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Chapter One: Introduction

1.1 Introduction

The aim of this dissertation study is to identify the perceived educational needs of qualified nurses to reduce the use of antipsychotic medication when caring for people with dementia in an adult care setting. The rationale underpinning this will be discussed, the aims and objectives presented at the end of chapter two and the methodology used to achieve this discussed in chapter three.

This dissertation presents relevant background information, from the literature reviewed, which shows that caring for people who have dementia presents a huge challenge to the NHS and to society. The literature review and the findings chapters highlight these challenges, particularly the challenges caused by behavioural and psychological symptoms of dementia (BPSD).

The use of antipsychotic medication to manage BPSD is explored. Other relevant management options, that can reduce the use of antipsychotic medications for this patient group, are also explored but the literature shows that there is a limited evidence base supporting their use which needs to be addressed.

In addition to this, the dissertation explores the need for more education and training for health care professionals caring for patients with dementia. This includes how information should be presented and what content is needed to provide nurses with the necessary knowledge and skills to care for patients with dementia effectively.

Chapter Two: Literature Review

2.1 Background

The National Dementia Strategy (Department of Health (DH), 2009a pg15) defines dementia as “a syndrome which may be caused by a number of illnesses in which there is a progressive decline in multiple areas of function”. Alongside this decline, individuals may have behavioural and psychological symptoms of dementia (BPSD) which can occur at any stage of the illness.

Dementia presents a huge challenge to the NHS and to society, both now and increasingly in the future. In 2009 there were 700,000 people in the UK with dementia but this is expected to double to 1.4 million in the next 30 years (DH, 2009a; DH, 2009b; Alzheimer’s Society (AS), 2007; AS, 2009). The Alzheimer’s Society (2009) identified that 97% of nursing staff reported that they always or sometimes care for someone with dementia. Up to 70% of acute hospital beds are occupied by older people and up to a half of these may be people with cognitive impairment such as dementia (DH, 2009a). Therefore, nurses working in busy, acute hospital settings must be able to care for patients with dementia effectively (Fessey, 2007; Nolan, 2006; Pulsford, Hope and Thompson, 2006).

BPSD are commonly mentioned in the health care literature - (National Institute of Clinical Excellence (NICE), 2006; DH, 2009a; DH, 2009b; AS, 2007; AS, 2009; Banerjee, 2009; Soyinka and Lawley, 2007; Andrews, 2006; Lee, Gill, Freedman et al, 2004; Neil, Curran and Wattis, 2003). Symptoms include those attributable directly to defects in cognitive function and also to non-cognitive features such as disturbed behaviours (e.g. aggression, wandering, eating disorders), psychotic symptoms (e.g. hallucinations and delusions) and sleep disturbances.

Statistics show that BPSD have been observed in 60% to 98% of patients with dementia (NICE, 2006; Declercq, Petrovic, Vander Stichele et al, 2009; Ouldred and Bryant, 2008).

The literature shows that the BPSD are often a form of communication for the person with dementia and an expression of unmet needs or emotion (AS, 2009; Moyle, Olorenshaw, Wallis et al, 2008; Burgess and Page, 2003; Ouldred and Bryant, 2008; Harrison and Zohhadi, 2005). Aggression, for example, may represent a means of communicating loneliness, anxiety or avoiding shame, or a response to discomfort, pain or fear (Moniz Cook, De Vugt, Verhey et al, 2008).

A lack of understanding of the experiences of patients with dementia can lead to misinterpretation of the patients' symptoms (Cunningham, 2006) causing BPSD to be labelled as difficult and seen as challenging and problematic by nursing staff (Andrews, 2006; Fessey, 2007; Burgess and Page, 2003; Ouldred and Bryant, 2008; Nolan, 2007; NICE, 2006; DH, 2009b; DH, 2009a; Banerjee, 2009).

BPSD are associated with higher mortality, use of physical restraints, increased length of hospitalisation and they often precipitate admission into a nursing home (Declercq et al, 2009). Other studies and literature also show that some patients with dementia leave hospital in a worse state than when admitted (Pulsford et al, 2006; Nolan, 2006; AS, 2009). This suggests that interventions aimed at treating BPSD can have an important impact on patients, caregivers and society. Therefore such interventions are a legitimate object for intervention themselves (Banerjee, 2009; DH, 2009b).

The literature shows that the systems that are in place to manage BPSD have grown by chance rather than by specific planning or commissioning and there are important gaps in services and skills (Banerjee, 2009). The DH (2009b) explains

that the assessment and management of such behaviours in dementia can be complicated. Therefore it is important to explore what barriers there are preventing the effective management of BPSD.

2.2 Challenges and barriers to effective dementia care

Following the suggestion that nurses working in busy, acute hospital settings must be able to care for patients with dementia effectively, it is important to review the current nursing work force's knowledge. The evidence base shows that despite areas of good practice, the UK's current health and social care system is characterised by a widespread failure to support people with dementia and their families (AS, 2007; AS, 2009; Nuffield Council on Bioethics, 2009). Therefore, it is clearly important to explore what challenges in the system prevent nurses from providing the care people with dementia need.

Recently, the National Dementia Strategy (NDS) (DH, 2009a) has shown there are marked deficits in the knowledge and skills of general hospital staff that care for people with dementia, particularly regarding the management of difficult behaviour. This is supported by other relevant literature (Doherty and Collier, 2009; Pulsford et al, 2006; Moyle et al, 2008; Fessey, 2007).

An Australian literature review (Moyle et al, 2008) concludes that lack of knowledge and understanding among nurses is likely to contribute to the provision of sub-optimal dementia care. This is supported by some descriptive reviews conducted in the UK (Cunningham, 2006; Doherty and Collier, 2009) and Fessey (2007) adds that a poor understanding of dementia can leave nurses experiencing stress when trying to respond to challenging behaviour. Therefore, nurses providing dementia care in the acute setting require more education and support.

2.3 Interventions used to treat BPSD

The interventions aimed at treating BPSD can be divided into two main categories: (1) psychopharmacological therapy, underpinned by the biomedical model of care and (2) nonpharmacological, psychosocial and other alternative approaches, reflecting a more holistic vision of person-centred dementia care (Bates, Boote and Beverley, 2004).

Until recently, pharmacological regimens were used to treat BPSD, but increasing concerns over their modest efficacy, significant side effects and potential detrimental impact on quality of life have resulted in calls for non-pharmacological approaches as the first-line interventions (Moniz Cook et al, 2008).

2.3.1 Guidelines

There are good practice guidelines (NICE, 2006 pg 34) readily available for the management of BPSD which state:

People with dementia who develop non-cognitive symptoms or behaviour that challenges should be offered a pharmacological intervention in the first instance only if they are severely distressed or there is an immediate risk of harm to the person or other.

2.3.2 Antipsychotics

Antipsychotics are widely used to treat people with dementia in a hospital environment; data suggests that 180,000 people with dementia are being treated with antipsychotic medication by the NHS at any time (DH, 2009b).

The Royal College of Psychiatrists' (RCPsy 2005) report shows that there have been long standing concerns about inappropriate use of antipsychotic medication in older people with dementia; for example, drugs were given for the wrong reason or without any documented reason for the prescription, two or more antipsychotics were prescribed at the same time, or drugs were given at too high doses and for too long without reviewing the need or the dose. Other literature (DH, 2009b; AS, 2009; Neil et al, 2003; Burgess and Page, 2003) supports these findings. A recent finding shows that 77% of nursing staff said that antipsychotic drugs were used, always or sometimes, to treat people with dementia in the hospital environment and of those nurses up to a quarter thought that they were not appropriately prescribed (AS, 2009).

The All Party Parliamentary Group (APPG) on Dementia, (2008) adds that the widespread inappropriate prescribing of antipsychotic drugs is an unacceptable abuse of the human rights of people with dementia. Other literature also supports this (Burgess and Page, 2003; Cunningham, 2006; Andrews, 2006).

The evidence includes gaps, contradictions and complexity but there is emerging consensus with respect to the level of use and risk of antipsychotic drugs for people with dementia. Reviewing the evidence, these drugs appear to have only a limited positive effect in treating BPSD but can cause significant harm to dementia sufferers (DH, 2009b; Banerjee, 2009). Furthermore in the UK there is no drug licensed specifically for BPSD (RCPsy, 2005).

Antipsychotic medications come in two forms, typical and atypical. For many years typical antipsychotic drugs, such as chlorpromazine, haloperidol and trifluoperazine (Banerjee, 2009), were the most common treatment, however, they were found not to be useful in older adults because of their serious adverse side effects (Lee et al, 2004; Carson, McDonagh and Peterson, 2006). More recently, atypical antipsychotics, such as risperidone, olanzapine and quetiapine (Banerjee, 2009), have become available. Lee et al (2004) systematically reviewed five good quality RCTs about atypical antipsychotic use and concluded that there is insufficient evidence to support their use as a treatment for BPSD. Following this a Cochrane review (Ballard, Waite and Birks, 2006) showed that atypical antipsychotics are also associated with serious adverse side effects which confirms that they should not be used routinely to treat people with dementia. More recent evidence (Declercq et al, 2009; DH, 2009a; DH, 2009b; Banerjee, 2009) also confirmed this, adding that side effects can include increased risk of mortality, drowsiness, increased confusion, falls, stroke/ transient ischaemic attack and possible adverse effects on cognition (NICE, 2006; Soyinka and Lawley, 2007; Doherty and Collier, 2009).

Some evidence supports the use of atypical antipsychotics if the BPSD is severe and treatment is needed quickly, such as if the symptom is dangerous or distressing to the patient or others or the symptom occurs in a situation where carers cannot cope (Nuffield Council on Bioethics, 2009; APPG on Dementia, 2008; Soyinka and Lawley, 2007; Neil et al, 2003) or when non-pharmacological interventions have failed (Declercq et al, 2009; Banerjee, 2009). This is supported by official guidelines (RCPsych, 2005; NICE, 2006; DH, 2009a).

Antipsychotics have limited benefit for people with dementia particularly when prescribed for long periods of time (APPG on Dementia, 2008). Consequently, patients taking antipsychotic medication at home are at an increased risk of serious

side effects. The need for continuing treatment should, therefore, always be reviewed and withdrawn gradually when appropriate- when patients have been free from BPSD for at least three months (RCPsy, 2005; NICE, 2006).

Recent research identifies that it still appears that antipsychotics are too often used as a first-line response to behavioural difficulty in dementia rather than as a considered second-line treatment when other non-pharmacological approaches have failed (Banerjee, 2009). Due to the increased risks of antipsychotic medication it is clearly important for non-pharmacological management to be considered as first-line treatment, (Soyinka and Lawley, 2007) therefore, these need to be explored.

2.3.3 Non-pharmacological interventions

Within the literature there are many recommendations to reduce the use of antipsychotic drugs to treat people with dementia on a general ward (AS, 2009; DH, 2009b; NICE, 2006; Werezak and Morgan, 2003). Nonetheless there are few specific suggestions of how this could actually be achieved; this study aims to partly address this issue.

In the UK, enhanced non-pharmacological interventions that impact on the practices of prescribing doctors can also lead to reductions in the use of drugs. Despite this, psychogeriatricians appear to prefer pharmacological treatment. If professionals are required to reduce their reliance on medication, they will need to be confident in the use of non-pharmacological alternatives (Moniz Cook et al, 2008). However, it is interesting to note that no single non-pharmacological intervention has an evidence base that would justify its use as a direct alternative to antipsychotic medication (RCPsy, 2005; DH, 2009a). A Cochrane review (Clare and Woods, 2003) of nine Randomised Control Trials (RCT) found no significant

benefits from cognitive training (an approach designed to address difficulties with memory and other aspects of cognitive functioning). Similarly, a Cochrane review (Price, Hermans and Grimley, 2001) that was recently re-reviewed found no RCTs or controlled trials exploring the effectiveness of barriers for wandering patients and the review found no conclusive evidence to support the use of subjective barriers (that appear as an obstruction only to those who are cognitively impaired) to prevent wandering.

One of the National Service Framework (NSF) for Older People (DH, 2001) standards is person-centred-care. It states that patients must receive person-centred-care and services which respect them as individuals and which are arranged around their needs. Person-centred-care should underpin all nursing interventions, therefore, non-pharmacological interventions used to treat patients with dementia need to reflect the holistic vision of person-centred dementia care (DH, 2001; Bates et al, 2004; Brooker, 2007). Further information about person-centred-care can be found in the NSF for older people (DH, 2001 pages 29-40).

2.4 Education and training

Banerjee (2009) recommends that in order to reduce the use of antipsychotic drugs for people with dementia there is a need to develop a curriculum for the development of appropriate skills for staff in the non-pharmacological treatment of BPSD. This should include the deployment of specific therapies with positive impact.

In 2005, Everybody's Business (DH, 2005) highlighted the need for proper education and training for all professional staff involved with caring for people with dementia as did the NICE (2006) guidelines. The NDS (DH, 2009a) and other literature suggests it is still essential that adult nurses and other non mental health

professionals are educated and supported in development of skills and knowledge in dementia care (AS, 2009; Nolan, 2006; Smith, 2007; Nuffield Council on Bioethics, 2009), in both pre and post-registration programmes (AS, 2007; Pulsford et al, 2006; Doherty and Collier, 2009). However, the evidence indicates that coverage of dementia within pre or post-registration nursing programmes is variable, sometimes inadequate, and the training needs of adult nursing staff are not being met (AS, 2009; DH, 2009b; Pulsford et al, 2006; Fessey, 2007; Doherty and Collier, 2009; Ellis, 2008). For example, the AS (2009) found that 54% of nursing staff said that they have not received any pre-registration training in dementia and 83% felt that learning and development opportunities would help them to provide care, and nursing staff identified that they would like more training in responding to BPSD and the use of antipsychotic drugs.

All the key documents (AS, 2009; AS, 2007; DH, 2005; NICE, 2006; DH, 2009a; Nuffield Council on Bioethics, 2009) express the need for more education for nurses, but they do not give any specific guidance as to what form this should take. This study aims to explore what this education should look like from the nurse's perspective and has the potential to inform future nurse education.

2.5 Study Rationale

The need for improved training is a priority that runs across all the themes in the NDS (DH, 2009a) other important documents (DH, 2005; NICE, 2006; AS, 2009; AS, 2007) highlighting the need to reduce the use of antipsychotic drugs and improve nurse education to be able to respond effectively to the ever growing number of patients with dementia.

It is also clearly important for non-pharmacological management to be considered as first-line treatment (Soyinka and Lawley, 2007) and should reflect a person-centred approach (DH, 2001). However many professionals are not confident in the use of these alternative interventions (Moniz Cook et al, 2008; Wood-Mitchell, James, Waterworth et al, 2008). Therefore there is a need to provide professionals with knowledge and confidence, to support the use of alternative strategies for managing patients with dementia, through education.

Despite repeated suggestions that nurses need more education in dementia care (AS, 2009; AS, 2007; DH, 2005; NICE, 2006; DH, 2009a; Pulsford et al, 2006; Doherty and Collier, 2009; Nuffield Council on Bioethics, 2009) it is clear that the evidence to develop such appropriate educational programmes in the hospital setting is lacking. This study aims to address the gap in the evidence by exploring nurses' perceptions of their educational needs and try to identify what nurses think they need to know in order to reduce the use of antipsychotic medications. The full aims and objectives for the study are displayed in figure 2.1.

Figure 2.1; Aims and objectives

The aim of the study is:

To identify the perceived educational needs of qualified nurses in order to reduce the use of antipsychotic medication when caring for people with dementia in an adult care setting.

The research question is:

What do nurses believe they need to know in order to reduce the use of antipsychotic medication when caring for people with dementia in an adult care setting?

The objectives are to:

1. Explore nurses' educational experience in both pre registration and post registration courses.
2. Explore nurses' current management of BPSD, particularly with respect to antipsychotic medication.
3. Explore what nurses believe they need to know in order to reduce the use of antipsychotic medicine in their area.
4. Explore how nurses believe these needs should be met, particularly with respect to teaching and education.
5. Compare findings with the literature in order to formulate recommendations for future teaching and education.

Chapter Three: Methodology

3.1 Introduction

This chapter will present the methodology selected to answer the research question and achieve the study aims. This will include a discussion of the chosen research methods, the participants recruited, data collection and data analysis. In addition to this the research quality and ethical principles are considered.

To achieve the aims outlined in figure 2.1 pg12, a qualitative research approach was adopted because it allows the researcher to explore and understand in-depth meanings of the phenomena from the participant's point of view (Green and Thorogood, 2005; Golafshani, 2003; Kvale, 1996; Labuschagne, 2003). Furthermore, a qualitative researcher is open to ideas which emerge from the data and through their own reflection during data collection, the collection methods are flexible and can be moulded to allow participants the opportunity to talk fully about their view or experience (Parahoo, 2006). Whereas a quantitative approach, that measures variables more objectively and examines the relationship through statistical procedures (Parahoo 2006; Labuschagne, 2003), would neglect the participant's perspective (Holloway and Wheeler, 2002).

Understanding human experiences is the basis of a phenomenological approach to research (Pringle, Hendry and McLafferty, 2011; Smith, Bekker and Cheater, 2011; Speziale and Carpenter, 2007; Earle, 2010). Phenomenology is a recognised approach for investigating experiences in health research. It tries to capture and describe subjective experiences but the researcher can remain objective by putting aside any preconceptions or acknowledging them as part of the research process (Holloway and Wheeler, 2002). Conclusions reached need to arise from the data and not from concepts imposed by the researcher (Pringle et al, 2011; Speziale and

Carpenter, 2007). In this respect it will be made clear how conclusions were reached in this study.

Pringle et al (2011) suggest that engaging too intensely in methodological awareness can hinder a research project's practice and progress so a balance must be struck. They suggest that it is more realistic to use a phenomenological orientation without being too explicit about it. This involves incorporating many of the different phenomenological stances that have evolved into one but by still detailing the rigorous methods used, clarity and rigour are not lost (Pringle et al, 2011; Earle, 2010). Therefore this chapter will detail the rigorous methods and quality control measures used in the study.

Semi-structured interviews were chosen as the means of data collection and the data collected from this study was analysed using a thematic content analysis framework. This procedure condenses the data through a system of coding in which subsequent themes are developed (Ryan, Coughlan and Cronin, 2009; Speziale and Carpenter, 2007; Elo and Kyngas, 2007; Lacey and Luff, 2007; Burnard, 1991) to describe the phenomenon under investigation, increase understanding, and to generate knowledge (Cavanagh, 1997; Holloway and Wheeler, 2002).

3.2 Method

3.2.1 Ethical considerations

Nursing research must be ethical (Parahoo, 2006). The principles of beneficence and non-maleficence, autonomy and justice must be respected and consent and confidentiality must be considered (Green and Thorogood, 2005; Walsh and Wiggins, 2003; Holloway and Wheeler, 2002; Speziale and Carpenter, 2007) Therefore ethical approval was sought and obtained from the University of Nottingham Medical School Ethics Committee. A copy of the ethics approval letter has been included in appendix one for reference. The methods used in this study to ensure these ethical principles were met are displayed in table 3.1 overleaf.

3.2.2 Sample

A purposive sample of 12 qualified nurses was recruited from students enrolled on five Learning Beyond Registration (LBR) modules. This method of sampling allowed participants to be selected based on their first hand experience of the phenomenon of interest (Parahoo, 2006; Speziale and Carpenter, 2007; Holloway and Wheeler, 2002).

The inclusion criteria; a qualified nurse who cares/ has cared for patients with dementia in an adult care setting, was used to select this relevant sample in the hope that they could provide in-depth and relevant data when interviewed. Anyone who was not a qualified nurse, worked in a non-adult care setting or was mental health nurse trained was excluded.

Qualitative research generally has small sample sizes because it is more concerned about depth and understanding than with generalisable findings (Holloway and

Wheeler, 2002; Parahoo, 2006) therefore the sample collected is of adequate size for this study.

Table 3.1: Methods used to ensure the ethical principles were met.

Principle	Methods used
<p>Beneficence and Non-maleficence; Doing good and preventing harm</p>	<p>The research aims to benefit the wider society.</p> <p>The research should not cause any harm either physical or psychological, to the participants.</p> <p>The interview would be stopped if the participant became distressed (Speziale and Carpenter, 2007).</p>
<p>Autonomy; The right to make free, independent choices</p>	<p>Informed consent was obtained from all the participants.</p> <p>Participants were aware of their right to withdraw from the study at any time.</p>
<p>Justice; Acting fairly to all</p>	<p>Participants were all given the same opportunities.</p>
<p>Informed consent</p>	<p>Information was provided to each participant regarding the study aims and the topic to be explored and participants signed a consent form.</p> <p>This included; if bad practice or potential misconduct was identified during the interview process the researcher would have to inform her supervisor.</p>
<p>Confidentiality and Anonymity</p>	<p>The researcher was the only person who conducted the interviews and heard the recordings and therefore knew the identity of the participants.</p> <p>A numbering system was used to identify participants, recordings and transcripts.</p> <p>As required by the Data Protection Act (1998) any identifying information in the interview was changed in transcribing and the data was kept securely on a password protected computer.</p>

3.2.3 Recruitment

E-mail contact was made with the module leaders of the LBR courses, run by the Division of Nursing, requesting permission to access their students to potentially recruit participants for the study. Once permission was obtained, the students were approached after a lecture. The research was explained verbally and the students were given an information sheet including the researcher's contact details for further information (see appendix 2). The students were given time to read the information and ask any questions before they decided whether they were willing to participate. Potential participants were asked to read, complete and sign the consent form (see appendix 3). This method of recruiting is supported by literature (Ryan et al, 2009; Holloway and Wheeler, 2002; Parahoo, 2006).

Following recruitment the participants were contacted by email to arrange a convenient time and place for an interview to take place. Speziale and Carpenter (2007) suggest this flexibility helps facilitate sharing of information by the participant and builds trust.

In addition to this participants were asked to complete, and return via email, their demographic attributes- (see appendix 4). The information was collected prior to interview to help inform the researcher during the interview and analysis process by clarifying what participants meant for example when they say "in my area...". The following table (Table 3.2) summarises this information.

Table 3.2 Demographic attributes of the participants.

Participant number	Gender	Year of qualifying	Type of qualification	Current area of work	Relevant work history
1	F	1997	Diploma	Trauma and orthopaedics; Sister	<ul style="list-style-type: none"> ◆ HCA nursing home
2	F	2004	Advanced Diploma	Community Orthopaedic rehabilitation	<ul style="list-style-type: none"> ◆ Carer in EMI home ◆ Care of the elderly ◆ Acute medical
3	F	1988	Enrolled RN	Gastroenterology and clinical nutrition; Sister	<ul style="list-style-type: none"> ◆ General surgery ◆ Gastroenterology
4	M	1995	Diploma	Cardiology; Charge Nurse	<ul style="list-style-type: none"> ◆ General medical ◆ Cardiology
5	F	2001	Diploma	Musculoskeletal and neuro sciences; Practice Matron	<ul style="list-style-type: none"> ◆ Spinal unit
6	F	1997	Diploma	Upper GI surgery; Sister	<ul style="list-style-type: none"> ◆ Lower GI surgery ◆ Upper GI surgery
7	F	1989	RGN	Practice Nurse	<ul style="list-style-type: none"> ◆ Nursing home for elderly ◆ Acute medical ◆ Gynaecology ◆ Oncology
8	F	2005	Advanced diploma	General surgical ward	<ul style="list-style-type: none"> ◆ HCA nursing home ◆ General Surgical
9	F	1995	Diploma Undertaking degree pathway	Dermatology; Sister	<ul style="list-style-type: none"> ◆ Placement as a student in MH setting
10	F	2005	Diploma	Acute Medical	<ul style="list-style-type: none"> ◆ Acute medical
11	F	2008	Diploma	Health care of the elderly	<ul style="list-style-type: none"> ◆ Community care assistant
12	F	1989	RGN	Neurological Rehab; Junior sister	<ul style="list-style-type: none"> ◆ Care of the elderly ◆ Rheumatology ◆ General medicine

3.3 Data Collection

3.3.1 Semi-structured interviews

One-to-one semi-structured interviews were conducted using open ended questions. The analysis of the previous literature and research, presented in the literature review, allowed a series of topics to be identified and the interview schedule to be developed- (see appendix 5).

Interviews facilitate the collection of large amounts of in-depth data (Ryan et al, 2009), can motivate respondents to participate who might otherwise not bother (Barriball and White, 1994; Walsh and Wiggins, 2003) and ensure that participants are unable to receive assistance from others while formulating a response (Barriball and White, 1994). Although interviewing can be a costly and time-consuming method of data collection and analysis (Ryan et al, 2009; Fox, 2006), the potential benefits outweigh this.

Unstructured interviews generate a large amount of rich data but much of it can be of no use to the study particularly if the researcher is inexperienced (Holloway and Wheeler, 2002). Conversely, highly structured interviews are constraining and the participant may feel their real opinion has not been properly represented (Sapsford and Jupp, 2006), which is contradictory to the aim of qualitative research (Holloway and Wheeler, 2002) and therefore would not be appropriate for this study. The flexibility of the semi-structured interview structure is one of its greatest strengths (Ryan et al, 2009).

As the literature shows, semi-structured interviews use structured and focused questions which facilitate access to interviewees' views and experiences whilst still allowing spontaneous and unanticipated responses and issues to emerge through

the use of probing questions (Ryan et al, 2009; Kvale, 1996; Walsh and Wiggins, 2003; May, 2002; Fox, 2006; Holloway and Wheeler, 2002; Silverman, 2006). This method ensures that a similar type of data is collected from all participants for comparison and analysis without neglecting the uniqueness of each experience (Parahoo 2006; Holloway and Wheeler, 2002). It allows deeper levels of meaning to be uncovered and clarity on the topic of interest can be sought (Ryan et al, 2009; Holloway and Wheeler, 2002; Barriball and White, 1994; Walsh and Wiggins, 2003; Hancock, Windridge and Ockelford, 2007; Fox, 2006), which suggests it is well suited for the aims of this study. This suggestion is also supported by the literature (Ryan et al, 2009; Holloway and Wheeler, 2002; Barriball and White, 1994; Kvale, 1996).

3.3.2 Interview process

As the literature recommends, the interviews were conducted face to face. This allowed the non-verbal cues, body language, facial expression and eye contact to be interpreted through observation. This has been shown to further enhance understanding of what is being said (Ryan et al, 2009; Barriball and White, 1994; Fox, 2006). Non-verbal prompts from the interviewer can also encourage reflection and help reduce anxiety of the interviewee (Holloway and Wheeler, 2002). This is important because the role of the interviewer is to ensure that the interviewee is at ease and not threatened (Ryan et al, 2009; Hancock et al, 2007).

The correct comfortable environment is also important (Ryan et al, 2009; Hancock et al, 2007) so the interviews were conducted in a quiet room of the participant's choice within the Division of Nursing or, if this was not achievable, in a suitable room in the participants clinical area. This minimised the chance of disturbances and provided a relaxed atmosphere. The participants were informed the interview would take no longer than an hour and the rooms were booked in hour intervals.

As the literature suggests, the interviewer allowed the interviewee to talk uninterrupted at their own pace and allowed the use of silence for interviewees to pause and reflect (Ryan et al, 2009; Fox, 2006; Kvale, 1996). This has been shown to help build a relationship based on mutual respect, trust and equality (Holloway and Wheeler, 2002) and therefore make the interviewee feel comfortable to reveal information (Speziale and Carpenter, 2007). Finally, the interviewer did not offer comment or pass judgment on the answers to questions except to probe or prompt the interviewees for clarification, to expand on a particular issue or to re-engage them with the interview process when they lost their train of thought. This is supported by literature (Ryan et al, 2009; Holloway and Wheeler, 2002; Fox 2006).

3.3.3 Digital recording

A digital recorder was used to collect data from the interviews for later transcription. Audio recordings allow you to listen again to the tone, any pauses and it is inclusive of all the questions and therefore ensures the data is transcribed verbatim (Holloway and Wheeler, 2002). This is important because it reduces the risk of the researcher being biased, for example, by only including those sections that seem relevant or interesting to them (Lacey and Luff, 2007) or potentially log an answer to a question incorrectly (Barriball and White, 1994) during the analysis process. Digital voice recorders have been shown to be easier to use and less intrusive than tape recorders (Hancock et al, 2007). Other methods of recoding are problematic; for example, writing notes during the interview can seem intrusive, it is hard to keep up and interrupts the flow of the interview (Walsh and Wiggins, 2003; Holloway and Wheeler, 2002).

3.3.4 Researcher

In qualitative research the interviewer is the main instrument and therefore they will influence the interview process and the results (Holloway and Wheeler, 2002). An interviewer's presence can have a biasing effect on the responses (Walsh and Wiggins, 2003) so all interviews were carried out by one interviewer to maintain continuity. None of the participants selected were previously known to the interviewer to reduce interviewer bias and maintain confidentiality.

The cultural and social experiences of both the interviewer and the interviewee will affect what is said and what is heard (Speziale and Carpenter, 2007). The interviewer and interviewee often share a common culture, they have similar, though not the same, understanding of it and base questions and answers on shared meaning (Holloway and Wheeler, 2002). Therefore, as a student nurse I share a nursing culture with the participants, either of us may assume the other understands the nursing terminology and concepts mentioned during the interview. Furthermore, it is important to recognise that ideas can be subjective and therefore clarity should be sought (Holloway and Wheeler, 2002; Pringle et al, 2011).

The use of probing can potentially influence the participant's response or even cue participants to give socially desirable answers but this potential limitation is also attributable to other qualitative and quantitative methods (Parahoo, 2006) and therefore the depth of information that can be obtained by this method outweighs this potential limitation.

3.4 Transcribing

The recordings were sent to, and transcribed by, an external transcriber ¹. In line with dyslexia guidelines (Kane and Gooding, 2009; Royal College of Nursing, 2010) individuals are entitled to receive reasonable adjustments such as a transcriber to help them overcome their difficulties. The external transcriber was informed of the need for confidentiality (Holloway and Wheeler, 2002; Walsh and Wiggins, 2003). It was also important not to forget that transcripts from recordings are subject to interpretation (Kvale, 1996) so the researcher checked through the transcripts for accuracy, for misinterpretation of content, effect of unfamiliar terminology and language errors (Speziale and Carpenter, 2007). The transcribing process is described in figure 3.1.

Figure 3.1; Transcribing process

- 1) Transcriber sent a copy of the recording in which the participant is only identified by a number to maintain participant confidentiality.
- 2) Transcriber wrote down literally what was said but omitted words such as 'umm', 'uh' and pauses.
- 3) Wherever there was uncertainty the transcriber highlighted in red and referenced the time for the researcher to check.
- 4) Transcripts and recording were returned to the researcher to be stored securely.
- 5) The researcher checked through all the transcriptions with the recordings to accurately transcribe any uncertain terms such as medical terms and drug names and checked for anonymity and confidentiality.

¹ *The researcher has dyslexia and therefore didn't feel able to accurately transcribe all of the data herself within the time constraints of the research deadline. This had been discussed with relevant academic support staff.*

3.5 Data Analysis

In qualitative research data analysis is continuous and, begins at the data collection stage (Speziale and Carpenter, 2007; Parahoo, 2006; Holloway and Wheeler, 2002). As themes emerged from the original interviews, questions were adapted and added to the interview schedule to further explore the issues that emerged.

Once all of the interviews were completed the data was formally analysed, for this a thematic content analysis approach was adopted to analyse the complete set of data. From looking at many frameworks of content analysis (For example, Elo and Kyngas, 2007; Hancock et al, 2007; Speziale and Carpenter, 2007; Parahoo, 2006; Holloway and Wheeler, 2002; Burnard, 1991), one can summarise the process in three stages; firstly break the data up into many codes, then group together similar codes into manageable themes and finally link the themes together in order to describe and understand the phenomenon as a whole. The full data analysis process is shown in table 3.3 and appendix 6.

Content analysis has been criticised for being a simplistic technique (Elo and Kyngas, 2007; Cavanagh, 1997) but others conclude that content analysis is a systematic and objective means of describing and quantifying phenomena, allowing the researcher to test theoretical issues to enhance understanding of the data (Elo and Kyngas, 2007; McCain, 1988; Green and Thorogood 2005) and preventing the researcher imposing their own framework and ideas on the data (Holloway and Wheeler, 2002; Speziale and Carpenter, 2007; Pringle et al, 2011).

It is important to recognise that excessive interpretation on the part of the researcher can overly compress the data so ideas become fragmented and the holistic view of the phenomena may become lost (Holloway and Wheeler, 2002). However, this can apply to all qualitative methods of analysis (Elo and Kyngas,

2007). In addition to this, important information can be lost because the code doesn't fit any of the themes (Holloway and Wheeler, 2002) therefore it is important not to disregard these ideas without thought.

Table 3.3; The data analysis process Method	Rationale	Supporting References
1) Transcripts were read and re-read	To immerse the researcher in the data	Elo and Kyngas (2007); Sapsford and Jupp (2006); Hancock et al (2007); Lacey and Luff (2007)
2) Transcripts were checked for accuracy	To check for misinterpretation of content, effect of unfamiliar terminology and language errors.	Speziale and carpenter (2007)
3) A system of open coding was used; <ul style="list-style-type: none"> • Copies of the transcripts were annotated using a number system where each number corresponded to a code which was recorded on an index card. • For each new code that emerged a new index card was made and assigned a number. • Each time the code emerged in the data the interview, page and line number were recorded on the index card for future reference. 	This process began during the data collection phase. To generate an exhaustive list of codes that describe and account for all aspects of the interview data.	Burnard (1991); Elo and Kyngas (2007); Cavanagh (1997); Sapsford and Jupp (2006); May (2002)
4) Codes with similar names and meanings were then grouped together into categories.	To look for relationships, links, patterns or outcomes emerging from the data and form initial themes.	Speziale and carpenter (2007); Pope, Ziebland and Mays (2000); May (2002); Sapsford and Jupp (2006); Graneheim and Lundman (2004); Cavanagh (1997)
5) The researcher constantly read and reread the transcripts moving backwards and forwards between data and concepts.	To continuously developed themes in response to new information	Parahoo (2006); May (2002); Hancock et al (2007)
6) Once all the data had been initially coded the lists of codes and categories were re-analysed and re-grouped.	To ensure any repetitious or similar categories were removed	McCain (1988); Burnard (1991); Sapsford and Jupp (2006); Graneheim and Lundman (2004); Hancock et al (2007)
7) The categories were then grouped under higher order headings All the data relevant to each theme were identified and categorised.	To produce the final themes.	McCain (1988); Burnard (1991); Pope et al (2000); May (2002); Sapsford and Jupp (2006); Graneheim and Lundman (2004)
8) Themes used to link the underlying meanings of the categories together and are used to describe the phenomenon.	To increase understanding and generate knowledge	Cavanagh (1997); Pope et al (2000)
9) Throughout the analysis process the transcripts and the original recordings were continually referred back to.	To ensure the original meanings and contexts were not lost	Burnard (1991); Pringle et al (2011)

3.6 Research quality

This section discusses the quality of the study and the measures taken to ensure trustworthiness. In qualitative research the concepts dependability, credibility, transferability and confirmability have been used to describe various aspects of trustworthiness (Graneheim and Lundman, 2004; Golafshani, 2003; Speziale and Carpenter, 2007; Holloway and Wheeler, 2002). The quality control measures taken in this study are discussed in table 3.4.

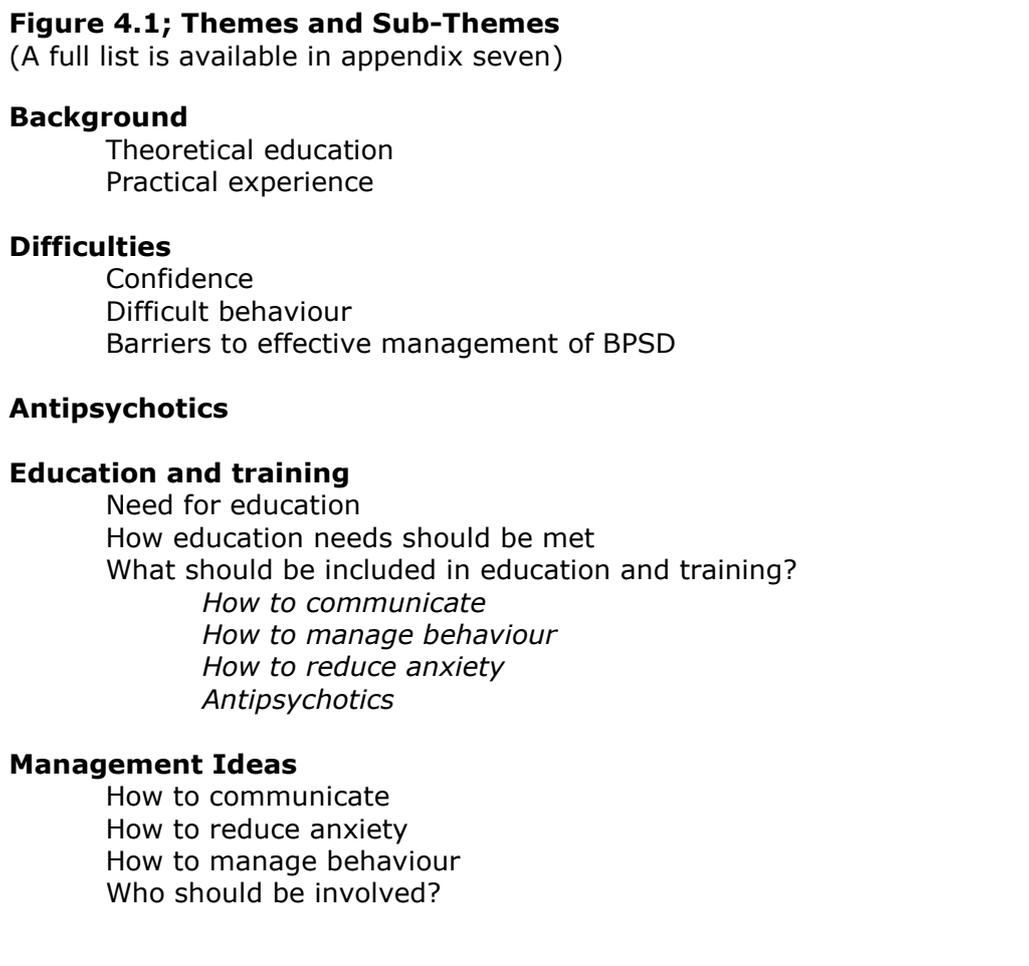
Table 3.4 Measures taken to demonstrate how the issue of trustworthiness was addressed in this study.

	Definition	Method used	Supporting references
Dependability	Findings must be accurate and consistent	The researcher accurately described the research process so the researcher's decision making process can be followed to see how they reached their conclusions	Holloway and Wheeler (2002) Speziale and Carpenter (2007) Parahoo (2006) Pringle et al (2011)
Credibility	The validity of qualitative research in other words the truth of the findings.	Following data analysis, the researcher gave each participant the opportunity to review his or her transcript to ensure the findings reflect what the participants meant No data has been inadvertently or systematically excluded or irrelevant data included.	Holloway and Wheeler (2002) Elo and Kyngas (2007) Graneheim and Lundman (2004) Speziale and Carpenter (2007) Parahoo (2006) Graneheim and Lundman (2004)
Transferability	How well the findings can be applied to other similar settings and participants.	A clear description of the context, selection and characteristics of participants, data collection and process of analysis is given and these are justified. Classificatory data was collected and a reflective diary was kept by the researcher	Holloway and Wheeler (2002); Speziale and Carpenter (2007) Elo And Kyngas (2007); Parahoo (2006) Ryan et al (2009) Hancock et al (2007) Golafshani (2003)
Confirmability	Whether the findings and conclusions achieve their aim and are not a result of the researcher's assumptions.	The researcher is honest, open and sensitive to the phenomena under study. The researcher is also reflexive and demonstrates critical reflection upon their own thoughts, monitor their relationship with the participants and their reactions to the responses	Holloway and Wheeler, (2002) Speziale and Carpenter (2007) Parahoo (2006)

Chapter Four: Findings

4.1 Introduction

This chapter outlines the themes extracted from the interview transcripts during data analysis. Verbatim quotations are used to illustrate the points made by the participants. Figure 4.1 summarised the themes and subthemes that were identified and that are used to structure this chapter.



4.2 BACKGROUND

One of the objectives of the study was to explore nurses' educational experience in both pre-registration and post-registration courses. This section presents the findings related to this outcome.

Participants were asked about their experience caring for patients with dementia in their area of work. The responses show that participants had a range of experiences but most of the participants (1,4,5,6,8,10,11,12) routinely cared for these patients in their clinical area. Others had less experience in their area but either had previous experience in another area (2,7) or saw patients with dementia less frequently in their area (3).

Participant 9 had less experience than the other participants,

"I wouldn't say I have many patients with dementia"

This was not picked up before interview because the participant confirmed she met the inclusion criteria for the study and an interview took place. Therefore, her contributions to this study will be viewed with caution but she does make some valid points regarding education and the need for future training.

4.2.1 Theoretical education

When asked about their pre-registration education and preparation about dementia care all but one of the participants (1,2,3,4,5,6,7,8,10,11,12) described how little theoretical education they received.

“I don’t remember any specific training or sessions related to that [dementia] in the classroom” (Participant 6)

Some participants went on to emphasise that education was inadequate,

“...the odd day every now and then which went into dementia care but it wasn’t that thorough to be honest” (Participant 8)

There seemed to be variation in the amount of education and training received by the participants but it is important to take into account the participants’ demographic information which can be seen in table 3.2 pg 18. Participants qualified at different times and those who graduated longer ago may perhaps have received different training or cannot recall their training as accurately as newly graduated participants.

Some of the participants (4,6,7,9) that graduated before 2000 also mentioned that,

“I don’t know what your training involves now” (Participant 7).

Three participants (3,8,9) suggested that their education about dementia may have been affected by the branch of nursing they were studying and identified that education about dementia seemed to be related to the mental health branch. However, because all participants in this study were selected from adult care

settings and were excluded if they had received mental health training it is difficult to assess whether or not the lack of education is specifically related to branch.

Another explanation for the variation in education may be because participants had different types of qualification. Specific demographic information is displayed in table 3.2 pg 18. However most participants had completed a diploma therefore there is little scope for comparison, making it difficult to conclude whether or not the type of qualification affected the education received.

Participants were also asked about their post-registration education and training. At the time of interview, the majority of participants had been qualified for between five and twenty two years, but only two participants (5,12) mentioned they had received any post-registration training about dementia. Participant 5 said,

“I think the training that we’ve received in the last year or so has really helped myself and other staff”

Her training included recognising patients with dementia, the type of dementia they have, how it will affect patients coming into hospital and who to contact for advice.

Participant 12 recalled being

“Enlightened... as to what life would be like living with somebody with Alzheimer’s”

from a talk by the Alzheimer’s Society.

4.2.2 Practical experience

Participants were asked about their practical experience caring for patients with dementia. Three participants (1,2,8) had prior practical experience working in a nursing or care home which they perceived to be beneficial, but they received no specific training about dementia there. For example participant 2 said,

“I think I just found the experience helped when I did go onto a ward and encountered somebody with dementia”

Some participants (5,6,9,10) recalled learning to care for patients with dementia whilst on placement and suggested that newly qualified nurses’ confidence is affected when this opportunity is missed. Participant 6 adds that even recent students, she has mentored, are lacking confidence to care for patient with dementia if they have not had this previous experience.

Nurses’ confidence to care for patients with dementia may improve in practice because,

“it is something that you do probably just pick up in practice and gain confidence doing” (Participant 1).

“the only way you learn about dementia and confused patients is to work with them because they’re all so unpredictable and so different” (Participant 7).

“you pick up ways of managing people from working with people who are managing them effectively...” (Participant 12).

These overall findings, as four participants (1,2,3,7) specifically suggested, show that a specific placement involving caring for patients with dementia would be useful for student nurses to gain useful experience and confidence. Examples include; “the home setting or in the hospital setting or a day care setting” (Participant 3) or “working on specialist units” (Participant 7).

To summarise, this section highlights that in order to meet nurses’ education needs about dementia, student nurses should receive relevant education in their pre-registration education and also have a specific placement in a setting where they routinely work with patients with dementia. This will allow students to put theory into practice and learn further management techniques from more qualified, experienced nurses in practice.

4.3 DIFFICULTIES

This section explores what aspects of dementia care the participants found difficult in order to ascertain how to manage these patients more effectively. Themes that emerged from the interviews included the following issues; confidence and difficult behaviours and the barriers to their effective management.

4.3.1 Confidence

When asked, some participants (5,7,9,10,11) explained how they lacked confidence caring for patients with dementia as newly qualified nurses. For example;

“...not very confident at all... I didn’t know what to expect....I knew how to produce basic nursing care, but I don’t think anything could prepare you for what’s to come when you’re working with patients with dementia” (Participant 11).

Interestingly, both participants 10 and 11, who are the most recently qualified, expressed that they lacked confidence. This suggests that education is still not providing newly qualified nurses with adequate information.

Although, participant 8, who was also newly qualified said she,

“felt confident enough to look after their [patients with dementia] needs, as in what they came to hospital for...”

One explanation for this may be because she had previous experience in a nursing home.

Similarly, participant 6 was “fairly confident”, participant 12 was “usually okay” and participant 4 said he was “not unconfident” but adds that,

“in terms of how best to manage them [patients with dementia] and how best to go about your day-to-day dealings with them wasn’t really apparent to me” (Participant 4).

Using the previous information as a baseline the participants were then asked about how confident they felt caring for patients with dementia in their current area of work and participants generally felt more confident. For example,

“I feel a lot more confident in being able to cope with it now... but not fully confident and that’s because you don’t know what to expect”
(Participant 11).

One reason for this may be because participants felt generally more confident as a nurse, which was suggested by participants 10 and 7. However, participant 3 noted that she and several of her colleagues still lack confidence because they do not routinely care for patients with dementia. These findings suggest that you gain confidence and experience when you care for patients with dementia regularly.

4.3.2 Difficult behaviour

One key issue that emerged from this section was violence. Firstly participant 7 explains that she was scared of patients with dementia because she,

“...assumed that confused patients were violent”

Secondly, participants 10 and 11 recalled being attacked by patients with dementia. Their stories suggest that violence is a recurring problem that a nurse has to cope with and highlights both the impact violence can have on individual staff members and the need for support for staff experiencing violence.

For example, participant 11 says,

“if we get hurt no matter how badly we can’t report it and if we do report it nothing comes of it because the patient’s got dementia, but we’ve got to live with the scars that we’ve received from that.”

Findings suggest that patient’s general confusion is also a problem. For example,

“they get confused that they’ve not eaten and they think they’ve not had a drink. They think they’ve not been to the toilet” (Participant 11).

This can lead to a lot of complaints from relatives. Another particular problem occurs during the night because patients with dementia tend to become more confused at night, so increasing the risks falls or injury. Participants 5 and 8 mentioned this.

Another problem was related to the environment. For example in an acute care setting,

“Management [of difficult behaviour] didn’t really work where you’ve got drips and all sorts of things to have a wandering dementia patient at the same time... staffing was always an issue” (Participant 8).

4.3.3 Barriers to effective management of BPSD

Throughout the interviews, participants were also keen to discuss other practical problems they experienced, which meant they could not manage patients with dementia effectively.

Staffing limitations were discussed by five participants (5, 7, 8, 10,11). Participant 11 suggested that,

“If there was more staff, care would be managed and would be a lot more effective than it is today”

Participant 8 recognised that there was a need to spend time with patients with dementia and that they require a lot of attention but suggested that,

“People [nurses] do get frustrated because they’re really busy and we’re rushed for time and we need more time to spend with them [patients with dementia]”.

Another problem some participants mentioned was that,

“There used to be wards that took dementia patients but that’s recently closed down: funding so we’re told ‘well there is nowhere else for them to go’ it’s not practical” (Participant 10).

Participant 7 adds that this means there is,

“no periphery to take somebody, you’ve either got the clinical setting or home. There’s no in-between”

These findings suggest it is important to address and overcome these barriers before other improvements for care for patients with dementia can be made.

4.4 ANTIPSYCHOTICS

The focus on the use of antipsychotics in the literature led me to question participants about their experiences managing patients with dementia and the use of antipsychotics. Within this sample, six of the participants (1,2,5,10,11,12) stated they had experienced the use of antipsychotic medications for management of some patients with dementia. The main example given was Haloperidol. Others (3,4,8) said antipsychotics were not used routinely or were only given if the patient was already taking them at home (3, 7).

Most participants (1,2,4,5,7,8,11,12) from a wide range of clinical settings explained how antipsychotic medication is only routinely used for the patient’s own safety.

The following examples were given,

“they’re not safe, they’re going to harm themselves really by falling”

(Participant 1)

“only to get somebody over an acute phase of an infection or of an illness” (Participant 7)

“acutely-confused post-op patients” (Participant 6)

Some of the participants (1,2,3) were prompted to talk about what effect they thought the antipsychotic medications had on the patient with dementia. One response from participant 2 highlighted the negative effect of antipsychotic medication,

“Sometimes none [no effect] at all to start with, but we did find that after a while it was sort of like a gradual build up, and then sometimes they’d just sleep all day. ...which is not nice really because then you’ve got family saying ‘Well why are they asleep like that?’”

Interestingly, participants (2,5,7,8,10) suggested that the doctors in their areas often prescribe antipsychotic medication when it is not always appropriate to do so. Participant 8 went on to makes suggestions as to why this may be;

“doctors aren’t experienced in that area... they’ll turn to us [nurses] and say ‘what is it you’re wanting for the patient?’”

“doctors give a one off prescription that is not a treatment for that patient and so that could go on for so many nights... instead of putting an action plan into place”

Participants suggest that, instead, doctors “need to look at why they are confused” (Participant 5) and look at different ways of how they’re managing these patients” (Participant 2) .

Finally, it is important to note that participant 6 states,

“I still don’t have a lot of knowledge about the pharmaceutical side of things”

Therefore, as others suggested, training about antipsychotic medication would be useful for nurses. Participant 3 specifically stated this should include,

“How they work; what they do; side-effects; contraindications; How long have they been on those medications? Are those medications needed? Is it the most up-to-date information we’ve got regarding care of patients with dementia for medications? and do our nurses know whether they should be giving those medications... Do they know it’s safe practice to give those medications?”

Two participants (7,10) made an interesting point regarding dual trained nurses, which links back to the suggestion that dementia education is related to the mental health branch of nursing, dual trained nurses were very good at avoiding the use of giving antipsychotic medications with patients with dementia.

These findings suggest that educating both nurses and doctors about antipsychotic medication may help reduce the number of prescriptions for them.

4.5 EDUCATION AND TRAINING

The main objective for this study was to explore what nurses believe they need to know in order to reduce the use of antipsychotic medicine in their area. This section identifies what the participants thought they needed to know in order to care for patients with dementia effectively. The themes that emerged from the interviews included the need for education, how these needs should be met, and what, more specifically, needed to be included in education.

4.5.1 Need for education

The general consensus from the participants was that there needed to be, "some sort of training" (Participant 2).

The main justification for this was,

"With the dementia being so vastly growing you could end up on any ward and still care for a dementia patient" (Participant 11).

This was also discussed by participants 5, 7 and 10.

Four participants (1,5,7,8) emphasised the need for more training on dementia in pre-registration education and that it should not be overlooked as a general mental health issue. Participant 10 emphasised the need for staff training and participant 3 recommended that newly qualified nurses definitely need some input too.

Furthermore three participants (5,6,10) recognised a need for medical training because,

“they’re the prescribers and they’re the ones that need to be looking at if that’s the right thing to be given at that time, but it would be useful for nurses to have too” (Participant 5)

4.5.2 How education needs should be met

A number of suggestions were made by the participants. One of the most popular suggestions, made by five of the participants (2,3,5,7,9), was the need to update staff about dementia and provide mandatory ongoing training because information changes all the time. Participant 3 nicely summarises this,

“Something needs to be put in mandatory training for staff who are permanent or in the pre-reg training so that they can have that information, but it needs to be something that’s ongoing. It can’t be just learning the block and then that’s it and off you go. It needs to be something that sort of embedded into the training throughout.”

It is interesting to note that participant 3 said she still lacked confidence caring for patients with dementia because she does not routinely care for them. This suggests that there may be a need to repeat training to prevent knowledge being forgotten.

With respect to how information should be presented in education and training one participant said,

“in practical scenarios and also theoretical scenarios on communication aimed at dementia patients” (Participant 11)

She suggested that it would be useful for lecturers to act as patients with dementia, allowing students the opportunity to run through assessments or show the student coping strategies they can use in practice.

Participant 9 suggested that case studies could be used to talk and think about how to manage patients with dementia. It would enable practitioners to look at the good and bad management techniques and reflect on them.

Another suggestion was to use outside speakers who routinely look after patients with dementia then,

“you could ask them about different scenarios and they could explain about how they manage different scenarios because they can bring in their knowledge and experience” (participant 1)

This was also mentioned by participant 12 who recommended outside speakers from the Alzheimer’s Society because they could talk about the patient’s needs more holistically.

Participants also suggested that, in practice, there needs to be,

“better instruction on how to deal with certain situations... there needs to be that generic, recommendations about how you should deal with these patients” (Participant 9)

“A ‘Practical Guide to Dementia Patients’ if there is such a thing” (Participant 10).

4.5.3 What should be included in education and training

Participants were asked to comment and elaborate on what they thought they specifically wanted, both practically and theoretically, in order to be able to care for patients with dementia more effectively. Various themes emerged from the transcripts, including; how to communicate, how to manage behaviour, how to reduce anxiety and antipsychotics.

Firstly participants (4,5,8,12) wanted to know about the disease process, the types of dementia and how these affected the patient with dementia. This was justified because as a nurse,

“if you’re treating somebody you need to know how that treatment’s going to work in order to use it” (Participant 8)

Another reason was,

“to understand about the disease and where this person’s come from
and making sure that everything’s available to them that can be”
(Participant 12)

Secondly participants (6,7) wanted to know about the relevant legislation such as benchmarking, government acts and the legal policy documents that relate to dementia care. Participant 7 says,

“we should look at a patient’s capacity... where we stand legally... we
need to know the channels that we go down to, for the best interests
of the patient as well”

4.5.3a How to communicate

The participants emphasised how it is important to know how to communicate with patients with dementia. The main issue, raised by four participants (1,5,9,10) relates to whether you should correct patients who are confused or whether you should just go along with what they are saying. Another concern was that there is no consensus among staff as to which approach is correct and this is currently still a problem in practice. Another issue was how to communicate with patients with sever dementia because it is difficult to,

“find something that they can sort of react to and you can have some
sort of communication with” (Participant 3)

4.5.3b How to manage behaviour

Most participants wanted to know how best to manage patients with dementia.

The main concern was,

“what do we do? It’s knowing what’s right and wrong...”

(Participant 7)

Participant 4 suggested that nurses need specific training on how to best manage patients with dementia day-to-day. Others (2,5,6,12) also wanted to be taught how to cope with difficult behaviour including techniques that would,

“keep them occupied... if they’ve got nothing to do then the problems start” (Participant 2)

“distract people and get them involved in other kinds of tasks rather than just focussing on the behaviour that is not good” (Participant 12).

Participant 7 also mentioned,

“how we should deal with aggression, how we should deal with violence”

4.5.3c How to reduce anxiety

Related to how to manage behaviour was the theme of how to reduce anxiety. Participants (3,7,10) wanted to know how to reduce patients' anxiety and know what frightens them.

The main question was whether there could be,

“any changes, small changes, or even big changes that can be made to sort of make the patient's stay much more comfortable”
(Participant 5)

Participant 6 also mentioned that it would be useful to know which professionals they should get involved and what support is available around in the trust.

4.5.3d Antipsychotics

Finally, participants (2,4,8) believed that a better understanding about antipsychotics would be useful because,

“Antipsychotics aren't always the way forward. We should always try to aim for less intervention; start off very basic” (Participant 8).

Therefore there should be training about antipsychotic medication.

4.6 MANAGEMENT IDEAS

Participants were asked about what other forms of management they use in their clinical area to reduce the use of antipsychotic medications. A number of participants made useful suggestions for alternative management strategies, for patients with dementia, which often reflect a person-centred approach to dementia care. The themes that emerged include; how to communicate, how to manage behaviour, how to reduce anxiety and who should be involved.

Two participants (3,7) thought the results of this study would be interesting and hoped that the findings would help to find out if there is anything, and what nurses can do, to improve the care for patients with dementia.

4.6.1 How to communicate

Participants recommended "reassurance" (Participant 5); "trying to calm and reassure people" (Participant 12) or "just talking to them" (Participant 8). The main rationale for this was to inform patients about what you are doing because their poor memory means they are forgetful and do not understand. Participants suggested that even these little interventions can often calm an agitated patient with dementia. Participant 3 also suggested that it might be helpful to,

"try and sit and talk with them and try and relax them 'cause a lot of our patients are in side rooms for isolation reasons and they get very agitated".

A final suggestion was re-orientation. Participant 7 says,

“use the orientation boards, write things down for people, have notebooks and diaries and that sort of thing just to kind of jog people’s memories as to what’s been happening with them and what we’ve been doing with them and we write it in the diary”

4.6.2 How to reduce anxiety

All the above suggestions also relate to reducing anxiety. Another suggestion specifically relating to reducing anxiety included the use of “distraction” (Participant 7, Participant 2). Participant 3 says maybe there is,

“...something they [nurses] can do to help the patient psychologically to try and stimulate them or try, you know, get them more involved”

Participant 12 suggests using photographs and knowledge about the patients to try and redirect patient’s thoughts and initiate conversations can reduce their anxiety and recommends trying to “*get them involved in some sort of activity*”. Participant 12 says this works in her experience. However, it is important to note that she was referring to patients with head injuries and general confusion on a neuro-rehabilitation ward rather than dementia patients specifically.

Participant 11 suggests that one of the main reasons we get so many behavioural problems in hospital today is because there is nothing for the patients with dementia to do and they get bored.

She suggests,

“involving volunteers or therapists to come and play games with them and distract them and get them to socialise, get them together to promote social interaction... in hospital we’re guilty of isolating them”

Some of the participants gave specific examples of how they would adapt and adjust the care they give for patients with dementia therefore making care more individualised and person-centred. Participant 5 mentions discussing the patient’s care needs with the carers or family which also helps ensure patients are consented correctly for surgery if they lack capacity. Participant 7 adds that they try not to keep patients with dementia in the acute care setting for too long because the environment is not suitable. She also adds that a more familiar setting or surroundings are useful, for example giving returning patients the same bed, however this is not always easy to achieve.

4.6.3 How to manage behaviour

One-to-one nursing was a method used by 4 participants (2,4,8,10) who work in a range of clinical settings. This is where a nurse or carer is employed to sit with a difficult patient to maintain their safety. Participant 2 said the one-to-one approach usually helped more than antipsychotics but highlighted that,

“you can’t always do it... you had to constantly watch them... which in a hospital you can’t do all the time”.

An alternative suggestion was varying the location. For example, participant 6 suggested moving patients closer to the nurses' station to keep an eye on them for safety. Participant 5 discussed the use of side rooms,

"If we can put them in a side room, if that's safe and in the interests of other patients as well if they're noisy we do, but we don't have enough side rooms to isolate so obviously there are issues around dignity if they're taking their clothes off and that, and those sort of behaviours are sort of present, so we could use more side rooms I would think"

One final suggestion was the use of a quiet room. Participant 7 described how they used to have a quiet unit where patients with dementia could go and eat or relax. The environment was more homely and quiet and she concluded that dementia patients ate better there and returned calmer.

Participant 1 recognised that it is important to not neglect other causes of their behavioural symptoms such as pain or an underlying medical problem or,

"if it's something that's new, ...check the blood, check the fluid levels, check they're not dehydrated which is quite a big cause" (Participant 1).

4.6.4 Who should be involved?

Participants were keen to highlight the importance of involving specialists and family members in the care of a patient with dementia.

Some participants had positive experiences with specialists that they wanted to share. These included participant 12, who found that a clinical psychologist helped teach the staff strategies for dealing with behavioural problems; participant 2, who found an acute care liaison team helped give advice and would come and see that patient or make suggestions about medication; participant 7, who found an in reach team useful as they gave staff knowledge and backup support in person or over the phone. Participant 7 adds that,

“They were really helpful for violent patients that we were finding ‘Ooh, we’ve got to sedate them, we’ve got to sedate them, we’ve got to give them medication’. They would come and, with their techniques and things of handling the situation, would diffuse it before it needed medication. So from that point of view it was an invaluable service”.

These findings may not be realistic in terms of acute care settings today because this participant had not worked in this setting for some time, and unfortunately participant 10, who works in an acute care setting, now experiences problems obtaining any information or support from psychiatric staff.

Four participants (5,7,8,12) discussed how it is useful to involve the family in patient care. The main rationale for this was,

“because most of the time they know the patient better than we do. They know what could settle the patient, calm them down... keeping them in the routine ‘cause they’re in a strange environment”
(Participant 8).

“‘cause a stranger telling you you’re in hospital you don’t necessarily believe them and just hearing the family explain it sometimes helps”
(Participant 8).

Two participants (5 and 6) recommended allowing carers to visit at any time if they wanted.

Participant 8 states that it is important to remember that,

“most of the time the families are their main carers and I think they can get overlooked sometimes about how much they actually do for the patient and what stress they’re under”

Participant 10 also highlighted this, adding that families may not be able to cope anymore and this may have contributed to the patient’s admission.

Finally, participant 7 suggests that communication between the community, where the patient lives, and hospital settings needs to be improved. It is interesting to note that participant 7 currently works in a community setting and previously worked in an acute medical setting. Therefore she has experience regarding communication from both sides.

Overall these findings suggest that access to a specialist team would be beneficial for staff caring for patients with dementia and that active involvement from family member or carers needs to be encouraged.

4.8 Summary

The findings show that participants want to provide better care for patients with dementia and reduce the inappropriate use of antipsychotics. In order for this to happen the participant's felt there is a need for student nurses to be educated about dementia in their pre-registration education and be provided with the opportunity to experience caring for dementia patients in placement. Further training or updates also need to be incorporated in to qualified nurses' mandatory training to ensure their knowledge and skills are maintained at a high standard.

The findings recommend that nurses need to know how to communicate with patients with dementia which includes knowing whether to correct confused patients and how to orientate them. There is a need for nurses to know how to reduce the anxiety suffered by these patients by knowing what makes them anxious, how to keep patients distracted and stimulated and how to provide more individualised and person centred care. Nurses also need to know how the environment affects the behaviour of patients with dementia and what adaptations can be made to help manage difficult behaviour.

Finally participants thought nurses should know about the specialists, who can provide advice and teach them strategies for managing difficult behaviour, and family members and carers, who can help nurses to provide individualised and effective care for patients with dementia.

Chapter Five: Discussion

5.1 Introduction

The high use of hospital services and the potential negative impact of hospitalisation on the health of older people, means it is important to understand the care management of older people with dementia (Moyle, Borbasi, Wallis et al, 2010). Furthermore, because of the well documented negative impact of antipsychotic medication in the literature, (RCPsy, 2005; DH, 2009b; AS, 2009; Neil et al, 2003; Burgess and Page, 2003) there is a need to explore what non-pharmacological options there are for management of patients with dementia.

This chapter presents the findings from this study, analyses the current evidence base and relates the findings to some of the wider contexts of nursing from the relevant literature. The themes identified in the findings chapter will be used to structure this chapter.

5.2 Background

The findings show that participants in this study had a range of experiences caring for patients with dementia but most of them routinely cared for these patients in their clinical area. Analysis of the findings also shows that participants lacked the confidence needed to care for patients with dementia effectively when they were newly qualified, and that newly qualified nurses today still lack confidence. Many explained this was because their pre-registration education was not adequate or not in-depth enough to provide them with the knowledge and skills they needed.

Some participants said dementia education was often grouped under, or partially included in, broader topics including mental health or general care of the elderly,

and may have been affected by the branch of nursing studied. Respondents from another study (Pulsford et al, 2006) also stated that dementia was not the specific focus of modules or sessions within pre-registration courses. Similar findings have been found in Australia (McPhail, Traynor, Wikstrom et al, 2009) and suggest this may be because the clinical focus tends to be on the medical and surgical care needs of the patient. Therefore, as McPhail et al (2009) identifies, there is a need to develop an education programme to create a workforce with the skills and knowledge to provide safe, effective, patient-centred care for older patients.

The sample recruited for this study excluded those who were qualified mental health nurses and the demographic information (Table 3.2 page18) shows that most of the participants attended a diploma course. Therefore, it is beyond the scope of this study to assess whether the branch of nursing or the course studied affects nurses' knowledge about dementia. However, Pulsford et al (2006) shows that, in the UK, mental health branch students receive anywhere between three and fifty four hours of education about dementia and on average adult branch students receive three hours. Furthermore, evidence suggests that some mental health nurses also lack the skills and knowledge to provide evidence based interventions for challenging behaviour, within their own field (Mullen, 2009) which may suggest that the branch of nursing studied does not necessarily affect nurses' knowledge and skill. These findings highlight the need for further education about dementia and about the necessary skills for managing patients with confusion and difficult behaviour.

Recent research shows that coverage of dementia within pre and post-registration nursing programmes is variable, sometimes inadequate, and the training needs of adult nursing staff are not being met (DH, 2010, AS, 2009; DH, 2009b; Fessey, 2007; Doherty and Collier, 2009; Ellis, 2008; Office for Public Management (OPM), 2009). This might be due to the local flexibility and decision making when

developing nursing curricula and because the Nursing and Midwifery Council (Nursing and Midwifery Council (NMC), 2007) make no specific mention of dementia, or skills required to care for people with dementia, in their essential skills clusters.

Recent findings also show that health and social care staff routinely report not receiving any training about care for people with dementia, despite the fact that they are now increasingly in contact with them (Dementia Action Alliance (DAA), 2010; DH, 2010). Interestingly one of the biggest gaps in current training includes those working in acute settings on general wards (OPM, 2009), an issue which is reflected in the findings of this study. However, it has been shown that many professionals are apparently not accessing the education about dementia that is available (Pulsford et al, 2006). Only two participants in this study had received some sort of post-registration education about dementia but both found the experience positive. Therefore, those planning educational sessions need to consider strategies to increase attendance (Forsetlund, Bjørndal, Rashidian et al, 2009) because poor attendance will decrease any positive impact on professional practice and especially because staff who avoid training will have the attitudes and behaviours that are more difficult to change (Campbell, 2007).

5.3 Difficulties

5.3.1 Introduction

Many difficulties associated with caring for patients with dementia are discussed in the literature (Andrews, 2006; Fesey, 2007; Burgess and Page, 2003; Ouldred and Bryant, 2008; Nolan, 2007; NICE, 2006; DH, 2009b; DH, 2009a; Banerjee, 2009). The participants in this study highlighted similar difficulties, the main one being managing the Behavioural and Psychological Symptoms of Dementia (BPSD). As

previously discussed, nurses find BPSD challenging because they lack the confidence, knowledge and skills needed to understand these behaviours. The literature shows this lack of understanding can increase patients' anxiety, aggression or violence and often leads to the inappropriate use of antipsychotic medication (Declercq et al, 2009; Kwasny, Hagen and Armstrong-Esther, 2006; Cunningham, 2006; Andrews, 2006; Burgess and Page, 2003). Therefore it is important to explore these difficulties in order to improve the way they are managed.

5.3.2 Confidence

One issue reported by participants in this study was that they lacked confidence when caring for patients with dementia, particularly as newly qualified nurses. The main reasons were not knowing what to expect or how best to manage patients with dementia. Some participants still lacked confidence because they are not routinely caring for patients with dementia in their clinical area. This is supported by the finding that participants found practical experience in caring for patients with dementia helpful. This implied that experience and confidence were gained by routinely looking after patients with dementia in the clinical setting and through learning from other staff who were already caring for patients effectively.

Participants suggested that student nurses should have a placement in a setting caring for patients with dementia in their pre-registration education. They highlighted that, from experience, if students do not have this opportunity they will lack confidence caring for patients with dementia when they are qualified. The evidence suggests that the quality, rather than the extent of placements, is key to enhancing learning among students around dementia care (Pulsford et al, 2006). This is important when making educational recommendations. However, it is

important to note that, as some participants implied, although they became more confident when dealing with patients' acute care needs because their general confidence as a nurse increased, they were not always more confident caring for patients' dementia care needs. This suggests there is a need for more than just practical experience alone.

5.3.3 Difficult Behaviour

Another possible reason for a lack of confidence is that some participants assumed patients with dementia were violent. Finfgeld-Connett (2009) also found that aggression among patients with dementia may be perceived as the norm. This can increase nurses' stress and cause them to react in such a way that could, in fact, exacerbate problematic behaviours (Nolan, 2007; Fessey, 2007; Nuffield Council on Bioethics, 2009), or lead to inappropriate use of medication (Parahoo, Whall, Colling et al, 2006). These findings imply that understanding difficult behaviour and managing violence are essential to managing BPSD effectively and education about this could, therefore, reduce the use of antipsychotics.

Another issue highlighted by participants was that such patients' confusion can lead to complaints, for example if patients think they have not eaten or drunk. Birch and Stokoe (2010) adds that unless possible complications caused by confusion are shared with families, there is potential for them to be seen as markers of substandard care and the subsequent development of conflict can be a further barrier to supporting families.

5.3.4 Barriers to effective management of BPSD

The NHS Confederation (2010) also says there are barriers preventing the NHS organisation from implementing the NDS (DH, 2009a); firstly, the priority given to dementia care varies between PCTs and secondly, it will take time to close the knowledge gap about the needs of people with dementia. Finally, there is a lack of quality measures of care for people with dementia in acute settings. Therefore, there is an urgent need to address these barriers.

The APPG on Dementia (2008) states there are good practice guidelines about effective dementia care available, such as the NICE (2006) guidelines, but there are barriers to this good practice being implemented. Participants showed that one barrier include poor staffing; almost half of the participants said this led to poor management of BPSD because they are too busy to provide the time and care patients with dementia need. The literature supports this and adds that lack of support from external services, inadequate staff training, low morale among nurses, poor support from managers and absenteeism can also lead to a poor quality of care and patient safety (Byers and France, 2008; Wood-Mitchell et al 2008; Davison, McCabe, Visser et al, 2007). This suggests that the current system does not enable or support good practice on a wide scale.

In relation to the lack of support, participants mentioned that when they had been threatened or hurt by a patient with dementia, they had not been adequately supported. Support from managers is important because, following a violent experience, nurses may become hypervigilant, anxious, sad and depressed or express feelings of anger, frustration, and fear that have the potential to reduce the quality of their nursing care (Finfgeld-Connett, 2009). Therefore, optimal strategies for minimizing and managing aggression are needed (Finfgeld-Connett 2009; McCabe, Davison and George, 2007; Nuffield Council on Bioethics, 2009).

Furthermore, managers sometimes enforce inflexible daily routines and a reward system that focuses on physical tasks, rather than quality of interaction or outcome for the individual with dementia (APPG on Dementia, 2009; Moyle et al, 2010). This has created a culture that devalues people with dementia because of the inconvenience they cause to nurses' routines (Moyle et al, 2010). This ultimately leads to ineffective management and can increase the use of antipsychotics (Fingeld-Connett, 2009). If staff are not encouraged and supported by managers to implement individualised, patient-centred-care they are unlikely to make these important changes (McCabe et al, 2007; Nuffield Council on Bioethics, 2009). There is a need to change the organisational culture and a Cochrane review (Parmelli, Flodgren, Schaafsma et al, 2011), looking at how to achieve this, shows that the current evidence is weak. Therefore, it is important for policymakers to review the effectiveness of strategies aiming to change organisational culture on healthcare performance to improve dementia care.

Literature suggests that most of the legislation on physical restraint does not provide practical guidance for dealing with the reality of situations (Edberg Bird, Richards et al, 2008; Nuffield Council on Bioethics, 2009). This creates an ethical dilemma for nurses who then need to balance the patient's wishes against the need for physical care and safety (Edberg, et al, 2008; Nuffield Council on Bioethics, 2009). This is linked to the use of antipsychotics. Literature shows that health care professionals focus primarily on the physical safety of the person with dementia but this is likely to be detrimental to the overall well-being of an individual (Clarke, Wilcockson, Gibb et al, 2011; Nuffield Council on Bioethics, 2009) and devalue people with confusion (Moyle et al 2010).

Medical staff also play a part in the seeming lack of priority given to the needs of people with dementia (Moyle et al, 2010), which is another important barrier that needs addressing. Moyle et al (2010) found that rather than trying to accommodate the needs of the patient with dementia, the focus was spent on how to move the person to another unit. Wood- Mitchell et al (2008) believe that in order to reduce prescribing of antipsychotics for patients with dementia, the nature and culture of care settings and the availability and feasibility of non-pharmacological interventions have to be addressed.

A final problem mentioned by participants was that the ward environment is inappropriate for caring for patients with dementia, whilst other literature shows that the acute environment is viewed as a barrier to optimal care delivery and that there is little time available for people with dementia (Moyle et al, 2010; Nolan, 2006). Two participants also said that they were experiencing more problems because their specialist dementia wards had been closed down. Therefore, it is important to explore what environmental adaptations can be made to assist nurses to care for patients with dementia effectively.

5.4 Antipsychotics

The review of the literature, including a recent report (DAA, 2010), shows that antipsychotics are inappropriately used to treat people with dementia in a hospital environment which may increase risk of death and reduce quality of life (RCPSy, 2005; DH, 2009b; AS, 2009; Neil et al, 2003; Burgess and Page, 2003; Kwasny et al, 2006).

Half of the participants in this study stated they had experienced using antipsychotic medication to manage patients with dementia. However, another recent finding by the Alzheimer's society (2009) shows 77% of nursing staff said that antipsychotic drugs were used always or sometimes to treat people with dementia in the hospital environment. This is slightly higher than the result of this study and may be more accurate because their sample is representative of more clinical settings and had a larger sample size.

Most of the participants emphasised that antipsychotics were used for the patient's own safety, particularly during an episode of acute illness where the current illness had worsened the patient's confusion. There is evidence that supports the use of antipsychotics when the symptoms are dangerous or distressing to the patient or others (APPG on Dementia, 2008; Soyinka and Lawley, 2007; Neil et al, 2003) and this follows the recommendations made in the guidelines (RCPsy 2005; NICE, 2006; DH, 2009a).

Some of the other participants stated that they did not use antipsychotic medication routinely, except, if a patient had been taking them at home. This is interesting to note because the literature highlights that antipsychotic drugs are given for too long and are not reviewed regularly enough (DH, 2009b; AS, 2009; Neil et al, 2003; Burgess and Page, 2003; Kwasny et al, 2006). Therefore, patients taking them at home may be at increased risk of side effects. It is well documented that antipsychotic medications have a negative effect on people with dementia (DH, 2009a ;DH, 2009b; Declercq et al, 2009; Banerjee, 2009; Lee et al, 2004; Carson et al, 2006; NICE, 2006; Soyinka and Lawley, 2007; Doherty and Collier, 2009). Antipsychotic treatment should always be reviewed and withdrawn when appropriate (RCPsy, 2005) and there is evidence to support that antipsychotics can be withdrawn successfully in people with dementia who have been relatively free from distressing symptoms for three months (Soyinka and Lawley, 2007).

Wood-Mitchell et al (2008) revealed that psychiatrists felt pressured to prescribe antipsychotics, due to the lack of viable alternative treatments. They concluded that guidelines do exist, but are difficult to implement in practice. Alternative non-pharmacological strategies are required, but as yet they are difficult to access and have a questionable evidence base. One opinion is that the development of non-pharmacological treatments is being impeded, because giving antipsychotics is seen as potentially a 'quick-fix' and a cheaper option (Wood-Mitchell et al, 2008). The wider literature shows that, even though aggression and difficult behaviour are routinely displayed, there is limited evidence justifying the alternative non-pharmacological methods used in mental health (Muralidharan and Fenton, 2006) and learning disability settings (Hassiotis and Hall, 2008). Therefore, there is a need to explore and evaluate alternative interventions for the management of people with confusion and aggression, including patients with dementia.

5.5 Education and Training

One of the main objectives for this study was to explore what nurses believe they need to know in order to reduce the use of antipsychotic medicine in their area. Key documents, including the NDS (2009a), and studies within the literature review (AS, 2009; AS, 2007; DH, 2005; NICE, 2006; DH, 2009a; Pulsford et al, 2006; Doherty and Collier, 2009; Nuffield Council on Bioethics, 2009) clearly illustrate that there is a need for more education about dementia, for all health care professionals.

It was clear that participants also felt there needed to be more education about dementia for students in pre-registration education, more training for newly qualified staff and ongoing training for nursing staff and doctors. This is because the number of people with dementia is increasing and any staff, on any ward, could come into contact with and care for these patients. This is consistent with recent publications (DH, 2009a, Fessey, 2007; Nolan, 2006; Pulsford et al, 2006; Bradley, Bellis, Guerin et al, 2010). The participants in this study felt that a mandatory training update would be most useful and said education should start in pre-registration training and be followed through.

Ideas about how information should be presented during training sessions were discussed with participants and a summary of their recommendations is displayed in figure 5.1.

Figure 5.1; Condensed list of ideas about how information should be presented during training.

- ◆ Outside speakers – bring personal knowledge and experience
- ◆ Alzheimer’s Society
- ◆ Scenarios – practical and theoretical
- ◆ Case studies
- ◆ Reflection
- ◆ Role play – coping strategies
- ◆ Time in practice setting - Placement

Evidence suggests that higher quality training courses should adopt a variety of methods including role-playing, group work, scenarios, guest speakers and reflective learning and ensure that training has a practice-based focus and is person-centred (OPM, 2009).

There are a number of different suggestions in the literature about how best to present information which are presented in table 5.1.

Table 5.1; Suggestions for presenting educational material.

Suggestion	Rationale
Talks from family and carers. (Thompson and Devenney, 2007)	Input from expert carers provides an invaluable insight.
Case studies, examining both positive and negative care practices. (Bradley et al, 2010; Ouldred and Bryant, 2008; Pulsford et al, 2006; Moriconi and Stabler-Haas, 2010)	These allow students to discuss the realities of everyday life and practice and learn from those who care for the person with dementia.
Role-playing a brief scenario, incorporating questions. (Moriconi and Stabler-Haas,2010; Levitt and Adelman, 2010)	This allows students to engage in active learning and this method has received positive feedback from students.
DVD such as the training DVD 'Yesterday, Today, Tomorrow' by the Alzheimer's Society. (Moden, 2009).	This provides students with an insight from specialists.

All of these initiatives appear to be helpful but, as Iliffe and Wilcock (2009) suggest, perhaps the individual group should identify the highest priority topics for learning and decide how it wishes those topics to be presented.

As previously discussed, a placement in a dementia care setting would be helpful. Bradley et al (2010) also found that many healthcare professionals expressed a requirement to educate healthcare undergraduates on how to interact with people who have dementia during clinical placements, prior to commencing their professional career. Similarly, Doherty and Collier (2009) recommend pre-registration placements because they help make specific links between theory and practice. However they also found that education was more influential than practice

experience in terms of staff awareness and use of a person-centred approach to dementia care. Therefore, it may be better for undergraduate nursing students to have a combination of both formal education and practical experience to link theory and practice.

A review of the literature reveals that most staff education program methods that have been reviewed have been tested in a care home environment. However there are lessons that can be learnt from this research. A systematic review shows that training programs increase staff skills and knowledge and reduce staff turnover rates but these gains are not sustained over time (McCabe et al, 2007). This highlights the need to implement refresher training sessions. Other care home studies found similar results but state that training does not substantially reduce the level of challenging behaviours among residents or impact on levels of staff burnout/stress (Davison et al, 2007; Visser, McCabe, Hudgson et al, 2008). This may be related to the barriers to effective management discussed earlier. The organisational characteristics of aged care facilities, including low levels of management support for staff training initiatives, limit the potential outcomes (Davison et al, 2007; Visser et al, 2008). As suggested, educational programmes, offered in conjunction with additional support, including peer support, may be associated with greater success (Moyle et al, 2008; Visser et al 2008; Davison et al, 2007).

These findings suggest that organisational factors are critically important to the success of staff education in terms of outcomes for staff and patients. Moyle et al's (2010) study supports the premise that organisational structures have a role in influencing care of people with dementia in the acute care setting. Therefore education and training must go beyond the education of individuals and move to being a facilitator of positive organisational change if changes are to be obtained and sustainable.

Another barrier, as participants identified, is the need for better instruction on how to deal with certain situations. There need to be generic recommendations about managing patients with dementia. The literature highlights that although there are guidelines, they alone are not enough to provide staff with the skills needed to make some difficult ethical decisions (Nuffield Council on Bioethics, 2009). Therefore, ongoing education about ethical decision making is required.

With regards to training and education content, the participants highlighted a number of topics they would want covered. These ideas are presented in figure 5.2.

Figure 5.2; Condensed list of ideas about what topics should be included in education and training.

- ◆ The disease process
- ◆ Types of dementia
- ◆ Legislation
- ◆ Where to get help and advice
- ◆ Legal aspects including capacity
- ◆ Understanding the disease from the patient's point of view
- ◆ How to communicate
- ◆ How to manage behaviour
- ◆ How to reduce anxiety
- ◆ Antipsychotics

Reviews of education programs (McPhail et al, 2009; Wesson and Chapman, 2010; Moyle et al, 2008; Doherty and Collier, 2009; Monette, Champoux, Monette et al, 2008), with similar content, demonstrate that they are beneficial for enhancing dementia care skills and improving knowledge and understanding about dementia. They also led to a reduction in the use of antipsychotics and an increase in appropriate referrals to psychiatric liaison for dementia assessment.

These reviews suggest that nurses' knowledge could be improved in a number of areas. Recommendations are displayed in figure 5.3.

Figure 5.3; Condensed list of ideas about what topics should be included in education and training from the literature.

- ◆ An overview of dementia and how it differs from delirium.
- ◆ Local and national dementia guidelines, tools and assessments.
- ◆ Early detection of mental illness through the recognition of signs and symptoms.
- ◆ Factors that contribute to cognitive decline during acute illness and hospital admission.
- ◆ The origin of behaviour and the patient's potential underlying needs.
- ◆ Pain assessment, monitoring and management in patients with communication difficulties.
- ◆ Medications in the elderly, sedation policy and the use of restraint.
- ◆ The need to administer the lowest effective dose of antipsychotics, review, and consider discontinuation every three months.
- ◆ Nonpharmacological approaches including successful communication, adaptation of the environment, involvement in therapeutic activities.
- ◆ Palliative care in dementia.
- ◆ Person centred care.
- ◆ Mental Capacity Act.
- ◆ Partnership with the family and carers and providing support.

As mentioned before, an understanding of how care practices and staff behaviour can influence or trigger aggressive behaviour is also essential in any training in order to provide effective care (Doherty and Collier, 2009; Finfgeld-Connett, 2009; Fessey, 2007). Bradley et al (2010) goes on to suggest that educating students on how to interact with people who have dementia can help diminish the fear and uncertainty that may be felt when initial interactions occur.

Furthermore, training and education about balancing ethical and legal issues such as enabling independence, against professional working requirements including patient safety, would also be useful (Fessey, 2007; Chang, Daly, Johnson et al,

2009; Nuffield Council on Bioethics, 2009). Training, therefore, needs to provide an understanding about the mental capacity act (see Nuffield Council on Bioethics, 2009 and Alonzi, Sheard and Bateman, 2009 for more information).

Lastly, both the participants and the literature recommend education, about antipsychotics and the non-pharmacological treatments for BPSD, for all health care professionals (Banerjee, 2009) which includes nurses, doctors, pharmacists and managers (NHS confederation, 2010).

In summary, undergraduate nursing students should have a combination of both formal, interactive education and practical experience to link theory and practice. Training for staff should also have ongoing mandatory updates about dementia. Figures 5.2 (pg.69) and 5.3 (pg.70) provide examples of what education should include, but to specifically reduce the use of antipsychotics there needs to be education about alternative interventions that have a positive impact on patients with dementia. Therefore these need to be explored.

5.6 Management Ideas

Given that agitation is the most frequently manifested BPSD and increases with the progress of dementia, effective non-pharmacological interventions may contribute to the improvement of the quality of life of these patients and their caregivers (Kong, Evans and Guevara, 2009). This need for non-pharmacological interventions is justified, firstly, because of the negative impact of antipsychotics (DH, 2009a; DH, 2009b; Declercq et al, 2009; Banerjee, 2009; Lee et al, 2004; Carson et al, 2006; NICE, 2006; Soyinka and Lawley, 2007; Doherty and Collier, 2009) and secondly because common troublesome behaviours (refusal of care, repetitive vocalisations, arguing) do not respond to pharmacological treatments (Gitlin,

Winter, Dennis et al, 2010). Although guidelines (NICE, 2006) recommend non-pharmacological approaches as the initial treatment, literature suggests it is unclear which non-pharmacological approaches are effective (Gitlin et al, 2010; RCPsy, 2005; DH, 2009a; Wood-Mitchell et al, 2008).

A number of the participants made useful suggestions for alternative management strategies for patients with dementia, which often relate to person-centred approaches and reduce the need to prescribe antipsychotic medications. See table 5.2.

Table 5.2; Recommendations of non-pharmacological interventions for managing BPSD made by participants.

Recommendation	How	Theme
Reassurance	<ul style="list-style-type: none"> <input type="checkbox"/> Explaining to them where they are. <input type="checkbox"/> Just talking to them. 	Reduce anxiety Aid communication
Redirection	<ul style="list-style-type: none"> <input type="checkbox"/> Use photographs and knowledge about the patient to try and redirect the patient's thoughts and initiate conversations 	Reduce anxiety Aid communication
Regular reiteration.	<ul style="list-style-type: none"> <input type="checkbox"/> Talk about what you were doing and why you were doing them. 	Reduce anxiety Aid communication
Re-orientation	<ul style="list-style-type: none"> <input type="checkbox"/> Orientation boards <input type="checkbox"/> Write things down for people. <input type="checkbox"/> Notebooks and diaries <input type="checkbox"/> Photographs <input type="checkbox"/> Familiar things 	Reduce anxiety Aid communication
Make adjustments	<ul style="list-style-type: none"> <input type="checkbox"/> More personalised care. <input type="checkbox"/> Provide familiar settings if possible. 	Reduce anxiety Manage behaviour
Distraction	<ul style="list-style-type: none"> <input type="checkbox"/> Try and stimulate them. <input type="checkbox"/> Involvement in activities. <input type="checkbox"/> Magazines <input type="checkbox"/> Napkins to fold in half to then set on the tables. 	Reduce anxiety Manage behaviour
Involving volunteers or therapists	<ul style="list-style-type: none"> <input type="checkbox"/> Play games <input type="checkbox"/> Promote social interaction 	Reduce anxiety Manage behaviour Who should be involved
One-to-one nursing		Manage behaviour
Location	<ul style="list-style-type: none"> <input type="checkbox"/> Close to the top of the ward <input type="checkbox"/> Nearest the nurses' station <input type="checkbox"/> Move to a side room <input type="checkbox"/> Quiet room 	Reduce anxiety Manage behaviour
Specialists	<ul style="list-style-type: none"> <input type="checkbox"/> Clinical psychologists <input type="checkbox"/> Specialist teams 	Reduce anxiety Manage behaviour Who should be involved?
Family and carers	<ul style="list-style-type: none"> <input type="checkbox"/> They know the patient better than we do. <input type="checkbox"/> It's somebody that patients know. <input type="checkbox"/> Allow visiting at any time 	Reduce anxiety Who should be involved?

5.6.1 How to communicate

The Essence of Care (DH, 2007) and NSF for Older People (DH, 2001) documents state that patients and carers should experience effective communication, sensitive to their individual needs and preferences which promotes high quality person-centred-care for the patient. However, the participants in this study said they were unsure whether they should correct confused patients with dementia or whether they should go along with what they were saying. Three participants stated that there is a disagreement about which is right.

This relates to the concept of reality. One study (Edberg et al, 2008) also found variation as to when the nurses should protect residents against 'reality'. Some of the nurses told white lies in these situations, but were not sure if it was right, which in turn caused nurses stress. Parahoo et al (2006) explains that patients use their past experiences to make sense and cope with the present. Confronting patients' 'reality' leaves them in a world lost between the past and the present, in a state of helplessness and despair, which can lead to uncharacteristic behaviour. Borbasi, Jones, Lockwood et al (2006) found that nurses believed it was better not to try to re-orientate patients, but to try to provide a more 'normal' environment.

Another challenge in the management of patients with more severe dementia is that cognitive impairment may hinder treatment because of limited ability to either consent and/or adhere to treatment (Birch and Draper, 2008) and makes it difficult to understand the patient's needs (Edberg et al, 2008). Distress due to pain or other physical discomfort will cause patients to become vocally disruptive, aggressive or agitated (AS,2010a; Birch and Stokoe, 2010; Bradley et al, 2010; Chang et al, 2009). Failure to recognise and manage these situations proactively can lead to inappropriate prescription of antipsychotic drugs (AS, 2010a; AS, 2010b). One of the participants in this study also recognised that it is important not

to neglect other causes of behavioural symptoms. Interestingly, the National Audit of Dementia (AS, 2010a) found that the majority of hospitals do not have a policy/protocol in place for these circumstances. However, a literature review (Moyle et al, 2008) found a number of strategies which facilitate communication. See figure 5.4.

Figure 5.4; Condensed list of strategies which facilitate communication adapted from Moyle et al (2008)

- ◆ Approach patient in a calm, gentle and relaxed manner
- ◆ Use person's preferred name
- ◆ Speak directly to the patient even if unable to respond
- ◆ Avoid moving or walking around during conversation
- ◆ Remain calm if patient becomes agitated
- ◆ Repeat sentences using the same words
- ◆ Quieten area or remove excess stimuli during communication
- ◆ Use short, simple sentences and a soft tone
- ◆ Allow ample response time before repeating information
- ◆ Ask simple questions that require a short answer, e.g. yes/no
- ◆ Limit choices
- ◆ Model the desired behaviour
- ◆ Observe and value both verbal and non-verbal communication

5.6.2 How to reduce anxiety

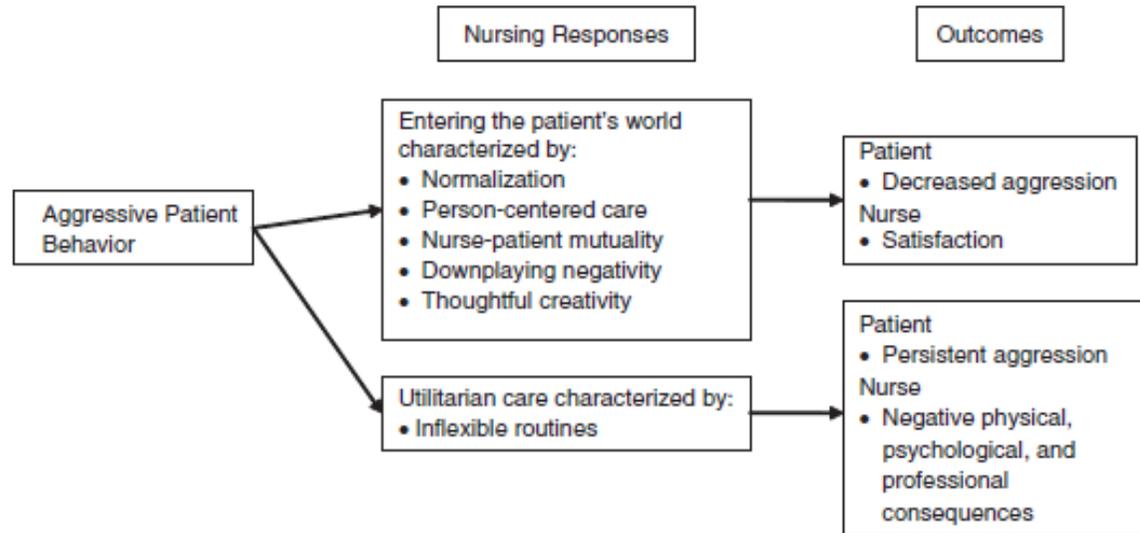
Participants wanted to be taught how to deal with aggression and violence and how to reduce anxiety. However, the literature shows that there is limited research evidence about the treatment of anxiety in people with dementia, so recommendations are based on clinical experience (AS, 2010b).

The National Audit of Dementia (AS, 2010a) found that a lack of training about effective approaches to extreme agitation or aggression in a person with dementia,

such as calming or distracting techniques, increases the risk of the use of sedation. However, very few hospitals actually have training in awareness of dementia which is mandatory for all staff (AS, 2010a). Research shows that if staff are well trained in this area and are able to anticipate and interact in a positive way with people who may actually be disorientated and frightened, the challenging behaviours can be reduced (Atwell, 2010) and therefore, potentially reduce the use of antipsychotics.

A recent systematic review (Finfgeld-Connett, 2009) evaluated seven qualitative reports about the management of aggression among patients with dementia. Although none of the research reviewed was based in the UK, the report shows that therapeutic management of aggression results in positive outcomes for nurses as well as patients. This is also supported by Werezak and Morgan, (2003). A summary of the key concepts of a therapeutic relationship are shown in figure 5.5

Figure 5.5; Figure adapted from Finfgeld-Connett (2009) pg 276 showing interventions used to manage aggression among patients with dementia.



Normalization;

Become a part of the patient’s lived experience and to strive for mutual understanding and action.

Patient-centered care;

Know who patients were prior to their current problems and to contextually associate them with their former and/or current religious practices, family roles, work roles, and positions in the community.

The person’s needs, experiences, and feelings remain a focal point instead of procedures.

Nurse-patient mutuality;

Mutually work through problems rather than always doing things to and for patients and reflectively listen.

Fully explain situations and give patients time to think about what was said before moving forward.

It is important to give patients choices, negotiate, and make deals.

Downplay negativity;

Develop a positive interaction style with potentially aggressive patients and to disregard or overlook negative behaviour.

Voices ought to be calm, quiet, and soft and gentle. Open, friendly, and non-threatening gestures are recommended.

Thoughtful creativity;

There is no one right way to respond to all aggressive patients. Nurses are urged to be reflective, use their imaginations, and be flexible.

The key aspect of the therapeutic relationship is person-centred-care which is also one of the key standards of the NSF for older people (DH, 2001). The literature states that person-centred-care, originating from work by Kitwood, centres around seeing the individual as unique, respecting their past and focussing on what the person with dementia is able to do rather than the skills that have been lost (Aveyard, 2001; Adams, 2008; Dewing, 2008; Hampson, 2009; Long, 2009). Following this, Nolan, Davies, Brown et al (2004) developed relationship-centred-care which recognised the need for relationships and communication between the person with dementia, their family or carers and the care worker. Subsequently, Adams (2008) produced a whole-systems approach which incorporates all of this and takes into account people's interaction with the wider cultural, societal and governmental factors that impact on dementia care. Research has found this kind of approach promotes individualised behavioural management and environmental changes, and involves family members, which all leads to a reduction in the use of antipsychotic medications (Fossey, Ballard, Juszczak et al, 2006).

Other literature also promotes the need for person-centred-care to be incorporated into nursing care for patients with dementia and suggests that it should be a key element of education and training (Williams, Hyer, Kelly et al, 2005; AS, 2010d; Fossey et al, 2006; Nuffield Council on Bioethics, 2009). Brooker's (2007) book on person-centred-care highlights four key elements of person-centred-care which are displayed in figure 5.6.

Figure 5.6; summary of the four elements of person-centred-care adapted from Brooker (2007) VIPS model.

- 1) Valuing people with dementia and those who care for them.
- 2) Individualised approach by treating people as individuals and appreciating that all people have a unique history and personality.
- 3) Understanding the world from the perspective of the person with dementia.
- 4) Providing a special environment that supports psychological needs; Recognising that all human life is grounded in relationships and that people with dementia need an enriched social environment.

Although the participants in this study did not explicitly mention person-centred-care when discussing the content of education, the ideas that they did mention are related to the wider concept of person-centred-care and their ideas about management of BPSD are also related to person-centred-care. Evidence argues that if person-centred-care is at the heart of education, then the content of an education program will reflect the needs of the person with dementia (Aveyard, 2001).

5.6.3 How to manage behaviour

Most of the participants in this study explained that they wanted to know how best to manage patients with dementia and be taught ways of coping with behaviour. This included ways to keep patients occupied, to distract them and get them involved in other tasks. Table 5.3 displays some of the evidence underpinning these non-pharmacological interventions for BPSD.

Despite the seemingly limited evidence base, there are convincing arguments that these interventions provide pleasure, improve the mood and well being of patients with dementia and thus may be worthwhile (Livingston, Johnston, Paton et al, 2005; Brooker, 2007; Woods et al. 2005). Other literature shows cognitive stimulation therapy (using information processing rather than factual knowledge to address problems in functioning in patients with dementia) and reminders of orientating information (day, date, weather, time, and use of names) can improve functioning (Ouldred and Bryant, 2008; NICE, 2006; Clare and Woods, 2003; Weaver, 2007; Knowles, 2010). This is recommended by NICE (2006) for all people with mild/ moderate dementia and it helps to promote person-centred-care (Brooker, 2007). Therefore it could be concluded that the recommendations the participants made, based on their clinical experience, could be beneficial for patients with dementia and help nurses to provide patient-centred-care.

Table 5.3; Systematic reviews about non-pharmacological interventions for BPSD.

Intervention	Suggestion	Systematic reviews
Reality Orientation	Insufficient evidence	Warner, Butler and Gupta, 2010; Livingston et al, 2005; Bates et al, 2004
Sensory stimulation (aromatherapy, thermal bath, calming music and hand massage)	Reduce agitation effectively But it is poor quality research.	Kong et al, 2009; Warner et al, 2010; Weaver, 2007
Reminiscence therapy (using materials to stimulate memories)	Insufficient evidence	Livingston et al, 2005; Warner et al, 2010; Woods, Spector, Jones et al, 2005
Validation therapy (encouraging and validating expression of feelings)	Insufficient evidence	Livingston et al, 2005; Neal and Barton Wright, 2003
Structured activity (games, music, exercise, socialising)	Insufficient evidence	Livingston et al, 2005; Kong et al, 2009; Forbes, Forbes, Morgan et al, 2008
Environmental adjustments	No conclusive evidence Supporting evidence	Kong et al, 2009; Price et al, 2001. Livingston et al, 2005

The Alzheimer's Society (2010c) states that people with dementia have a clear need for regular, everyday, one-to-one social interaction, and this will have significant benefit to their quality of life and social inclusion. This is supported by a study based in a care home (Hampson, 2009).

A recent evidence based study (Logsdon and Teri, 2010) identified that individuals at all levels of cognitive impairment can benefit from exercise but the degree of impairment must be taken into consideration when developing a specific program. Exercise may be particularly beneficial for individuals who exhibit depressive, anxious, or agitated behaviours.

Whilst a number of participants recommended one-to-one nursing they had mixed experiences of success, suggesting one-to-one nursing did usually work but was impractical because of staffing. However the literature does not recommend using untrained staff to sit and observe people with dementia as a risk management strategy because this would not be an evidenced based approach (Moyle et al, 2010). Furthermore, the allocation of the one-to-one nurse should ideally be determined by the needs of the patient but in reality, this is more often determined by other constraints, such as nurse shortages and budget (Moyle et al, 2010).

Wood-Mitchell et al (2008) support using environmental adjustments, such as moving a resident's room. Others (Livingston et al, 2005; Ouldred and Bryant, 2008; The NHS Confederation, 2010; Borbasi et al, 2006) state that providing an environment that is easier to navigate for cognitively impaired patients can make it easier for them to settle in hospital, reducing stress and releasing staff to provide care. Some examples are shown in figure 5.7.

Figure 5.7; Condensed list of examples of environmental modifications

- ◆ Coloured privacy doors to aid orientation
- ◆ Signs
- ◆ Utilising photos and symbols
- ◆ Obscuring exits
- ◆ An activity lounge running social activities

Werezak and Morgan (2003) support the use of quiet and day rooms because one way in which individuals with dementia exert control over their environment is by being able to choose to move between private and social spaces, as they feel the need to withdraw and rest from over-stimulation or move into an interactive social space to resolve feelings of boredom, isolation, or under-stimulation. Nichols and Heller (2002) also suggested there should be somewhere where patients could interact with other patients and their families in a somewhat more spacious setting like a day room.

Literature suggests that doing research with individuals with dementia is extremely difficult and therefore it is, perhaps, hardly surprising that research is lower quality (Bates et al, 2004; Brooker, 2007; Livingston et al, 2005). However, although more high-quality investigations are needed, these findings should not be dismissed. Booker (2007) suggests that seeing people happy and engaged in an activity is evidence enough that these are worthwhile interventions and Banerjee (2009) recommends educating nurses about the non-pharmacological treatment of BPSD. Looking at the wider literature also shows that similar non-pharmacological interventions have been helpful for reducing the use of physical restraints in mental health care settings, although it is important to note that each patient should be individually assessed for the appropriateness of each intervention (Markwell, 2005).

5.6.4 Who should be involved?

One participant mentioned that it would be useful to know who to get involved and what support there is around in the trust. The participants' reflections about their past experiences imply that specialists, including clinical psychologists and specialist liaison teams, can provide help, support and important advice about behaviour, communication and medication. There is literature to support this (AS, 2010a; The NHS Confederation, 2010; Iliffe and Wilcock, 2009; Birch and Draper, 2008; Borbasi et al, 2006). However, it was noted in the findings of this study, that there is currently a lack of specialist support particularly in the acute medical care setting. The APPG on Dementia (2009) suggests that this is another barrier to workforce development and it is important to note that research suggests many patients do not get referred to liaison psychiatry teams despite the hospital having access to one (AS, 2010a; Wood-Mitchell et al, 2008).

Both participants and the literature identify that there is a need to improve links with external services, in particular for older people's mental health services, to provide support and training to staff (APPG on Dementia, 2009). According to Nichols and Heller, (2002) hospitals have not previously been prepared to listen to what staff in rehabilitation settings or long-term care know, and incorporate that knowledge into the hospital's culture and systems of care. These findings suggest that access to a specialist team would be, as demonstrated, beneficial for staff caring for patients with dementia in hospital.

Another suggestion, made by four participants in this study, was to involve the family and carers of patients in the patient's care. The literature agrees and says this can provide vital information which will help hospital staff to detect signs of deterioration in the person's physical or mental health and therefore help plan appropriate and individualised care (AS,2010a; Birch and Draper, 2008; The NHS

confederation, 2010; Nuffield Council on Bioethics, 2009; Atwell, 2010; Birch and Stokoe, 2010; Nolan, 2006; Borbasi et al, 2006) which promotes person-centred-care (Long, 2009). However, some research suggests that nurses have not yet realised the contribution that carers and relatives might make (Ellis, 2008) or that there is no clear strategy for involving families in care (Moyle et al, 2010).

The findings implied that families and carers can sometimes get overlooked. Literature adds that it is important for nurses to support caregivers (Quinn, Clare, Pearce et al, 2008; Nuffield Council on Bioethics, 2009) and suggests that having more flexible visiting times, enabling carers to help care for the patient can be useful (The NHS Confederation, 2010). These findings suggest it would be beneficial for nurses to be educated about carer involvement and support.

A number of conclusions have been drawn during this discussion. The concluding chapter will summarise these and make recommendations about what is required to reduce the use of antipsychotic medications in adult care settings.

Chapter Six: Conclusion

6.1 Introduction

This chapter will outline the key findings and the final conclusions from this study and make relevant recommendations for nursing education. Following this, the strengths and limitations of the study will be explored and finally, a personal reflection of the dissertation process will be presented.

6.2 Conclusions and Implications for Nursing

It is clear that it is essential for nurses working in adult care settings to be able to care for patients with dementia effectively (Fessey, 2007; Nolan, 2006; Pulsford et al, 2006) because a large number of patients with dementia are routinely admitted to these areas and because this is going to increase over time (DH, 2009a; DH, 2009b; AS, 2007; AS, 2009). However, in reality, the management of patients with dementia is often poor (AS, 2007; AS, 2009) and the management techniques used, including inappropriate use of antipsychotic medication as a form of chemical restraint, can have a negative impact on patients (DAA, 2010; Moyle et al, 2010; RCPsy, 2005; DH, 2009b; AS, 2009; Neil et al, 2003; Burgess and Page, 2003). Therefore there was the need to explore and identify what nurses thought they needed to know in order to reduce the use of antipsychotic medications when caring for patients with dementia in an adult care setting.

Although, the main focus of this dissertation was about what education is needed to reduce the use of antipsychotic medication, the findings from this study illustrate, that in order for this to happen, a wide range of factors need to be taken into

consideration. The nurses wanted to talk about other aspects of effective interventions and the management issues surrounding BPSD and dementia which broadened the focus of this dissertation. These findings highlight recommendations about the need for nursing education around dementia and make suggestions about how and what this education needs to incorporate. In addition to this, recommendations about how to manage BPSD and provide better care for patients with dementia were identified, which will make an important contribution to this area of nursing care.

Analysis of the findings showed that, in order to improve nurses' confidence and provide them with the skills and knowledge they need to care for patients with dementia, dementia must be fully incorporated into pre-registration nurse education for adult branch students. Interestingly, the findings show that the sessions need to be interactive using techniques such as role-playing, group work, case studies or scenarios, guest speakers and reflective learning, that are effective (OPM, 2009). A placement in a clinical area caring for patients with dementia routinely is also recommended. In order to maintain a competent workforce, qualified nurses must receive ongoing education about dementia care and it is recommended that this is mandatory.

The findings identified a number of key topics that need to be covered (See figures 5.2 and 5.3 in chapter five). Having an understanding about the causes and effects of BPSD and how they can be managed effectively may not have an effect on the level of challenging behaviour but will help reduce the use of antipsychotics, ensure better management and communication is provided, and reduce staff stress and absenteeism (Bradley et al, 2010; McPhail et al, 2009; Wesson and Chapman, 2010; Moyle et al, 2008; Doherty and Collier, 2009; Monette et al, 2008; Davison et al, 2007).

For education and training to be successful and sustainable it is essential that there is an overall change in organisational culture (Moyle et al, 2010) and inflexible routines and task-focussed care that lead to ineffective management (McCabe et al, 2007; Parmelli et al, 2011; Edberg et al, 2008) must be addressed. Staff need to feel supported to utilise their new techniques, which could improve staff morale and reduce absenteeism (Byers and France, 2008). Furthermore, adequate support and effective strategies for managing aggression are also required.

Despite the clear need for alternative forms of management for patients with dementia the literature suggests that there is a lack of viable alternative non-pharmacological treatments because there is a limited evidence base (Gitlin et al, 2010; RCPsy, 2005; DH, 2009a; Wood-Mitchell et al, 2008). Therefore antipsychotics are used inappropriately as a first line intervention. To address this, there is a need for doctors to be educated about the use of antipsychotic medication in patients with dementia.

Findings recommend trying to keep patients with dementia occupied or stimulated and suggest making changes to the environment, where appropriate, because this seems to help manage BPSD. They recommend using non-pharmacological interventions rather than antipsychotics. Other literature makes similar suggestions (AS, 2008; Ouldred and Bryant, 2008; NICE, 2006; Clare and Woods, 2003; Weaver, 2007; Knowles, 2010; Woods et al, 2005; Livingston et al, 2005; Brooker, 2007) which improves the validity of this finding. Therefore, although a robust, supportive, evidence base for many interventions is lacking, convincing arguments can be made to support the use of non-pharmacological activities.

Findings reported in this study suggest it is important to recognise symptoms that may cause behavioural difficulties. To reduce anxiety it is better to try to provide a quiet, more homely environment or try to re-direct conversation to something that is meaningful to the patient, whilst not specifically trying to re-orientate their reality (AS, 2010b; Borbasi et al, 2006; Parahoo et al, 2006; Moyle et al, 2008). Knowing the person's life history is essential for this, enabling person-centred care (Aveyard, 2001; Adams, 2008; Dewing, 2008; Hampson, 2009; Long, 2009; Brooker, 2007) and also helping in the management of aggression (Finfgeld-Connett, 2009). In order for this to be achieved it is essential that nurses learn to liaise with, develop relationships with, and support, the patient's family and carers (AS,2010a; Birch and Draper, 2008; The NHS Confederation, 2010; Atwell, 2010; Birch and Stokoe, 2010; Nolan, 2006; Borbasi et al, 2006). These techniques, or similar examples, therefore need to be incorporated in nurses' education and training.

Furthermore, nurses need to learn to utilise specialist nurses and liaison teams who can provide help, support and give specialised advice on subjects such as management of behaviour, communication and medication (AS 2010a; The NHS Confederation, 2010; Iliffe and Wilcock, 2009; Birch and Draper, 2008; Borbasi et al, 2006).

6.3 Strengths and Limitations of study

This study has drawn some interesting conclusions and discussed a variety of important themes and topics. However, it is important to recognise that the generalisability of these conclusions is limited to an extent by the demographics of the sample. The twelve participants were all adult branch trained. It is also interesting to note that most participants were senior nurses, including sisters and charge nurses and a practice matron. As the participants were all volunteers it is possible that they have more of an interest in the topic (Parahoo, 2006) and therefore their opinions may not be fully representative of other nurses working in adult care settings.

The effect of the researcher on the participant's responses also needs to be considered. As a student nurse, the researcher is expected to have similar values and understanding to those of the participants who share a common culture (Holloway and Wheeler, 2002). Although attempts were made to probe and clarify participant's responses, on reflection my inexperience, as a novice researcher, may have limited the extent of this. However, Holloway and Wheeler (2002) explain that the common values of the researcher and the participants become an integral part of the research process and can positively contribute to the findings.

The sample may be small, handpicked and localised thereby reducing the generalisability of the findings but Parahoo (2006) states a well conducted qualitative study can still be of value beyond the sample studied. Furthermore, the aim of this study was to increase understanding about nurses' experiences of dementia care and education and generate further knowledge about this topic rather than the generalisability of the findings. This was achieved thorough a phenomenological approach and therefore, these results can provide valuable

insight and make a positive contribution to the evidence base surrounding dementia care and education.

6.4 Reflection upon the Dissertation Process

Firstly, writing a document like this is something I have never done before and having dyslexia made the dissertation process an even bigger challenge for me. I worked hard to overcome the fear of writing it and managed to organise my time effectively to read and research around the main focus. I feel I have developed and improved my writing style and research skills significantly.

The dissertation process also presented me with a number of challenges out of my control. I learnt to communicate with and work with people effectively and learnt to be patient during the recruitment and data collection process. I learnt to be flexible with my time for interviews and travelled a lot at my personal expense to get the results I wanted. I was able to recognise a limitation of myself as a researcher and successfully overcome it by having a professional transcriber. The extra time this created, I used efficiently to become immersed in my data and to formulate my ideas. Being a novice researcher, presented a few problems. If I had felt more confident I think I could have used probe questions to elicit other ideas from the participants. In hindsight I should have been more critical of the participant's responses and ensured that they elaborated and explained everything. Although I recognise that this did improve in the later interviews.

I have found the whole process very useful and I am proud of myself for achieving it. It has given me an opportunity to explore an area of nursing that I am interested in and one that is otherwise not covered sufficiently in our education. Therefore, I feel this experience has given me a professional advantage and a wealth of knowledge for when I am a qualified nurse. Ultimately, I appreciate that the next stage of this process involves dissemination of my findings to ensure that this work makes a contribution to other nurses' knowledge and to the evidence base for dementia care education. Having successfully overcome the challenges associated with this dissertation, I am preparing myself for the next stage in the nursing research process.