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Staff confidence, morale and attitudes in a specialist unit for general hospital patients with dementia and delirium – a qualitative study

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Abstract

Background: The prevalence of dementia across countries worldwide is challenging the capacity of health and social care systems. One in three emergency hospital admissions in England is of a confused older person. Patient outcomes are poor for this group and their quality of care often criticised. Staff involved in their care describe feeling underprepared and lacking in skills and confidence.

Objectives: To explore confidence, morale and attitudes among staff working on a specialist unit for general hospital patients with dementia and delirium (Medical and Mental Health Unit).

Design: Qualitative interview study.

Settings: Recruitment was from a single unit in an English general hospital.

Participants: 22 ward staff from the unit comprising; two deputy ward mangers (senior nurses), six registered general nurses, three registered mental health nurses, one student nurse, two occupational therapists, three health care assistants, two activity co-coordinators, one junior doctor, one receptionist and one domestic.

Method: An interview schedule was constructed covering; education and training, job satisfaction, care of patients with dementia, team working, communication with family and other carers', and organisational barriers to change in practice and culture. The data were analysed thematically using a framework analysis that allowed a systemic process to be followed in the development of knowledge and theory. Familiarization with data involved constant comparison across data to identify categories and themes.

Results: Health professionals suggested that working in a specialist unit allowed them to provide better care to cognitively impaired patients. Five main improvements reported by staff were across the following themes; improved dementia awareness and confidence in competence, improved staff coping strategies and morale, working with mental health

professionals, practicing a person-centred model of acute care, and developing positive attitudes towards patients with cognitive impairment. Staff also identified the need to overcome organisational pressures to change in practice.

Conclusion: Staff working on an acute general hospital ward can develop and maintain expertise and confidence in caring for patients with delirium and dementia. These are challenged by competing pressures, which requires a strong team spirit and leadership.

Background

The prevalence of dementia across countries worldwide is challenging the capacity of health and social care systems [1]. One in three emergency hospital admissions in the UK is of a confused older person [2]. One estimate suggested a quarter of all acute hospital beds in the UK are occupied by people with dementia [3]. Patient outcomes are poor for this group [4], [5], [6], their quality of care often criticised and staff involved in their care describe feeling underprepared and lacking in skills and confidence to care for them [3], [7], [8], [9] and that this represented a major barrier to achieving good quality care [10]. Improving dementia care on acute wards is seen as a priority by the UK Government [11], [12]. Although older people are increasingly becoming the most frequent users of acute care, a number of studies have suggested that hospitals and their staff worldwide are not well equipped to care for them, especially those with dementia or delirium [13], [14], [15]. Other studies have highlighted lack of education and training in dementia, and that although some staff attitudes towards older patients with dementia were negative, most staff wanted to do a good job and felt frustrated by lack of skills or knowledge, leading to dissatisfaction and stress amongst staff [8], [9], [16]. Challenges include communication, management of disruptive behaviour, safety including falls prevention, providing activity and protecting an individual's dignity. Services are geared towards assessment, diagnosis, cure and discharge and the acute problem for which a patient has been admitted often becomes the sole focus and priority in delivering care. Current best practice encourages person-centred approaches to care [10], [17], [18], but recent research suggests that multiple conflicting organisational and staff priorities can result in task-orientated and disrespectful care [19].

We developed a 28-bedded specialist Medical and Mental Health Unit (MMHU) over an 18-month period from an existing acute geriatric medical ward in an English general hospital [20]. This involved: the employment of additional multi-professional staff (three mental health nurses, a mental health specialist occupational therapist, three unregistered activity co-ordinators, and additional physiotherapy, speech and language

therapy, psychiatry and medical time), working alongside standard acute hospital staff; enhanced staff training in dementia, delirium and patient-centred care [17], [18], changes to the physical environment; provision of a purposeful activity programme; and an inclusive and proactive approach to family carers. The aim of this approach was to: promote constructive relationships between patients and staff, and feelings of identity, inclusion, attachment, activity and comfort. Specific didactic education was provided in mental health problems (dementia and delirium), symptoms, diagnosis and care (in collaboration with the University of Nottingham School of Nursing). Three time-out days for all staff (from November 2009) introduced the philosophy of person-centred care. Work books on dementia care and recognising delirium were distributed to all staff [21]. A series of ward-based topic teaching sessions was instituted, on different types of dementia, use of medication, mental capacity legislation, and the role of family carers. Occupational profiling was used to grade activities to a person's level of functioning [22]. Patient personal profile and family carer collaboration documentation was developed to engage relatives with nurses and affirm staff interest in patients.

The intervention was evaluated in a randomised trial [23], complemented by a non-participant observation study [24], and interviews with family carers [25] and staff. In this study we aimed to explore confidence, morale and attitudes among staff working on the specialist unit, in order to evaluate the effectiveness of the training programme, understand how the model of care worked in practice, and identify outstanding challenges.

Methods

Sampling and Data Collection

Twenty-two ward staff from MMHU was purposively recruited to take part in face-to-face semi-structured interviews, from January to March 2011. There were no exclusion criteria. Staff interviewed included; two deputy ward mangers (senior nurses), six registered general nurses, three registered mental health nurses, one student nurse, two occupational therapists, three health care assistants, two activity co-coordinators, one

junior doctor, one receptionist and one domestic. The mean age of the sample was 37 (range 20-64); and 15 (68%) were female. Working patterns for nursing staff were three x 12½ hour shifts per week. Most other staff worked seven hour shifts over five days. One deputy sister, health care assistant and receptionist worked seven hour shifts over three days only. The doctor worked a complex shift pattern. Length of experience in profession ranged from four months to 29 years. Interviews lasted between 30 and 90 minutes. An interview schedule was constructed including; education and training, job satisfaction, care of patients with dementia, team working, communication with family and other carers', and organisational barriers to change in practice and culture. The interviewer was a University-employed experienced post-doctoral medical sociologist, who was not involved in clinical care or service management. Interviews were audio recorded, transcribed and pseudonyms assigned. Assurances of confidentiality were given. Data were managed using N-Vivo 10 software. Approval was received from Nottingham Research Ethics Committee and conducted in accordance with the Declaration of Helsinki.

Data Analysis

Sampling continued until data saturation was achieved in the analysis of key themes. The data were analysed thematically using a framework analysis that allowed a systemic process to be followed in the development of knowledge and theory [26], [27]. Familiarization with data involved constant comparison across data to identify categories and themes. Coding transcripts to identify recurrent statements and expressed feelings formed the basis of the thematic framework. Themes were compared and contrasted between settings via indexing, charting and mapping to provide a detailed understanding and interpretation of participants' experiences of staff confidence, morale and attitudes. All authors met on a regular basis to discuss the development of codes, themes, categories and theories about the phenomenon being studied.

Role of the funder

The researchers were independent of the funder, which had no role in study design; analysis or interpretation of data; report writing; or decision to submit for publication.

Findings

Health professionals suggested that working in a specialist unit allowed them to provide better care to cognitively impaired patients than they had previously done on standard care wards. Five main improvements reported by staff were across the following themes; improved dementia awareness and confidence in competence, improved morale and coping strategies, working with mental health professionals, practicing a person-centred model of acute care, and developing a positive attitudes towards patients with cognitive impairment. Staff also identified the need to overcome organisational pressures to change in practice, the need for improvements to the quality of staff-carer communication and increased staffing levels. A further theme was therefore identified during the data analysis labelled organisational barriers.

Confidence in competence / improved dementia awareness

Participants reported increased confidence in their ability to care for cognitive impaired patients. Staff attributed this to the additional training that they had received (educational and practical) for patients with cognitive impairment. This related both to becoming more dementia aware and delivering person-centred care. All staff agreed that the level of training they had previously received on-the-job or during more formal pre-registration had been 'non-existent'. There was consensus among staff that working on a specialised unit had increased their knowledge and awareness of dementia and delirium which allowed them to develop alternative strategies when caring for agitated or aggressive patients. This left staff feeling competent which had a positive impact on their emotional wellbeing and increased job satisfaction:

"Well, it's helped, it's given us strategies to use. And obviously, it's sort of, gives us a bit more insight into, you know, what, what that sort of patient is going through at that sort of moment in time, or what the triggers might be, or, you know, gives us some way of working out, you know, what is, what is the cause of this current episode" (male, staff nurse).

"With all the training we've had and the way we look after patients, now compared with before, it was like, you know, the wandering about or if they were shouting, sedate them, we don't sedate now. And we know how to talk to them, I mean, there are times when there's somebody that can be a bit more violent than the others, but they're not too bad" (female, deputy sister).

Improving staff coping strategies / improved moral

Working on a specialist medical and mental health unit was considered a busy and sometimes challenging environment for the majority of staff interviewed. However staff described a strong ward team spirit and supportive ward culture which individuals described helped improve stress-related coping strategies when dealing with unfamiliar situations. Staff further considered morale on the ward to be good and many participants felt the ward was a beacon for improved dementia care. Staff highlighted that the team spirit and supportive culture they felt was due to the positive leadership participants experienced on the ward in the form of motivation and encouragement. Staff further highlighted that they considered ward management to be approachable and supporting:

"I was really frustrated with one particular patient I'd dealt with all day, and I felt, and I'd really tried hard to understand what they're trying to communicate and invested a lot of time, but I knew I still had sort of half an hour to go. So I said to one of my colleagues, if he needs anything, would you mind stepping in. She said, Oh yeah" (female, staff nurse).

"Well, in my opinion, we're a very strong team. And, the team has a lot of commitment to one another, and in a way that has helped the ward succeed particularly through the change period and I think when you speak to others,

you may find that they say, you know, I would have left if it hadn't been for the leadership on the ward" (female, staff nurse).

"We've got a brilliant management team, I've always feel supported by them and also, I've just got a good set of friends as well as colleagues. It's really nice" (female, health care assistant).

Working with mental health professionals

Staff commented positively about the skill-mix of nursing care available to patients on MMHU, specifically the introduction of three mental health nurses. Participants described how this also helped increase staff confidence and morale when less experienced staff were faced with unfamiliar or perceived challenging behaviour. For general nursing staff on the ward working alongside mental health specialist staff was a particularly effective way of on-the-job learning by observing or shadowing more experienced staff:

"I think it's, sometimes, someone, keeps saying they don't want to have a wash or something, and they're very agitated by the idea of any kind of nursing intervention, I think that's when we would speak to one of the mental health nurses because, they've got a bit of a knack to persuade someone to do something that none of the rest of us could" (female, staff nurse).

"The mental health nurses give the general nurses the confidence to do their job and to do their job looking after people that are very poorly, physically, and have got cognitive memory problems at the same time. So having a multidisciplinary team has really strengthened people's confidence" (female, mental health nurse).

Person-Centred Care

Staff generally considered that they had a good understanding of the principles of person-centred care. In discussions with participants about improving the culture of acute care for older people who have confusion as well as acute clinical needs, staff

highlighted how they had begun to move from a task-focused approach to one more person-centred. Staff also described that within the hospital environment complete individualised person-centred care for patients was difficult to achieve:

> "I mean, I'm guilty of it myself, I've said blue 6 [referring to a patient by their bed space rather than by name], I but I think that's a cultural thing within the wards. It's just as easy to remember somebody's name as it is what bed they're in, but I think it's habitual and a bad one. And … there are a few examples of things like that, it's easy to communicate bed numbers and see patients as a condition rather than as a person. And I think it's, I think it's just bad habit" (female, staff nurse).

> "We've got all the organisational barriers, like, you can't adjust mealtimes to fit in with someone with dementia, you can't not send them to x-ray when the porter comes to get them for an x-ray, you can't ignore infection control issues where you might have to isolate somebody" (male, mental health nurse).

Staff on MMHU gave numerous examples of how they had developed skills in delivering person-centred care by promoting constructive relationships with patients to improve their feelings of identity, inclusion, attachment, activity and comfort. In order to aid staff in this area health professionals utilised 'personal profile' documentation (called 'About me') to engage relatives and affirm staff interest in patients. Staff completed documentation with relatives about patients past lives, likes and dislikes and other personal information:

> "The About Me and Caring Together forms are useful, especially when you get patients who might be distressed or slightly aggressive and stuff, to be able to have something that you can just try and talk to them about" (female, occupational therapist).

> "They [personal profile forms] can be very useful, you know, because, you'll be able to find out the names of people and how many children patients have got, and if you can get them talking about their family or their pets or where they

used to go on holiday, it can often take their mind off what was annoying them or making them angry" (female, staff nurse).

Staff also described the variability of delivering person-centred care in the acute setting related to shift length, pace of work, differences in patients retained abilities, their length of stay and their wishes:

> "I think how you prioritise delivering person-centred care and medical task varies day to day because quite often, you could have a bay that's not got much medical intervention that needs to be done. So therefore you can spend more time, you know, chatting to people, taking your time to listen to stories and things like that" (female, health care assistant).

> "I think delivery person-centred care is as good as it can get. I know that sometimes I am really busy and you feel like you haven't got the time so you don't do it and then at other times, like this morning, there was a confused lady looking for her handbag so I, we went and we had a look for it together" (female, mental health nurse).

> "Activities are great but they [patients] have to go to the day room for that. So if they're bedbound, and we can't get the bed in there, they are potentially sat in that bed twenty-four/seven. And it's not that you don't do person-centred care, where the patient needs, you know, IV drips and that sort of thing. Person-centred care does encourage better care, but you've got to understand, if they're [patients] not very well, they don't always want to be doing things" (female, staff nurse).

Positive change in attitude towards patients

Having a greater understanding of both dementia and person-centred care had helped staff display a more positive attitude towards this population of patients.

"I'm more flexible with them [patients] now, and I try and talk the way they talk and do things differently than before like holding their hand" (female, health care assistant).

One student nurse who had observed care practices across a number of different wards described the positive attitude staff had towards patients with cognitive impairment on MMHU compared with standard care wards:

"I'm just covering every medical ward in, in the hospital, so that's given me the opportunity to compare and contrast the two. I've definitely seen like a difference in staff attitudes. For example, some nursing staff almost take it personally when someone with dementia is demanding something, too much of them or, you know, it's almost like they get offended and it's almost comes across as a lack of understanding for example, on a nightshift when someone was moaning to her colleague, 'I've just done this, why is he asking me again', really, really getting agitated and working herself up about it. That wouldn't exist on here" (male, student nurse).

Organisational barriers

Health professions highlighted that they felt the conflicting pressures of delivering person-centred care in an organisation that valued measuring quality of health care in a quantifiable way. Staff considered that this sometimes hindered the time staff could spend caring for patients at the bedside or collaborating with relatives:

"I think my stress levels are up, definitely more so than before. But that's, that's not necessarily because of the client group. I think some of that's down to erm, various sort of external pressures with regards to sort of, documentation audits and bits and bobs like this, which are additional to bedside care" (female, staff nurse).

Participants further commented about the lack of understanding they felt senior management held whose priorities staff perceived don't encourage or foster the

delivery of person-centred care. Staff therefore felt that the organisational culture within the hospital would not reward health professionals in the delivery of best practice:

> "Because it is, everything, it is so target-orientated, it completely dehumanises the whole thing, doesn't it? You know, they're [senior management] not dealing with people, they're dealing with numbers in beds. So, in, in improving the quality of care for older people then, do they, do the executive management and nurses need to understand that it's not just all about what's measurable? How do you, how do they encourage you to be more person-centred if they're not really going to reward you for it?" (male, staff nurse).

Some members of the general nursing staff felt that the acute hospital setting was too task focused and an inappropriate place to deliver person-centred care:

> "That level or, you know, of expertise, it's a very specialised type of working, [person-centred care] and we're not geared up to do that. Acute hospitals are task-orientated settings because, it's about the numbers, it's all about the throughput of people, freeing up the bed, and so on and so forth" (male, staff nurse).

Some staff commented that they felt the true delivery of person-centred care was more suited to long-term settings and felt that the fast pace of an acute hospital ward meant that best practice and the current model of person-centred care didn't sit as well in a hospital setting. All staff appreciated the ethos of enhancing and protecting patient's personhood by adopting a person-centred approach in the acute clinical setting:

> "People are here to have their medical needs met and hopefully out the other end of the hospital quite quickly so the whole, the drive of a hospital is sort out the medical problem, and discharge. So, it's supposed to be, they always, they want it to be a fast place that you move through quickly, that's why there's bed pressure, that's why there's four hour waits [government target for maximum time spent in Emergency Department], that's why admissions units are hugely busy, and that is not an ideal place for a person who's disorientated and

confused and worried and ill as well and, I think, and to hope that within that, someone, you know, has the time to get to know that person, but they're moving through the system so quickly, so one nurse might not, you know, I just think that's a massive challenge". (female, staff nurse).

Many participants considered that further work was needed to deliver a truly person-centred model of care within the acute hospital setting.

Staff-carer communication

Staff views about communication with relatives highlighted that they sometimes struggled to collaborate with relatives due to time constraints. Staff considered the ward to be a busy environment and some staff viewed relatives as demanding. Some staff expressed regret and disappointment that they could not offer more time to relatives:

> "But nurses on the ward just, we really struggle to have the time to listen to every relative as long as they might want us to. And I think … but then again, I see it from the carer's point of view as well, which is, they're the experts, they're the ones who know their relative, the patient really well, you know, they need to know what's going on, they often feel that they're not communicated with" (female, staff nurse).

> "If there was some way that family members could get some sort of update, without having to ask a nurse who's busy, is there any way it could be done, do you think, in an ideal world, could there be some sort of tick box and left for relatives, to say, Oh well, Alex had his breakfast, yes, no, oh, he's been in the activity room, yes, no" (male, staff nurse).

> "It's a tough one really, because I think, again, it comes back to the conflict of interest, I would love to be able to spend more time having a chat about keeping relatives involved and updated, I personally regret not being able to" (female, health care assistant).

Staffing levels

Due to the nature of the ward, staff tended to view the work load as 'heavy' and considered extra staff allocated to the ward would help reduce pressure and stress. Working long shifts (12½ hours) on a specialist dementia ward was considered to be stressful by some nurses, although others were grateful that they could complete their weekly work over a three day period.

> "Yeah. I think you do need extra staff on a ward like this, for the type of patient. To make it, because the staff, they're very good, and, you reach a breaking point where you can do so much but it's nice and you feel comfortable having extra staff on there that you don't feel rushed all the while". (female, staff nurse).

> "Well, we have enough staff on the ward but the thing is we have quite a lot of patients that need more attention. So, in a way, well, saying from the other way is, we're short staffed because of the patients demanding the help" (male, staff nurse).

Discussion

This is the first qualitative study to explore staff confidence, morale and attitudes in a unit which had attempted to improve general hospital care for patients with dementia and delirium through improved staff education and skill mix. All participants reported how their confidence in their own competence to care for this group of patients had increased, and developed a more positive attitude towards patients with cognitive impairment. Most staff displayed a sympathetic attitude towards person-centred care but felt constrained by workload and delivering fundamental nursing care in a task-focused environment. Integrating mental health professionals to provide a better nursing skills mix for confused patients was supported by all staff. Participants recognised the limited collaboration staff had with relatives which was in part related to workload. These findings suggest that by developing a unique skill mix in this setting (introduction of

mental health specialist staff) and encouraging multi-disciplinary working alongside increased education and training has allowed MMHU staff to share and deliver more appropriate dementia care in the acute hospital setting.

Strengths and Limitations

This study describes an evaluation of an intervention to improve care. Interviews were in 'real time' (staff were still working on the ward). Staff proved willing to reflect on and describe their experiences including difficulties and areas where they felt care could be further improved. A little under half of the staff on the ward were interviewed, and although bias due to a volunteer effect is possible, findings are likely to be representative. The semi-structured qualitative methodology allowed an in-depth exploration of views, including themes that had not been anticipated in advance. We had undertaken similar interviews in standard wards across the same hospital before the MMHU development, providing comparison data [8], [9]. However, staff are likely to report a 'public voice' and may have wanted to present themselves and their work in a good light [29]. Interviews were from a single ward in a single hospital may not be generalizable.

Context and interpretation

Previous studies have identified that staff in standard wards lacked confidence in caring for this patient group, were ill-prepared for the work and lacked knowledge of person-centred care [3], [9], [30], [31]. Further research has highlighted that the priorities of healthcare organisations can act as barriers to delivering person-centred care by focusing on achieving measureable activity, quality or safety targets at the expense of person-centred care [32]. Staff described the conflicting pressure they experienced in developing person-centred care practices in an acute hospital setting that demands focus on completing medical tasks. This has resulted in an increased use of audit measures to manage Trust (hospital organisation) concerns with risk, such as falls and infection control. Tadd et al., highlights the fact that 'trade-offs can occur between efficiency, safety and the quality of patient experience' [15]. Staff on MMHU also expressed the

view that Trust proprieties took precedent over person-centred care. For example, a patient with cognitive impairment may be moved to a single room because of infection control, even though that patient may feel more isolated or disorientated.

The ambitious development of a specialist MMHU has clearly made headway in improving the delivery of care for confused older patients who are admitted to hospital with a medical crisis, through intensive staff training, extra staffing and improved skills mix. The findings from this study have implications for research, policy and staff education. Staff who lack knowledge, skills and confidence in care for dementia patients are unlikely to be able to undertake and support the on-going patients fundamental caring needs, especially when faced with challenging or unfamiliar patient behaviour such as wandering, patients disrobing or refusing/not wanting to eat, particularly if communication is difficult. This research has shown that staff attitudes and perceived expertise can be improved. However, the intervention was intensive, and lesser intensity may not be as effective. The findings from this study also support the idea that acute Trust priorities have a role in influencing care of older patients with chronic confusion. Senior management need to be aware of this potential problem, and take steps to mitigate it.

Implications and future work

Given the widespread prevalence of delirium and dementia in hospitals, greater expertise is required throughout the workforce. Improvements need to be made in pre- and post-registration curricula to deliver a comprehensive training in the knowledge skills and attitudes required to meet the specific needs of this population. This may require more cross over between physical and mental healthcare training. Further work should include how to deliver improvements at scale across hospitals. Delivering person-centred care across the health service is a challenging prospect which must go beyond the education of front line staff to promote and facilitate environmental and organisational change. Service-wide commitment and organisational support is needed to develop a changing

culture of delivering best practice for older people admitted to hospital with dementia and delirium.

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