the questionnaires will be approximately 2 weeks.

After completion of the research study, I would be happy to share the results with any participant who may wish me to do so. I am undertaking this study as partial fulfilment of the requirements for my PhD degree in nursing with the School of Nursing and Midwifery, Trinity College Dublin.

Yours sincerely

Anna C Ayton, RGN, MSc
anna.ayton@tcd.ie or aayton@stjames.ie. Phone – 01 416 2266

Appendix 16: Phase One – Participant Information Leaflet

Participant Information Leaflet

Title of the Study
A Mixed Methods Study to Explore Nurses' Views and Opinions about Dementia Care Nursing

Background to the Study.
Our older population is increasing in number, the figures for people aged over 65 years in Ireland for 2001 was 430,000, this is estimated to rise to 1.1 million by 2036 (Central Statistics Office, 2011). There is a distinct correlation between ageing and dementia with the prevalence rate doubling approximately every 5 years after the age of 60 from 1% for those in their 60s increasing to 30-50% for those over 85 years (Mendez and Cummings, 2003; Cahill et al, 2012). Consequently, within hospitals which provide dedicated health care services for the older person, nurses are encountering an escalation in the number of both acutely and chronically ill older people with coincidental dementia. The complex nature of dementia which can include confusion and problems with speech and understanding means that providing care for patients with dementia is different from caring for patients with no cognitive impairment.

There is limited research in the area of nursing care of the older person with dementia. The purpose of this study is to explore the nurses' views and opinions about dementia care nursing in dedicated health care services for the older person in three university teaching hospitals. Due to the demographic changes in our population and the increasing prevalence of dementia, an exploration of the variables that contribute to dementia care nursing is warranted.

To undertake a study of nursing care of the person with dementia, it is important to explore the views and opinions of nurses about dementia care nursing, nurses' attitudes towards dementia and nurses' beliefs about the environment of care. I am undertaking this study as partial fulfilment for my PhD degree in nursing with the School of Nursing and Midwifery, Trinity College Dublin.

Why was I selected to take part in the study?
As a nurse practicing in a dedicated health care facility for the older person your views and opinions are extremely valuable in contributing to the body of nursing knowledge relevant to the care of the older person with dementia.

What will Participation Involve?
Participation will involve completing the enclosed questionnaire booklet which will take approximately thirty minutes. The booklet contains four questionnaires set out in sections and these include:

- Section One – Demographic Questionnaire, 10 questions to collect demographic information
- Section Two – Satisfaction with Nursing Care and Work Assessment Scale (Hallberg *et al,* 1994) 32 questions to explore nurses' views and opinions about dementia care nursing
- Section Three – Approaches to Dementia Questionnaire (Lintern *et al, 2000)* 19 questions to explore nurses' attitudes towards dementia
- Section Four – Ward Organisational Features Scale, Physical Environment of the Ward (Adams *et* al, 1995) 20 questions about the environment of care

The completed questionnaire booklet can then be placed in the self-sealing envelope and posted into the identified sealed box at the nurses' station.

Risks and Benefits in Taking Part in the Study

It is not anticipated that there will be any adverse outcomes for you. While there may be no direct benefit to you from participating in the study, it is anticipated that the findings will lead to a greater understanding of the factors that influence nursing care of the older person with dementia.

Confidentiality
All data will be held in accordance with the Data Protection Act (1988). Confidentiality and anonymity are guaranteed. All questionnaires will be given a code and will not be traceable to the participant. All data from this research study are confidential and will be used for research purposes only. Data from the questionnaires are anonymous. Information generated from the study will be presented in my dissertation and published findings, however, the study sites and participants will not be identified.

Where will the data be stored and for how long?
- All data collected will be stored in a locked filing cabinet only accessible by the researcher
- Data will be shared between the researcher and the supervisory team during the analysis of data but this will not be personally identifiable
- All computerised data will be stored on password protected computers which can only be accessed by the researcher
- The information will be securely stored for five years after the research study is completed

Do I have to Take Part in the Study?
Participation is entirely voluntary. If you decide not to take part, there will be no repercussions.

Will people know that I took part in the study?
The study is anonymous and people will not know that you have taken part

What Approval Does the Study Have?
The study has Research Ethics Committee approval from all institutions involved.

What will happen to the information collected?
After the data is collected I will start the process of reading the responses in the questionnaire booklets. Data will be analysed using the computer programme SPSS to answer all research questions.

It is likely that the findings will be published in an appropriate journal or presented at a suitable conference. Published findings will not identify the study sites or the participants.

What happens at the end of the study?
At the end of the study, a copy of my published dissertation will be available from Trinity College Dublin.

Where can I get Additional Information?
If you need any further information, please contact me at the following number **01 416 2266** or email address: anna.ayton@tcd.ie or aayton@stjames.ie I know that this is a busy time for you and I really appreciate you taking the time to read this information leaflet and I do hope that you will complete the enclosed questionnaire.

Name of Researcher
Anna C Ayton, Lecturer/Practitioner, Gerontological Nursing, St James's Hospital/Trinity College Dublin. Doctoral Student, School of Nursing and Midwifery, Trinity College Dublin
Supervisory Team:
Dr Elizabeth Curtis, Lecturer, School of Nursing and Midwifery, Trinity College Dublin
Dr Siobhan Corrigan, Lecturer, School of Psychology, Trinity College Dublin
Dr Conal Cunningham, Geriatrician, MedEL Directorate, St James's Hospital, Dublin

Appendix 17: Reminder Letter

School of Nursing and Midwifery
Trinity College Dublin
D'Olier Street
DUBLIN

Dear Nursing Colleague

Title of the Study
A Mixed Methods Study to Explore Nurses' Views and Opinions about Dementia Care Nursing

My name is Anna Ayton and I am undertaking the above study.

I recently sent a questionnaire pack via a gatekeeper to you. I would like to extend my most sincere thanks to you for participating in the study. Your participation is invaluable.

If you have not completed the questionnaire and are still interested in participating in the study, you can return the completed questionnaire into the sealed box at the nurses' station within the next seven days.

Thank you for your time and participation.

Yours sincerely

Anna C Ayton, MSc, RGN
Phone – 416 2266
Email – anna.ayton@tcd.ie or aayton@stjames.ie

Appendix 18:

Outline of the Development of the Focus Group Interview Schedule

Prior to conducting the focus group interviews, I arranged a number of meetings (four) initially with team member A, who undertook moderation of the first three focus groups. The purpose of the meetings was to work on the construction of an appropriate focus group interview schedule and to familiarise her with the current study. As Krueger and Casey (2009) state, planning is fundamental to the success of a focus group. They also advise that developing a good questioning route requires time and collaboration with the research team (Krueger and Casey, 2009). During our first meeting, we reviewed the purpose of the current study and discussed the themes derived from the literature review and the quantitative data analysis findings. We also discussed the draft format of the focus group interviews and the sites where they were to be conducted. Actions from the first meeting were that taking cognisance of our discussions and notes, I would develop a draft interview schedule, then forward it on to her for consideration and arrange a further meeting to discuss and review it.

The construction of the interview schedule was undertaken with reference to the works of Krueger (2002) and Krueger and Casey (2009). Finally, after a further three meetings, we agreed the contents of the interview schedule. An electronic copy of the agreed interview schedule was then forwarded on to team member B for review and a date was set for the team to meet and review the schedule and to arrange the structure and implementation of the focus groups. For the first three focus groups, it was planned that team member A was to undertake the role of moderator while team member B undertook the role of assistant moderator. According to Krueger and Casey's (2009) recommendations, it is good practice to use both a moderator and an assistant moderator when conducting focus group interviews. The draft interview schedule was agreed at this meeting and used during the pilot study, following which a number of adjustments were made. Similar actions were re-enacted for the purpose of conducting the fourth and fifth focus group interviews. This time around, team member A acted as assistant moderator while I undertook the role of moderator. Team member B was unavailable for this round of interviews. Conducting the fourth and fifth focus groups allowed me to hone my research skills in the moderation of focus groups. The fourth and fifth focus group interviews took place within hospital B to further reflect a need for the acute care environment perspective to be included.

Appendix 19:

Focus Group Consent Form

Title of the Study
Mixed Methods Inquiry to Explore Nurses' Experiences of Dementia Care Nursing in Non-Dementia Specific Wards/Units Contained in Dedicated Health Care Services for the Older Person Within the Acute Hospital Setting

Name of Researcher
Anna C Ayton, MSc, RGN
Doctoral Student, School of Nursing and Midwifery, Trinity College Dublin.

Supervisory Team
Professor Geralyn Hynes, Associate Professor, School of Nursing and Midwifery, Trinity College Dublin
Dr Louise Daly, Assistant Professor, School of Nursing and Midwifery, Trinity College Dublin

Summary

I have been invited to take part in a focus group, to explore my experiences of dementia care nursing. I have been asked to be a participant because of my experience of caring for the older person with dementia in non-dementia specific wards/units contained in dedicated health care services for the older person within the acute hospital setting.

I understand that the aim of the study is, to gain an understanding of nurses' experiences of caring for the older person with dementia in non-dementia specific wards/units contained in dedicated health care services for the older person within the acute hospital setting.

I have agreed a date and venue, with the researcher, for participating in one focus group discussion. I understand that the focus group will include 6-10 participants and will take approximately two hours. My participation is voluntary and I agree that written informed consent will be required from me prior to commencement of the focus group discussion. I understand that as it is unknown how the discussion will evolve, and as informed consent is a procedure, I can withdraw from the study at any given time until the point of data analysis without penalty. If I decide not to participate or if I withdraw, I understand I will not be penalised and I will not give up any benefits that I had before entering the study. I understand that the researcher may withdraw my participation from the study at any time without my consent

The focus group discussion will be tape recorded verbatim, with participant permission, and then transcribed and analysed. I understand that the study will be published in the form of a dissertation and it will be presented at conferences and may be published in academic journals. My identity will not be revealed in any way in any of these publications and will not be disclosed to anyone outside the study. All data will be anonymised. The name of the hospital where I work will not be disclosed.

I understand that as dementia care nursing can be a sensitive issue and consequently, discussion and reflection may lead to participant upset. If I experience becoming upset or distressed, I know that I have the right to withdraw from the interview at any time, until the point of data analysis, without penalty. If necessary the focus group interview will be stopped.

I understand that during the focus group discussions, it is possible that sensitive or upsetting topics such as poor clinical practice might be disclosed. I understand that the interviewer has responsibility as a nurse to report any incidents that may be considered malpractice or practices that may put other individuals at risk. If such disclosures are revealed, the interview will be stopped and the Director of Nursing will be informed, as soon as possible. The Health Information and Quality Authority and/or the Nursing and Midwifery Board of Ireland may also be contacted if deemed appropriate. The School of Nursing and Midwifery Research Ethics Committee will also be informed. In the event of a disclosure of information that may be considered a criminal offence, An Garda Siochana will be informed immediately.

I agree that all the data obtained during the focus group discussion will only be used for the purpose of this study as consented to by myself. Five years after completion of the study, all records will be destroyed by the researcher.

Consent to Participation in Focus Group Interview

I have read, or had read to me, the information leaflet for this project and I understand the contents. I have had the opportunity to ask questions and all my questions have been answered to my satisfaction. I freely and voluntarily agree to be part of this research study, though without prejudice to my legal and ethical rights. I understand that I may withdraw from the study at any time and I have received a copy of this agreement.

Participant's Name…………………………………………………………………

Contact Details …………………………………………………………

Participant's Signature……………………………………………………………

Date …………………………………………………………

Statement of Researcher's Responsibility

I have explained the nature and purpose of this research study, the procedures to be undertaken and any risks that may be involved. I have offered to answer any questions and fully answered such questions. I believe that the participant understands my explanation and has freely given consent.

Researcher's Signature…………………………………………… **Date**…………………

Appendix 20 - Role of the Moderator and Assistant Moderator

The role of the assistant moderator was to welcome the participants, offer refreshments, oversee the taping of the session, take written notes of the topics discussed and to observe and document verbal interactions. The assistant moderator's role also included keeping track of the time, as well as giving feedback on analysis. The assistant moderator did not participate in the discussion and sat in a designated location away from the group at the table These actions followed the recommendations of Morrison-Beedy et al (2001) Onwuegbuzie et al (2009) and Krueger and Casey (2009). I was also in attendance at the first three focus group interviews. As discussed in the literature the person who is undertaking the analysis should be present at the focus group interview (Cote-Arsenault and Morrsion-Beedy, 1999; Krueger and Casey, 2009). This recommendation stems from the fact that up to 80% of the content emanates from the focus group transcriptions whilst the remaining 20% emerges from the group dynamics (Krueger and Casey, 2009). I listened attentively to the on-going discussions, observed non-verbal interactions and the group dynamics and took notes to record the order in which the participants spoke and to reflect the general content of the discussion but I did not take part in the discussions. This is consistent with the writings of (Kitzinger, 1995; Rabiee, 2004; Parahoo, 2006). The purpose of note taking was twofold: (i) to act as a back-up in case of recording system failure; and (ii) notes taken in the order of the participants' responses aided identification and connectivity of comments during the audio tape transcription (Sim and Tingen, 1998). As previously narrated, I undertook moderation for the fourth and fifth focus group discussions and team member A acted as assistant moderator.

As recommended in the literature following each focus group, the team held a debriefing session to ensure that the recordings were audible and that the interview notes were completed (Kidd and Parshall, 2000; Morrsion-Beedy et al, 2001; Krueger and Casey, 2009). The team also held a general discussion which included interpretation of the group dynamics, how the questions had been answered, and developing ideas and themes. A diagram of the seating arrangements was created and the tapes and field notes were appropriately labelled.

Ms. Anna Ayton
Lecturer
Trinity College Dublin
Dublin 2

*Please quote this reference in any follow up to this letter: 2011/04/1 Chairman's
Action*
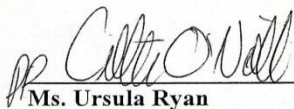
**Re: Correlational Study to Determine Relationships Between Demographical
Variables, Dementia Nursing, Nurses' Attitudes towards Dementia and Nurses'
Beliefs about the environment of Care.**

Dear Anna,

Thank you for your recent submission of the above proposal to the ▇▇▇▇▇▇
Research Ethics Committee.

The Vice-Chairman, having reviewed the proposal has perceived there to be no
ethical issues with your study.

Yours sincerely,

Ms. Ursula Ryan
Secretary
Research Ethics Committee

Appendix 21 - JREC Approval

OSPIDÉAL NAOMH ███ HOSPITAL

Ospidéal Naomh ███ Baile Átha Cliath 8.

███ Research Access Committee,

███

Our ref: NRAC 074

Ms Anna Ayton,
███ Hospital

.

RE Study: NRAC 074 An Exploration of Dementia Nursing Care & the Influence of Nurse's Attitudes & the Environment of Care.

Dear Anna,

The Nursing Research Access Committee has reviewed your request for access to the nursing staff in the ███ Directorate at ███ Hospital.

The committee note the study involves the following:

Participants (number, location & recruitment) – participants (staff nurses in ███ Directorate to be recruited via invitation flyer.

Data Collection – phase 1: anonymous questionnaire, phase 2: focus group.

Gatekeeper required to facilitate access: ███ Directorate Nurse Manager, ███ .

The committee require the following provisions:

- Staff participation is voluntary, completion of questionnaires and focus group participation must be in participants' own time and not during work hours.
- Facilities required ie focus group interview room to be arranged locally with relevant staff (gatekeeper) and participants.
- Ensure anonymity and confidentiality of participants & hospital is maintained.
- Agree procedures with the local gatekeeper identified (███ Directorate Nurse Manager: Michelle ███).
- Inform the Nursing Research Access Committee when data collection and thesis submission is complete.
- A copy of the thesis must be forwarded to the committee on completion – Submitted theses will subsequently be archived in the Centre for Learning & Development and uploaded to the Intranet.

You are hereby granted **permission to access the nursing staff** working in the ███ Directorate as outlined in your proposal, once the above provisions have been completed. Please note that the Nursing Research Access Committee **Does Not** confer ethical approval. It is the applicant's responsibility to ensure appropriate Ethics Committee approval is obtained. The committee acknowledge receipt of the copy of ███ Ethics Committee Approval. On behalf of the Nursing Research Access Committee I would like to take this opportunity to thank you for your application and I wish you success with your research. I look forward to receiving a copy of the study on completion. Also a research forum for presentation of findings is held annually and you are invited to participate and present your findings.

Yours Sincerely,

pp Lucy Kielty

Mr. ███ Director of Nursing / Chairperson Nursing Research Access Committee
CC: ███ Directorate Nurse Manager M. ███

███

Appendix 22 – NRAC Approval

Appendix 23 & 24 (A&B): Approval Letters (Hospital C)

From: e███████████████
Sent: ███████████
To: Anna Ayton
Cc: B███████████████████████████████████████
Subject: Research proposal

Hi Anna

Just a note to confirm that your proposal was agreed this morning at MAC, let us know what the next steps for us might be

Regards

███████

Director of Nursing

███████

Co. Dublin
01-601████
███████████.ie

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25

Anna C Ayton
Hillview, 51 The Chantries
Balrothery, Balbriggan
Co Dublin

24th April 2018

Study title:
"Mixed Methods Inquiry to Explore Nurses' Experiences of Dementia Care Nursing in Non-Dementia Specific Wards/Units Contained in Dedicated Health Care Services for the Older Person within the Acute Hospital Setting"

Dear Anna C Ayton,

I am pleased to inform you that your study has been granted ethical approval from the School of Nursing and Midwifery Research Ethics Committee.

Thank you.

Yours sincerely,

Dr. Aileen Lynch
Acting Chair of School of Nursing and Midwifery Research Ethics Committee

Scoil an Altranais agus an Chnáimhseachais
Dámh na nEolaíochtaí Sláinte,
Coláiste na Trionóide,
Baile Átha Cliath,
Ollscoil Átha Cliath,
24 Sráid D'Olier,
Baile Átha Cliath 2, Éire.

School of Nursing and Midwifery
Faculty of Health Sciences,
Trinity College Dublin,
The University of Dublin,
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Dublin 2, Ireland.

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Appendix 25 – TCD Ethical Approval Letter

Appendix 26   SNCW ((i) KOP, (ii) PPD, (iii) WL and WS sub scales) Kruskal-Wallis H ANOVAs

(i) Knowledge of Patients

Demographic	Response Rate	Mean Rank	χ^2	df	p-value
			13.45	5	0.02
Length Qualified (n=129)					
1-5 years	6 (5%)	34.08			
6-10 years	12 (9%)	60.29			
11-15 years	38 (29%)	79.14			
16-20 years	37 (28%)	53.97			
21-25 years	20 (15%)	67.97			
26-40 years	16 (12%)	68.31			
			12.569	3	0.004
Type of Ward (n=129)					
Acute/Admission					
Rehab	18 (14%)	42.28			
Residential	44 (34%)	61.48			
Other	48 (37%)	77.39			
	19 (15%)	63.39			

(ii) Personal and Professional Development

Demographic	Response Rate	Mean Rank	χ^2	df	p-value
			9.11	2	0.011
Nurse Grade (n=127)					
Staff Nurse	100 (79%)	59.79			
CNM1	6 (8%)	57.42			
CNM2/CNS/Mgt	21 (16%)	85.14			

(iii) Work Load and Work Satisfaction

Demographic	Response Rate	Mean Rank	χ^2	df	p-value
			10.636	4	0.031
Nurse Qualifications (n=127)					
MSc	10 (8%)	73.5			
Degree	80 (63%)	70.18			
Pre-reg Diploma	18 (14%)	48.39			
Post-reg Diploma	12 (9%)	53.08			
Certificate	7 (6%)	38.71			
			9.623	3	0.022
Length Employed in Area (n=126)					
1-5 years	36 (29%)	61.86			
6-10 years	61 (48%)	72.30			
11-15 years	22 (17%)	47.39			
16-25 years	7 (6%)	45.93			
			18.42	4	0.001
Country of Education (n=123)					
Philippines	40 (33%)	76.16			
India	30 (24%)	70.28			
Ireland	31 (25%)	47.82			
UK	13 (11%)	41.50			
Other	9 (7%)	49.78			

Appendix 27 - ADQ (Total score) Kruskal-Wallis H ANOVA

ADQ (Total score) Kruskal-Wallis H ANOVA

Demographic	Response Rate	Mean Rank	χ^2	df	p-value
Specialist Qualifications			10.248	3	0.017
(n=124)					
Dem degree/cert	11(8.8%)	68.64			
GN MSc	8(6.4%)	80.38			
GN degree/dip/cert	28(22.5%)	76.52			
Non specialist	77(62%)	54.57			
Nursing Grade			16.931	2	0.001
(n=123)					
Staff Nurse	97(79%)	55.16			
CNM1	6(5%)	88.67			
CNM2/CNS/Mgt	20(16.2%)	87.15			
Length Employed in Area: (n=123)			8.013	3	0.046
1-5 years	33 (26.8%)	67.33			
6-10 years	61 (49.5%)	53.25			
11-15 years	23 (18.6%)	73.30			
16-25 years	6 (4.8%)	78.33			
Length Employed in Hospital (n=124)			8.272	3	0.041
1-5 years	17 (13.7%)	68.71			
6-10 years	58 (46.7%)	54.68			
11-15 years	31 (25%)	76.47			
16-30 years	18 (14.5%)	57.78			
Country of Nursing Education (n=119)			29.596	4	0.001
India	29 (24.3%)	43.58			
Philippines	39 (32.7%)	48.54			
UK	13 (10.9%)	78.54			
Ireland	29 (24.3%)	84.72			
Other	9(7.5%)	55.39			

**Appendix 28: - Hope (Total Score) ANOVA summary and descriptive statistics**

Hope (Total score) ANOVA summary and descriptive statistics

Demographic	Response Rate	Mean	SD	*F*-value	*p*-value	η^2
Specialist Qualifications (n=124)				3.326	.022	0.08
Dem degree/cert	11(8.8%)	27.73	4.452			
GN MSc	8(6.4%)	28.63	2.875			
GN degree/dip/cert	28(22.5%)	28.07	5.643			
Non specialist	77(62%)	25.29	4.701			
Nursing Grade (n=123)				8.276	.001	0.12
Staff Nurse	97(79%)	25.43	4.873			
CNM1	6(5%)	30.83	4.446			
CNM2/CNS/Mgt	20(16.2%)	29.20	3.722			
Length Employed in Area: (n=123)				5.65	.001	0.12
1-5 years	33 (26.8%)	27.39	5.208			
6-10 years	61 (49.5%)	24.70	4.4064			
11-15 years	23 (18.6%)	28.78	.188			
16-25 years	6 (4.8%)	28.83	6.432			
Length Employed in Hospital (n=124)				4.861	.003	0.11
1-5 years	17 (13.7%)	27.59	5.185			
6-10 years	58 (46.7%)	24.69	4.721			
11-15 years	31 (25%)	28.45	4.493			
16-30 years	18 (14.5%)	26.89	4.813			
Country of Nursing Education (*n*=110)				8.463	.001	0.23
Philippines	39 (32.7%)	24.05	4.883			
India	29 (24.3%)	25.21	4.048			
UK	13 (10.9%)	29.38	4.788			
Ireland	29 (24.3%)	29.62	3.923			
Other	9(7.5%)	25.22	5.449			

Appendix 29:   PCC (Total Score) Kruskal-Wallis H ANOVA

PCC (Total Score) Kruskal-Wallis H ANOVA

Demographic	Response Rate	Mean Rank	χ^2	df	p-value
			9.009	2	0.011
Nursing Grade (n=126)					
Staff Nurse	100 (79.36)	58.54			
CNM1	6 (4.76)	82.92			
CNM2/CNS/Mgt	20 (15.87)	82.50			
			20.301	4	0.023
Country of Nursing Education (n=122)					
Philippines	40 (32.78)	59.41			
India	30 (24.59)	41.18			
Ireland	30 (24.59)	81.62			
UK	13 (10.65)	67.54			
Others	9 (7.37)	63.61			

Appendix 30 - Histograms for the Scale WOFS PEW and its Sub Scales broken down by item.
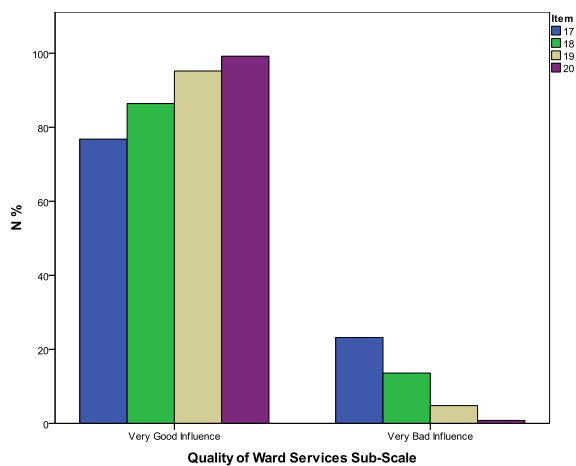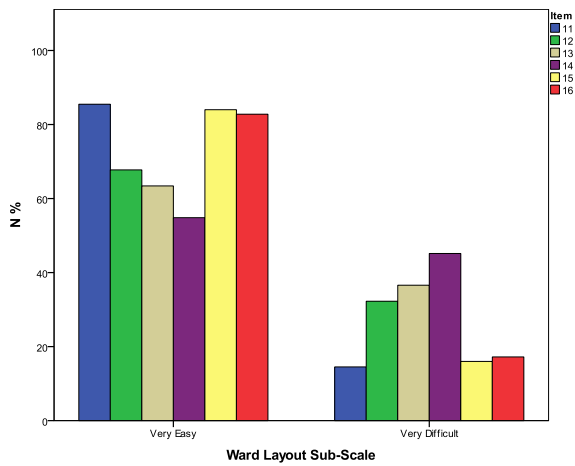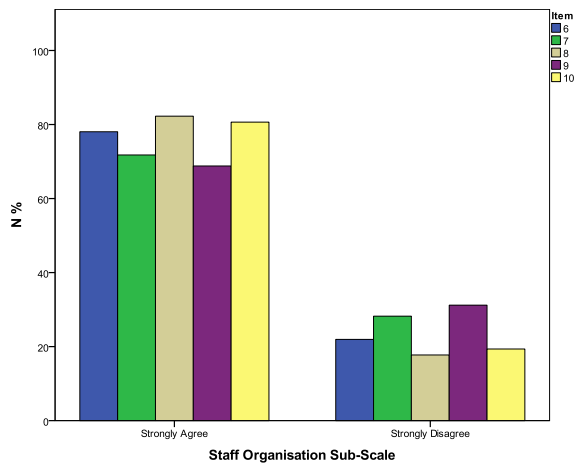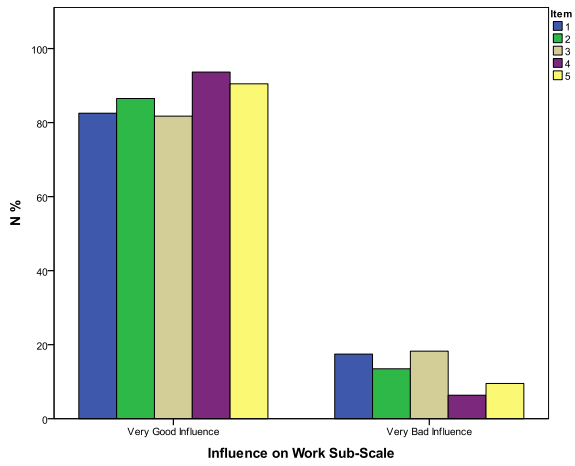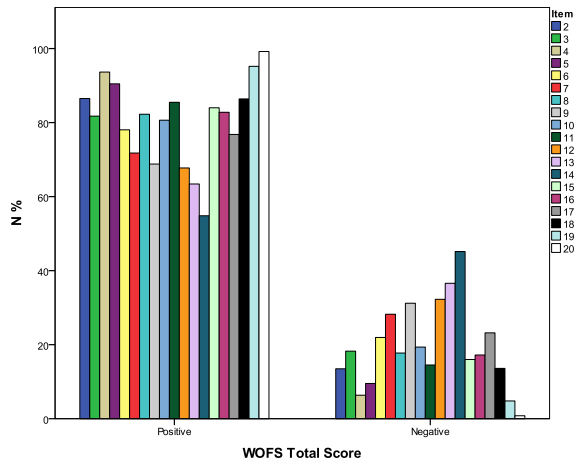
Histograms for the Scale WOFS PEW and its Sub Scales broken down by item.
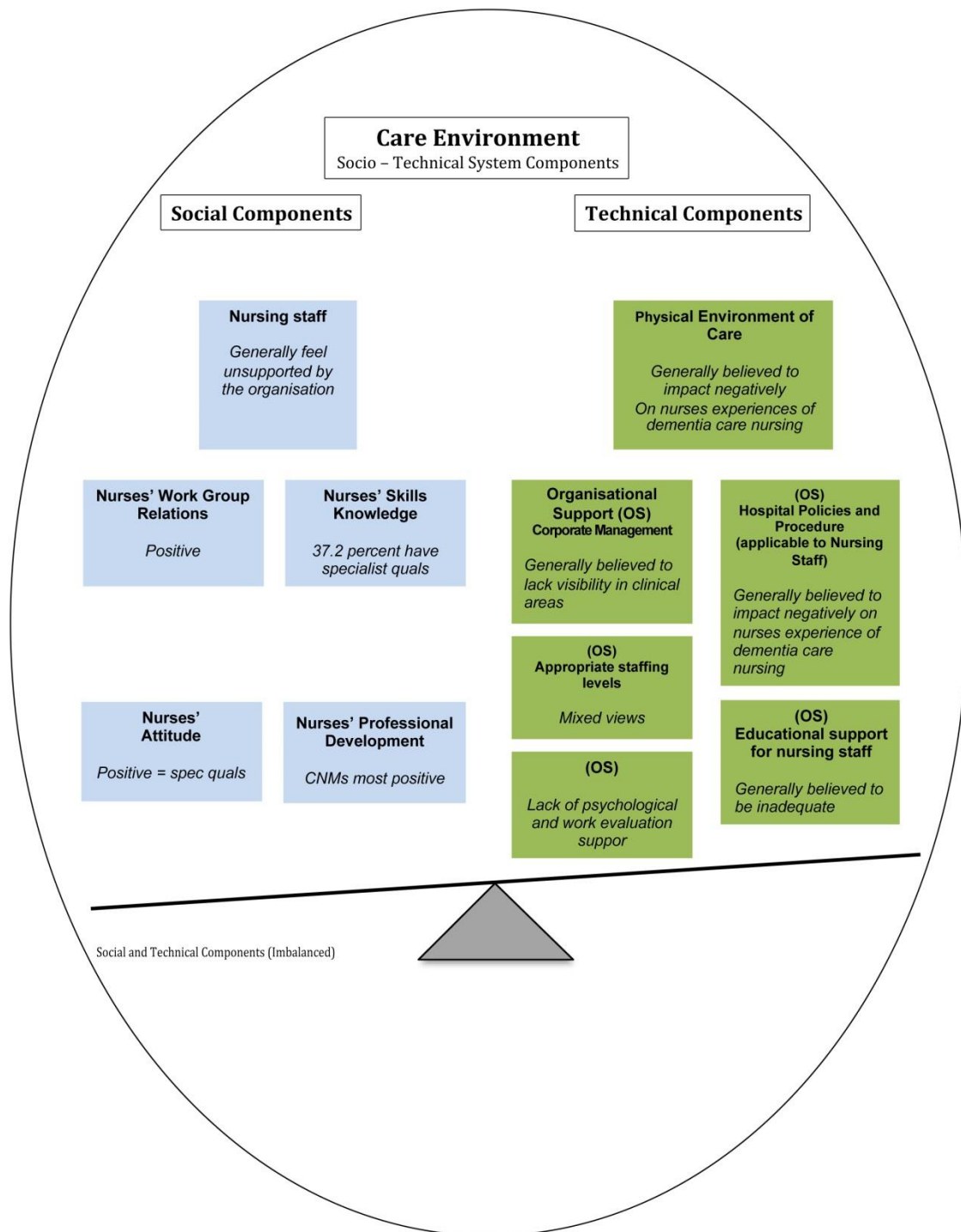
Appendix 31 – Correlation Analysis

Table 5.23   Inter correlation Matrix of SNCW, ADQ and WOFS (PEW)

Variable	SNCW (Total)	Co-op	KoP	Dev	QoC	Work	ADQ (Total)	Hope	PCC	WOFS (PEW) (Total)	WF	Org	Ward	QoS
SNCW (Total)	1.0													
Co-op	.89**	1.0												
KoP	.59**	.34**	1.0											
Dev	.76**	.73**	.188*	1.0										
QoC	.80**	.58**	.51**	.41**	1.0									
Work	.71**	.61**	.19*	.48*	.43**	1.0								
ADQ(Total)	.16	.14	.25**	.20**	.17	-.19*	1.0							
Hope	.07	.07	.27**	.06	.09	-.22*	.84**	1.0						
PCC	.20*	.18*	.15	.29**	.20*	-.08	.78**	.31**	1.0					
WOFS(Total)	-.63**	-.63**	.18	-.49**	-.51**	-.56**	.101	.11	.04	1.0				
WF	-.49**	-.48**	-.24**	-.47**	-.29**	-.40**	.11	.17	-.03	.64**	1.0			
Org	-.49**	-.54**	-.09	-.42**	-.38**	-.39**	.07	.07	.04	.80**	.40**	1.0		
Ward	-.51**	-.49**	-.15	-.30**	-.48**	-.51**	.07	.02	.09	.80**	.28**	.45**	1.0	
QoS	-.14	-.13	.04	-.12	-.11	-.11	.03	.08	-.06	.47**	.14	.27**	.24**	1.0

SNCW SUBSCALE   Co-op = Work Co-operation   KoP = Knowledge of Patient   Dev=Personal & Professional Development

                     Work = Workload & Work Satisfaction   OoC = Quality of Care
ADQ SUBSCALE   Hope   PCC =Person Centred Care Approaches
WOFS SUBSCALE   WF = Ward Facilties   Org = Staff Organisation   Ward = Ward Layout
                     QoS = Quality of Ward Services

Note.

Care Environment
Socio – Technical System Components

Social Components

Technical Components

Nursing staff

Generally feel unsupported by the organisation

Physical Environment of Care

Generally believed to impact negatively On nurses experiences of dementia care nursing

Nurses' Work Group Relations

Positive

Nurses' Skills Knowledge

37.2 percent have specialist quals

Organisational Support (OS) Corporate Management

Generally believed to lack visibility in clinical areas

(OS) Hospital Policies and Procedure (applicable to Nursing Staff)

Generally believed to impact negatively on nurses experience of dementia care nursing

(OS) Appropriate staffing levels

Mixed views

(OS)

Lack of psychological and work evaluation suppor

Nurses' Attitude

Positive = spec quals

Nurses' Professional Development

CNMs most positive

(OS) Educational support for nursing staff

Generally believed to be inadequate

Social and Technical Components (Imbalanced)

Appendix 32 – Socio-technical System (Imbalance)