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Abstract

This paper summarises a literature review focusing on the literature directly pertaining to the acute care of older people with dementia in general hospitals from 2007 onwards. Following thematic analysis, one overarching theme emerged: the consequences of being in hospital with seven related subthemes. Significantly, this review highlights that overall there remains mostly negative consequences and outcomes for people with dementia when they go into general hospitals. Although not admitted to hospital directly due to dementia, there are usually negative effects on the dementia condition from hospitalisation. The review suggests this is primarily because there is a tension between prioritisation of acute care for existing co-morbidities and person-centred dementia care. This is complicated by insufficient understanding of what constitutes person-centred care in an acute care context and a lack of the requisite knowledge and skills set in health care practitioners. The review also reveals a worrying lack of evidence for the effectiveness of mental health liaison posts and dementia care specialist posts in nursing. Finally, although specialist posts such as liaison and clinical nurse specialists and specialist units/shared care wards can enhance quality of care and reduce adverse consequences of hospitalisation (they do not significantly) impact on reducing length of stay or the cost of care.

Keywords

acute care, Alzheimer's, dementia, general hospital, older people, person-centred

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Introduction

As a consequence of ageing populations there are an estimated 35.6 million people living with a dementia worldwide (Prince et al., 2013). Some 700,000 people with dementia are in the UK and 570,000 in England. In the next 30 years, the number of older people living with dementia in the UK is predicted to rise to 1.4 million with an estimated cost to the UK economy of £50 billion a year. Despite this, the current level of funding for health care is far behind other major priorities such as cancer and heart disease (Department of Health [DH], 2009). It is known that older people are admitted to hospital more often than other age groups and occupy two-thirds of acute hospital beds (Smith, 2007). Mukaetova-Ladinska, Teodorczuk, and Cerejeira (2009) point out that the high levels of people with dementia across a range of hospital wards should not come as a surprise, since on average, older people with dementia (irrespective of the type) have three or more physical illnesses which at some point will require acute health care. For example, the Royal College of Psychiatrists (2005) estimates that a typical district general hospital in the UK will have approximately 100 people with dementia at any given time. Given the NHS Confederation (2010) estimates 50% of dementia goes unrecognised, numbers are likely to be higher. In a longitudinal study in a London general hospital, for example, researchers established that dementia was present in 42% of the 617-people cohort, with only half diagnosed prior to hospitalisation (Sampson, Blanchard, Jones, Tookman, & King, 2009). Further, a recent survey by the Alzheimer's Society (2009) reveals that 97% of nurse respondents always or sometimes care for someone with dementia. The same survey reveals that more than half of the carer respondents thought a hospital stay had a negative effect on the symptoms of dementia of the person, and 77% were dissatisfied with the quality of dementia care. Simultaneously, a large number of nurses (89%) found people with dementia challenging to care for (Alzheimer's Society, 2009). In the meantime, several countries have launched national strategies on dementia and dementia care (e.g. Department of Health Australia, 2006; Scottish Government, 2011; Welsh Assembly Government, 2011). The 'Living Well with Dementia' document outlines the issues and objectives of the national strategic framework in England (DH, 2009). Within all of these strategies there is an objective associated with improving the quality of care in general hospitals.

Aim

Our paper aims to present a themed review of the literature on the acute care of people with dementia in general hospitals. We frame our theming within a broadly person-centred perspective, although not favouring any specific model. We chose to do this as the general, notion of person-centredness is considered to equate with better if not best care across all care settings. Following this, we contextualise our discussion within a framework of 'cultures of care' in acute settings.

Method

The literature search comprised English-language papers and reports on the acute care of older people with dementia in general hospitals. Given Moyle, Olorenshaw, Wallis, and Borbasi published a literature review on the same topic in 2008, we decided to take this as our baseline in order to avoid duplication. In other words, the publications included in their literature review are not discussed here. As the paper was published in 2008, we reviewed

papers from 2007 onwards in order to include anything published between the submission and publication date of their paper. A few papers published prior to 2007 were later taken into account when they were deemed relevant and had not been cited in the review by Moyle and colleagues (2008). Databases searched were PubMed, CINAHL (EBSCO), MEDLINE and PsycINFO. The search terms used were 'dementia', 'Alzheimer's', 'confusion' or 'cognitive impairment' in combination with 'acute care', 'acute hospital', 'acute ward' or 'hospital'. Following this, a search with the use of Google Scholar was conducted to find 'grey' literature and articles in other databases than those mentioned above. The references in each retrieved paper found were scanned to find further relevant publications. Google Scholar reveals how many times academic work has been cited in subsequent articles, as well as providing a list of those papers. These lists were also checked to help identify further literature. Although most of the literature reviewed here is from peer-reviewed journals, reports, policy documents and theses have also been included where relevant and/or based on original empirical research. Of a total of 278 papers retrieved, a final total of 53 publications were included in the review according to the following criteria:

Inclusion criteria

- A clear focus on the care of older people with dementia in acute settings.
- Papers published between 2007 and 2013.
- Written in English.

Exclusion criteria

- Addresses care of older people in hospital but not older people with dementia in particular.
- A focus on non-acute care of older people with dementia in general hospitals.
- About people with dementia, but not focused on acute hospital care.
- The literature discussed in Moyle et al.'s (2008) review on older people with dementia in acute care.
- Opinion pieces and non-peer reviewed publications.

After reviewing the 53 papers that matched the selection criteria, we identified an omission; certain services and models of care known to exist in general hospitals, related to mental health or old age psychiatry, were missing. Therefore, additional searches were performed with the search terms 'shared care', 'mental health nurse', 'mental health liaison' and 'old age psychiatry'. From this we retrieved a small amount of publications. All the literature was read and the main findings and arguments were summarised and organised thematically. Independent general thematic analysis took place by one of the authors and was then refined by the second author. Any discrepancies were discussed to find agreement.

Findings

The overall theme we generated was defined as 'consequences of being in hospital'. From this, we established seven related subthemes: the care environment, cultures of care, attitudes, challenges for people with dementia, carers, staff and volunteers and researched service models.

Consequences of being in hospital

There are a number of significant consequences for people with dementia that arise simply from going into a hospital setting; beginning with being in an environment which is not

dementia friendly and escalating from there depending on the co-morbidities the person has, the type of interventions needed and the person's ability to withstand the overall care experience within any particular culture of care in the setting. Admission to hospital is demanding for the person with dementia, physically and emotionally. Poor detection and diagnosis, negative outcomes, longer hospital stays, higher mortality rates, increased likelihood of falls, functional decline, spatial disorientation, possible malnutrition and dehydration, increased reliance on care givers, depression and superimposed delirium are some of the reported consequences of being in hospital (Archibald, 2006; Bateman, 2012; Bezzant, 2008; DH, 2009; Digby and Bloomer, 2013; Gladman et al., 2012; King, Jones, & Brand, 2006; Moyle et al., 2008; Zieschang et al., 2010). Jurgens, Clissett, Gladman, and Harwood (2012) found that carers of people with dementia thought changes, most often deterioration, in the condition of the person with dementia to be due to the effects of hospital care and specifically attributed poor outcomes to what staff did or failed to do. Longer stays are also associated with higher costs (Draper, Karmel, Gibson, Pert, & Anderson, 2011; Leah & Adams, 2010).

There is some evidence to say that getting into hospital takes longer for older people than other patients especially when admission is via an emergency department (DH, 2006; Leah & Adams, 2010). Our review revealed little evidence to suggest the effectiveness of any multi-disciplinary interventions in emergency departments with the exception of those discussed in a systematic review by Fealy et al. (2009). They found that nursing assessment and referral interventions for older people attending emergency departments reduced functional decline and hospital service use. However, this needs to be regarded as tentative, as the included studies were inconsistent in their findings, probably due to the different methods used. Once in a ward, people with dementia are more vulnerable to experience pain, thirst, fear and over-stimulation than people without a cognitive impairment, partly due to a diminished capacity for communication (Bridges & Wilkinson, 2011). For example, with regard to pain, people with dementia may be at risk for undetected or un(der)treated pain: Morrison and Siu (2000) recorded analgesics administered to people with hip-fractures with and without dementia. People with dementia received only a third of pain relief medication in comparison to non-dementia patients – the latter of whom 40% reported severe pain. This result suggests that the majority of dementia patients were in severe pain postoperatively.

Additionally, there is evidence that staff fail to appreciate behavioural communication by people with dementia as a means of expressing unmet need, often related to distress and fear (Dewing, 2009; Heath, Sturdy, & Wilcock, 2010). Elliot and Adams (2011), for example, found that agitation was regarded as a 'disruptive' behaviour although people were actually attempting to communicate some form of distress, most notably pain and thirst. Law (2008) suggests that the introduction of liaison mental health nursing improves staff skills in communication and understanding and managing behaviour. However, this appears an unsubstantiated assertion. Liaison mental health services are further discussed below.

Getting out of hospital is also a more protracted experience for people with dementia and families/carers. On this aspect of acute care there is a relatively large body of evidence that shows there continues to be problems with a reported 38% of people with dementia previously living in their own home discharged to a care home compared with 2% for other older people (Bauer, Fitzgerald, Koch, & King, 2011; Leslie, Fitzgerald, Bauer, Koch, & King, 2011). A grounded theory study in an English NHS Trust by Jurgens et al. (2012) within medical and orthopaedic wards showed that a 'cycle of discontent'

builds up among carers that could be prevented by enhanced communication. The findings suggest that events (or 'crises') are associated with expectations. When these expectations are unmet, carers become uncertain or suspicious, leading to a period of 'hyper vigilant monitoring' during which carers seek out evidence of poor care, culminating in challenge, conflict with staff or withdrawal, which itself is a crisis. The cycle could be completed early during the admission pathway, and multiple cycles within a single admission were seen. Overall, research evidence indicates that discharge planning for family carers of people with dementia still needs to be substantially improved. Despite national and local hospital policy and processes, general hospitals still seem to fail to take full account of the family/carer's needs (Bauer et al., 2011).

The care environment

Acute care hospital environments are generally unsuitable for people with dementia. Moyle et al. (2008) conclude that the physical layout is not designed for people with dementia in mind. In addition, the impersonal and busy character of hospital wards can be disorientating for people with dementia (Moyle et al., 2008; Nolan, 2007). Improved signage, better lighting, minimising clutter, purposeful activity, using headphones with favourite music and personal objects can make a difference (Keenan et al., 2011; Moyle et al., 2008; Waller, 2012). Although one study reported that people with dementia and their carers deemed the hospital care provided more important environment than the surroundings, they used the physical environment as an indicator of the quality of care and mentioned problems with space, privacy and noise. The ability to see and/or access a garden was important to participants (Digby & Bloomer, 2013). Gladman et al. (2012) found that staff in a UK hospital also felt there to be too little space around and between beds, but too great a distance between some of the beds and the nurses' station. Adapting the environment with cognitively impaired people in mind can lead to better patient safety and overall outcomes (Waller, 2012). In addition to the physical surroundings, Edvardsson, Sandman, and Rasmussen (2011) highlight the effects of the psychosocial environment on the well-being of people with dementia. Their grounded theory study revealed that these people were influenced emotionally by the presence or absence of staff. When staff were present and engaged with them, the outcome was positive – described by the authors as an atmosphere of home, although not home in the physical sense. Rather, home was seen as an experience of feeling safe, connected and welcome. When staff were absent this created anxiety among people with dementia and the atmosphere changed into a sense of 'homelessness', where they seemed abandoned and lost. When staff were present but not really engaging when carrying out care or procedures, situations could turn positively or negatively depending on the person. Thus, even where efforts are made to create a more suitable physical environment, Edvardsson et al. (2011) conclude that this does not guarantee experiences of feeling safe.

Cultures of care

The literature exposed that the care culture(s) in general hospital leave much to be desired with regard to people with dementia. By a culture of care, we mean 'the way things are (actually) done around here' (Drennan, 1992). Much of this failure is attributable to senior management in health care organisations who have simply ignored or underestimated the

care needs of people with dementia and the needs of people who care for this group of patients (Care Quality Commission, 2013; Woods, Dixon, & Phillips, 2010). This 'blindspot' has been a feature of national and regional planning and funding. The ageing population demographic has now brought to attention the increasing challenge with dementia in westernised countries (Beard et al., 2011; National Institute on Aging & National Institutes of Health, 2007; Select Committee on Public Service and Demographic Change, 2013). Bezzant (2008) points out that if specialist needs (i.e. dementia) are not recognised and understood, care is likely to be poorly planned as a consequence. Similarly, Kang, Moyle, and Venturato (2011) state that the needs of a person with dementia are often less of a priority, or forgotten altogether, when admitted with an acute condition (cf. Moyle, Borbasi, Wallis, Olorenshaw, & Gracia, 2010). Chater and Hughes (2012) attribute this to inadequate training and lack of specialised education for practice, negative attitudes and poor practice development for the failure to deliver high-quality care. Staff in several studies report that an increase of staff, or a lower patient-to-nurse ratio would improve care quality, as many felt there was not enough time (Byers & France, 2008; Gladman et al., 2012). Edvardsson et al. (2011), however, argue that high staffing levels may not translate into better care when staff focus on tasks rather than meaningful interaction with people. In fact, Cowdell (2010a, 2010b) concludes that the culture of care in hospital wards is focused on physical needs, routine and meeting compliance targets, rather than on working towards meeting the needs of individuals. She describes patients being 'objects of care', providing care deemed correct, but with minimum interaction and involvement with the person with dementia. Similarly, in Australia, Moyle and colleagues (2010) argue person-centred care was neglected for the sake of 'safety' procedures, such as excessive monitoring and restraint, resulting in a risk management approach that focuses on reducing risks for staff and the organisation but disregarded the needs of disoriented people. The focus on safety, they write, seems to generate a culture that devalued people with disorientation and where staff viewed people with disorientation/dementia as a nuisance or inconvenience and not suitable for an acute hospital setting (Moyle et al., 2010: 423). The literature suggests this is probably still the majority view among many health care workers, although this may be a simplistic representation of a complex situation.

All of these studies, and others (Cowdell, 2010a, 2010b), show a lack of valuing people with dementia, or a (perhaps inadvertent) culture of devaluing of individuals with dementia in acute hospital settings, thereby disregarding their needs, personhood and emotional well-being (Burgess & Page, 2003). From the findings in this review the importance of providing person-centred care for a person with dementia is inherent in most of the literature reviewed, especially by nursing. Yet, the literature also reveals that in practice, the principles are not always applied, whether as a result of time pressures, an organisational culture focused on curing diseases or negative attitudes towards people with dementia. Moyle et al. (2010) have previously established that in Australia that there are significant discrepancies between best practice models of care and actual care provided. Nurses may choose different care approaches according to the situation that presents itself, rather than following a person-centred approach in all situations (Fessey, 2007). During observations in a general hospital acute ward, Gladman et al. (2012) noticed that the personhood of the patient was sometimes suspended when trying to cope with disruption and even witnessed unprofessional behaviour, such as mockery. Elaborating on the results of this study, Clissett, Porock, Harwood, and Gladman (2013) found that there were many missed opportunities to care for people in a person-centred manner and that there was more evidence of poor than

good practice. In an English study, Norman (2006) writes that at times nurses did not even acknowledge the presence of the person. Even the use of 'specialling' misses opportunities for meaningful engagement, Moyle et al. (2010) discovered, as interactions were mainly limited to unnatural observation of the person in question and the role was perceived as akin to that of a babysitter. In a literature review, Dewing (2013) warns that the implementation of special observation may lead to a 'custodial gaze' that has little therapeutic value. This is in part due to a lack of a standardised definition of special observation and guidelines on best practice of the activity, especially in relation to older adults with a cognitive impairment.

Despite task-focused routines being embedded in many ward cultures of care, there is evidence that when care focuses on the person, rather than tasks or the acute condition, it is more effective than 'routine' care (Webster, 2011). Furthermore, rather than there not being enough time to follow person-centred care guidelines, Webster (2011) believes it saves time. A therapeutic relationship between the person with dementia, their family and hospital staff caring for them can have a positive impact on the person's well-being and may reduce 'challenging' behaviour. Helpful measures include recording the person's biography, getting information from carers, being sensitive to the cultural and religious background of a person and taking into account the person's interests, likes, dislikes and daily routines (Heath et al., 2010; Keenan et al., 2011). Touch and a positive demeanour are reassuring to people with dementia (Nolan, 2007). Bridges and Wilkinson (2011), following Bridges, Flatley, Meyer, and Nicholson (2009), stress that people with dementia want hospital staff to 'see who I am', 'connect with me' and 'involve me'. This is backed up by Gladman et al. (2012) and Norman (2006), who found that people with dementia try to gain some form of control of their situation in order to cope with their hospital stay. In light of the evidence above, however, it has become clear that the ward culture needs to value person-centred approaches for it to work (Webster, 2011). Clissett et al. (2013) believe there is evidence to say that a focus on financial and productivity targets goes at the expense of care that is person-centred. On a positive note, Gladman et al. (2012) and Clissett et al. (2013) describe beneficial outcomes when staff embraced the personhood of the person with dementia in their hospital under study. Nilsson, Lindkvist, Rasmussen, and Edvardsson (2012) also recorded positive responses and concluded the majority of staff they surveyed enjoyed working with older persons with dementia, although they did not measure the impact on the resulting care that these people received. Thus, a person-centred approach to care of people with dementia has been observed in acute hospital settings, although this better/best practice approach is not widely evidenced in the literature on acute care at this point. Clissett et al. (2013) further note that an insufficient understanding of what constitutes person-centred care for the acute hospital context may be part of the problem.

Attitudes

Fundamental to any culture are the values and beliefs displayed as attitudes and action by staff. Nilsson et al. (2012) argue that it is essential to address staff attitudes in order to facilitate change. Positive nurse attitudes have been shown to have a positive effect on care (Kang et al., 2011). In Japan, Nakahira, Moyle, Creedy, and Hitomi (2009) linked negative attitudes with the use of chemical or physical restraint. They further found that staff who reported listening to people with dementia tended to have more positive attitudes. In a Korean setting, nurses in medical wards had more positive attitudes than those in surgical wards as in the latter, high-tech nursing interventions were the priority (Kang et al., 2011).

Prioritising acute care for existing co-morbidities over dementia care has also been reported elsewhere, for example, Australia (Moyle et al., 2010) and the UK (Cowdell, 2010b). A Swedish study by Nilsson and colleagues (2012) found no negative attitudes towards older people with cognitive impairment in general; however, some variables were associated with negative attitudes, such as perceived higher prevalence of people with dementia on the ward, younger age of staff and working as an unregistered team member. They conclude that the attitudes of non-registered team members reflect greater exposure to challenging behaviours from providing the majority of personal care. In an English hospital, Norman (2006) observed that persons with dementia who were compliant and somewhat independent were regarded positively but that so-called 'difficult behaviours' led to negative attitudes among the team. Galvin et al. (2010) showed that targeted education improved attitudes towards older people with dementia in hospitals. Not only have staff been reported to have negative attitudes towards people with dementia but also co-patients and their relatives, family carers and even other disoriented patients felt negatively towards these people (Gladman et al., 2012). Overall, there is a small body of evidence in this area.

Challenges for people with dementia as an acute 'patient'

Despite what is known about the consequences of being in hospital, there are few studies that take into account the perspectives and experiences of people living with dementia when they become patients in hospital. Further, we found no real discussion of this omission in the published literature. However, it is likely to be the case that people are too ill when in hospital and the ethical issues around consent and mental capacity may deter many researchers from directly including people with dementia in research as tends to happen in other dementia care research (Dewing 2007, 2008). Cowdell (2010a, 2010b) in a rare exception details how people with dementia find their hospital stay difficult and sometimes disturbing. People described being ignored, and how they found the surroundings were noisy and busy. In contrast, Digby and Bloomer (2013) found in their study that general ward noise does not adversely affect people with dementia that much; however, it is notable that television noise and people calling out in the night were cited as problematic. Gladman et al. (2012) in an observational and interview study found that disruption from the usual home routine is the main problem for people and that as a consequence, there is a need to gain a sense of control to cope with the disruption to routine. More specifically, Norman (2006) observes that people with dementia attempt to exercise control over the treatment they receive. Thus, behaviours perceived as 'challenging' by hospital staff, such as shouting and resistiveness, could be related to attempts to communicate unmet needs.

Challenges for carers

Hospitalisation not only disrupts the established routine for the people admitted but also for families and carers. Hospital staff often assume that a hospital admission offers some respite for carers. In fact, a grounded theory study in an English NHS Trust by Jurgens et al. (2012) within medical and orthopaedic wards showed that hospital admission is not a respite but rather adds to carers' physical and emotional exhaustion, regardless of the quality of care received in hospital. Further, changes in the condition of the person with dementia were often perceived to be the result of poor hospital care. Carer expectations contrasted with the

busy task-focused atmosphere of the acute hospital ward. According to the authors, a 'cycle of discontent' builds up among carers that could be prevented by enhanced communication. Carers were rarely asked for information. Conversely, carers are not always provided with updates (Clissett et al., 2013). The findings suggest that events (or 'crises') are associated with expectations. When these are unmet, carers become uncertain or suspicious, leading to a period of 'hyper vigilant monitoring' during which carers seek out evidence of poor care, culminating in challenge, conflict with staff or withdrawal, which itself is a crisis. The cycle could be completed early during the admission pathway, and multiple cycles within a single admission were seen (Jurgens et al., 2012). Gladman et al. (2012) also note that the outcomes for family carers are mainly negative. Carers report being frustrated with a lack of basic amenities, such as chairs and refreshments and blamed staff and the NHS in general for what they perceived to be an inflexible system. In Australia, Digby and Bloomer (2013) note carers' dissatisfaction is associated with a lack of facilities rather than staff, such as a place for patients and visitors to spend time together. Carer needs and preferences are not always taken into account in the discharge process either (Bauer et al., 2011). These studies echo findings by the Alzheimer's Society (2009) that 77% of carers are dissatisfied with the quality of care in hospital. This dissatisfaction centres on recognising and understanding dementia; opportunities for activity and social interaction; involvement in decision-making and aspects of dignity and respect. The NHS Confederation (2010) list some recommendations from carers for better hospital care such as more flexible visiting times so carers can help with care, increasing involvement by carers, increasing awareness and having a dementia care lead or specialist. Several papers inform us that hospital staff acknowledge that information and input from families and carers would be useful, yet there is limited published evidence for strategies actually addressing this (Alzheimer's Society, 2009; Gladman et al., 2012; Moyle et al., 2010). This may be hampered by negative attitudes to carers: Gladman et al. (2012), for example, find that some staff thought carers to be demanding and disruptive.

Challenges for staff

Hospital staff are frequently reported to be challenged by behaviours such as agitation, resistance (non-compliance) to care, aggression, wandering and persistent calling out, from people with a cognitive impairment (Alzheimer's Society, 2009; Bateman, 2012; Gladman et al., 2012; Norman, 2006). Many staff feel that time pressures and staff shortages impact on their ability to deal with such behaviour and to meet the needs of all patients (Alzheimer's Society, 2009; Byers & France, 2008; Gladman et al., 2012; Nolan, 2007). Communication difficulties among teams were found to exacerbate these challenges (Chater & Hughes, 2012; Gladman et al., 2012). Feelings of frustration, stress, exhaustion and guilt have been reported to accompany these perceptions (Burgess & Page, 2003; Byers & France, 2008; Gladman et al., 2012). In a comparative study, Cocco, Gatti, de Mendonca Lima, and Camus (2003) showed that staff in acute wards experienced higher levels of stress and burnout than their nursing home counterparts. This may be because acute nurses in general hospitals are prepared, and probably more confident, to provide short-term care related to medical co-morbidities rather than complex on-going psychosocial care related to a condition such as dementia (Cowdell, 2010b). Indeed, several studies that focus on staff perspectives reveal that many nurses felt they did not have sufficient skills or education to care for people with dementia (Burgess & Page, 2003; Gandesha, Souza, Chaplin, & Hood,

2012; Moyle et al., 2010). Not mentioned in any other studies, Gladman et al. (2012) found that one of the main challenges for staff concerned handling disorientated people interfering with co-patients or their property. As a consequence, there was a pressure on doctors to prescribe sedation, especially at night, with a lower staff–patient ratio. Administering drugs to control perceived difficult behaviours has been common practice: the Alzheimer’s Society (2009) reports that 77% of nurses surveyed conveyed the use of antipsychotic drugs to treat people with dementia in hospitals, despite evidence of adverse or dangerous consequences (Banerjee, 2009; The NHS Confederation, 2012). Gladman et al. (2012) observe junior doctors come under pressure from nurses to prescribe sedatives for behaviour management. The Banerjee (2009) report highlights that doctors too often prescribe antipsychotics as a first-line response to manage challenging behaviours in people with dementia rather than advocate non-pharmacological approaches. Antipsychotics can increase some of the symptoms associated with dementia and also cause dizziness leading to falls and increased functional dependence. Dementia Action Alliance (2009) estimates that over 20%, or around 180,000 people, are currently being prescribed antipsychotic medication. The literature cites a number of service models that have enhanced or may improve the care of people with dementia in hospitals. These interventions range from volunteers and specialist roles, such as a liaison mental health nurse or teams, volunteers, to special care units and training and education. These are discussed in the next section.

Volunteers

Bateman (2012) trained a group of volunteers to provide person-centred support for people with dementia in an acute hospital. The outcomes were compared with a hospital without volunteers. Both staff and volunteers perceived positive outcomes: nursing staff experienced a reduction in workload pressure and volunteers enjoyed rewarding interactions with people admitted as patients. However, there were no significant differences in patient outcomes (including length of stay, falls, use of antipsychotic drugs and death rates) between the intervention and control hospitals. The author points out, however, that the intervention group had a much higher number of people with dementia, and therefore a higher number of people at risk. Gladman et al. (2012) mention that some staff they interviewed recalled a time when volunteers used to play a valued role; however they do not expand on why this was no longer so. Other than this, there is no evidence for the effectiveness of volunteers in this area of dementia care in terms of health outcomes. It is probably unreasonable to expect a volunteer role to be a solution to the complex needs of people with dementia when in hospital. However, considering the evidence that hospital staff feel they do not have enough time to meet such complex needs, a reduction (or perceived reduction) in workload burden for ward staff might lead to an enhanced focus on person-centred care.

Mental health liaison services/specialist roles

Despite it being a common practice in several countries, and a call by the Department of Health England (2009) for the commissioning of specialist liaison mental health teams for older people in hospitals, the role of the specialist nurse or liaison service is poorly documented and few recent published evaluations could be found. A literature review by Callaghan, Eales, Coates, and Bowers (2003) on liaison mental health services and a later review evaluation by Eales, Callaghan, and Johnson (2006) of this service fail to mention

older people and/or dementia at all. National Institute for Health and Clinical Excellence (2006) guidance states that acute trusts should have liaison teams from mental health services for consultation, training and assessment of those with suspected or known dementia. Yet, a comprehensive review and evaluation by Holmes et al. (2010) reiterates the lack of widespread, consistent and strategic liaison mental health services for older adults in the UK and a shortage of evidence on the effects (and effectiveness) of these provisions. The liaison role usually involves a Mental Health nurse/team 'in-reaching' into a general hospital service to give a range of interventions including specialist assessment, care planning, advice teaching and support to families/carers. Subsequently published summaries on liaison services report some benefits for people with dementia, such as increased referral rates for cognitive assessment, better detection and diagnosis, and greater staff confidence in caring for such patients (Atkinson & Mukaetova-Ladinska, 2012; Mukaetova-Ladinska et al., 2011; Tadros et al., 2013).

More worryingly, Holmes et al. (2010) demonstrate that nurses in this role tend to directly provide a crisis intervention service and are not significantly adding to upskilling within teams. Further, they find that management in both mental health and general hospitals tend to side step ownership and thus development of the specialist and liaison service. Some hospitals provide a multi-disciplinary team of specialists, although Holmes et al. (2010) point out that one of the main problems is that there is so much variation between the activities and services. This means the liaison team model is therefore difficult to generalise, replicate or evaluate. Such models are often established through projects funded on a short-term basis and are not embedded in the organisation and therefore not sustained. Despite the limited evidence base, Holmes et al. (2010) conclude their analysis suggesting that liaison mental health services have the potential to improve outcomes, despite that they are not properly set up and managed. Related to this they also found a wide range of different structures and staff skill-mix due to a lack of clarity and direction about service specifications and processes. Through practitioner-research, Boersma (2012) reveals some of the challenges of a 'lone' in-reaching mental health nurse, as a lack of understanding of dementia care by ward staff and poor communication between the mental health nurse and other teams would sometimes lead to differences in opinion about how dementia care should be achieved. As a result, the author believed the care received by patients was suboptimal and often felt frustrated and powerless in her attempt to achieve the best possible care for people with dementia. Elliot and Adams (2011) describe the outcomes of initiating a Dementia Care Nurse Specialist role in a district general hospital in the UK in accordance with the National Dementia Strategy. This one specialist nurse on average was involved in assessing 20–30 patients per month and another 18 who needed follow up. Elliot and Adams (2011) demonstrate a reduction on average of 2 bed days per patient totalling 720 saved bed days per year – not an insignificant financial saving. However in the longer term, the size of the population with dementia may mean that it is unlikely that one person with a dementia care remit can make a measurable and sustained difference (Griffiths, Bridges, & Sheldon, 2012). More significantly, the literature reveals no evidence that specialist roles contribute to upskilling of general staff. Indeed, there is a risk that such short-term specialist roles deskill general staff in the longer term. Law (2008) demonstrates that a specialist nurse needs to spend more time educating staff than direct time with patients if longer term outcomes are to be achieved. Overall, these roles remain poorly evaluated and a more rigorous evidence base is needed to support any longer term development of specialist and in-reach roles.

Special units/shared care

There is some evidence that specialised units such as ‘shared care wards’ have some positive outcomes for people with dementia (Nichols & Heller, 2002). However, they may not deliver everything that others expect of them. Zieschang et al. (2010) describe a special care unit within a larger acute unit in a German hospital. Within the unit, there is no through-traffic, the design resembles a living room and there is a focus on therapeutic interventions. This unit achieved a decline in falls and an improvement in daily function as shown through the Barthel Index, and lowered levels of referral to psychiatric services. There was also a reduction in challenging behaviours including wandering and forms of agitation and aggression. However, there was no overall reduction in length of stay (or cost). This is likely to be attributable to limitations in social care provision. Gonski and Moon (2012) report on a study in a multi-disciplinary behavioural unit. Some of the positive outcomes included low rates of falls and a lack of further injury. Again, there was no decrease in the average length of stay. This may have been related to discharge planning: the authors note that many people had to stay in the unit after their acute condition had improved because they had to wait for a placement in other care facilities. There is one example of a reported project in which several interventions were implemented across an organisation including a care pathway, a specialist post and a shared care ward (Upton, Krishnan, Bray, Owen, & Foote, 2012). This report recommends that a bundle or suite of interventions is needed and should include interventions to facilitate widespread cultural change in the organisation. Again, this project did not achieve any savings in relation to shorter lengths of stay or make any significant changes to discharge destinations. Based on our review, we suggest that specialist wards/units can enhance some aspects of the quality of care, reduce adverse consequences of hospitalisation but do not significantly impact on reducing length of stay; but neither do they add to it. This is a timely reminder that careful evaluation criteria for services and evaluation research studies are needed given that anecdotal evidence suggests that these wards/units are currently en vogue.

Education and learning

A lack of dementia care education has previously been cited as a major factor affecting the quality of care provided in hospitals (DH, 2009; Gladman et al., 2012; Leung & Todd, 2010; Wesson & Chapman, 2010). In the UK, this may derive from several factors including the dominance of medical needs in the acute setting, and the associated tendency of nurses to focus primarily on medical needs related care, along with poor dementia care related knowledge and skills (Lin, Hsieh, & Lin, 2012). Interestingly, results from the National Audit of Dementia Care (in General Hospitals) showed that doctors felt more adequately trained in dementia care than nurses and health care assistants, even though the latter two groups are most involved with direct care (Gandesha et al., 2012). There is an increasing amount of materials being developed on many different aspects of dementia care. However, their value and the outcomes they result in are usually not formally evaluated or published. As a result, the literature is short on examples of innovative learning programmes. Several studies do report on education programmes for hospital staff, for example, Banks et al. (2013), Burgess and Page (2003), Galvin et al. (2010), McPhail, Traynor, Wikström, Brown, and Quinn (2009), Waugh, Marland, Henderson, Robertson, and Wilson (2011) and Wesson and Chapman (2010). These authors report many positive outcomes, such as increased awareness of dementia, a positive shift in perceptions and attitudes towards people

with dementia, increased confidence in caring, better clinical and assessment skills, improved management, better communication between staff and relatives, better recognition of pain, a decrease in the use of sedatives and a better patient experience. However, not all of these evaluations looked at longer term outcomes or sustainability of education on practice. For example, Galvin et al. (2010) summarise the implementation and evaluation of an education programme targeted at nurses and other direct-care staff in four hospitals. Pre-and post-test questionnaires showed improvement in confidence, attitude and communication with families. A follow-up questionnaire after 120 days, however, showed a slight decline in knowledge at 3 of 4 hospitals and a significant loss of both knowledge and confidence at one hospital. Chater and Hughes (2012) also recommend experiential methods of teaching, with ways to relate to, and learn about the person with dementia, for example, by meeting a person 'living well' with dementia. In Scotland, two Dementia Champion programmes included meeting people with dementia outside of the hospital in the curriculum; an initiative that received a positive response from participants (Banks et al., 2013; Waugh et al., 2011). Cowdell (2010a) further recommends the engagement of staff on an emotional level in education and practice development strategies. In addition, Bezzant (2008), Cowdell (2010a, 2010b) warn that formal, knowledge-based education may not reflect in improved care and practice. This is supported by the recent findings in the Age UK Commission (2012) who recommend greater use of 'active learning' strategies and practice-based development programmes in the workplace and developing facilitators who can support this style of learning. Waugh et al. (2011), however, acknowledge that even if training programmes inspire the willingness to implement new ideas, it can be difficult to maintain new practices in the complex organisational cultures of hospitals. Hospital staff have to situate their experiential knowledge, values and beliefs in the context of the priorities, pressures and targets of the organisation (cf. Webster, 2011).

A focus on sustained action and culture transformation is therefore necessary for any dementia care education to have a lasting effect on practice and achieve a transformation of the care culture (Banks et al., 2013; Waugh et al., 2011). That the latter is challenging is evident from a reflexive study from a community mental health nurse who reported that communication with colleagues from other disciplines would sometimes break down based on conflicting views (Boersma, 2012). While Cowdell's (2010a) recommendation to engage staff on an emotion level may enhance care for people with dementia to some extent, Boersma's (2012) account also reveals that emotions, if not managed and charged by difference in opinion, can escalate into a situation whereby negative emotions affect staff, the ward culture and consequently, the care that is provided.

Discussion: Implications for research and practice

We need to situate the current focus on dementia care within a wider policy context (Care Quality Commission, 2013). Hilton (2010) argues that the National Dementia Strategy (England) is modelled on other similar failed strategies, and since neither mandatory nor fully funded, is likely to have little long-term impact. While this may seem a pessimistic position, the reality is that the ability to apply longer term practice and research solutions may need to be questioned especially if the current acute general hospital remains narrowly bio-medically driven. Harwood et al. (2010) argue there is an assumption that people are treated for defined acute medical or surgical problems with an ever increasingly short stay. Further, they state there is an assumption (promoted by UK governments and health care

commissioners) that non-acute problems will be managed elsewhere. In addition, economic constraints mean that finance and activity targets are adversely influencing health care practice (Clissett et al. 2013).

People with advanced dementia do not fit neatly, if at all, into these assumptions. Meanwhile, there is a small body of knowledge on what constitutes good care for older people with dementia in general hospitals, but the best way to deliver this within the existing acute medical services is still far from clear (Moyle et al., 2008; Royal College of Nursing, 2010). Approaches include improving the physical and psychosocial environment, improving attitudes to dementia and the understanding and management of behaviours of concern through enhancing staff knowledge and skills, access to or integrating mental health expertise with general nursing and partnerships with family carers.

However, as indicated by Holmes et al. (2010), rigorous evaluations of services that commissioners and providers seem to be advocating are lacking. Currently, there seems little to celebrate in the way of excellence in dementia care in the general hospital. Part of the issue here maybe that much of the research to date seems to capture existing poor practice and little research seeks out good practice. Connected to this, evaluation studies are usually small scale making it difficult to compare outcomes across studies as they are often methodologically different. Clearly, longer term and larger scale studies are needed. In summary, this review suggests that overall there remains negative consequences and outcomes for people with dementia and families or carers when they go to general hospitals. The acute hospital environment, both physical and psychosocial, is difficult for people with any degree of cognitive impairment. As a result, the experience is challenging for people with dementia who often respond by attempting to gain some control over the situation. This may lead to behaviours perceived as challenging by staff, who then often find it difficult to care for people with dementia and their care partners. As Age UK state, looking after older people is not simply a matter of common sense and sympathy as the older person is far more likely to be experiencing problems from a range of medical conditions (2012: 37); thus, we need to significantly invest in learning and development and not quick fix, low level training. Additionally, findings from recent reports such as The Francis Report (2013) suggest a culture that de-value people with dementia. Ward cultures are mainly task-focused and person-centred care may go at the expense of meeting targets such as shortening lengths of stay and risk management. Some individuals do provide care that is in part person-centred but this is not a widespread or consistent practice of caring for people with dementia in hospital, despite evidence of its benefits in other care settings. Interventions that have been suggested to be useful include the use of volunteers, mental health liaison services, shared care models and education. There is some evidence that these interventions are helpful but there is too little evidence for some of these models (mental health liaison). Thus, it is worrying how much these models are being relied on as solutions in the current health care response to the dementia care challenge. A focus on long-term sustainable action and culture change is necessary to transform the hospital cultures of care into one that is person-centred and where people with dementia are respected, valued and treated with dignity and receive high-quality treatment for their medical needs and do not negatively impact on the dementia. There seems to be too much emphasis on theoretical modelling especially in nursing and we argue there is a need to shift the research emphasis to testing of models or bundles of interventions in practice. Moyle et al. (2008) suggested models of care aim to improve outcomes for the patient, their family, staff and the organisation.

Since then, subsequent literature continues to focus on theorising about more possible models even though the underlying themes are similar. Research, urgently, needs to focus equally on the systematic testing including evaluation of different models for organising service delivery and providing care for people with dementia in acute hospital settings. Finally, based on the evidence in this review of the low level and inconsistency in person-centred care in acute settings we probably do need to ask: is person-centred care possible in our current busy acute care general hospital settings?

Conclusion

Most contemporary strategies are limited by the focus on prioritisation of service activity including throughput and length of stay targets; plus the tension between responding to acute care for existing co-morbidities and person-centred dementia care. This is further complicated by insufficient understanding of what constitutes person-centred care in an acute care context and a lack of the requisite knowledge and skills set in many health care practitioners. The review also reveals a worrying lack of evidence for the effectiveness of mental health liaison posts and dementia care specialist posts in nursing. Finally, these roles and specialist units/shared care wards can enhance quality of care and reduce adverse consequences of hospitalisation, they do not significantly impact on reducing length of stay or the cost of care. We find little evidence in the literature that any of these recommendations have been effectively realised in England or elsewhere to date. This current state is indeed precarious and is not a good foundation for future planning.

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