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Nurses experiences of delivering acute orthopaedic care to patients with dementia

**Running title:** Nurses experiences of acute dementia care

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Abstract
Nurses who care for acute patients with dementia in a hospital setting report a variety of challenges in regard to meeting the complex needs of their patients. In particular, known barriers to optimal care include: a lack of knowledge about dementia, lack of dementia-friendly acute clinical environments, lack of time to care for the individual patient, and a prioritised focus on the medical issues that triggered the hospitalisation. Research to date has not specifically focused on nurses’ experiences of caring for people with dementia in orthopaedic wards.

Aim: This study investigates nurses’ experiences of caring for people with dementia, in an acute orthopaedic hospital ward setting.

Methods: This qualitative study employs hermeneutic phenomenological research methods. Eight Danish nurses were interviewed in an orthopaedic ward about their experiences in caring for orthopaedic patients with dementia. Nurses with various levels of expertise were selected for interview so that a full range of nursing experiences could inform the research study.

Results: The results of the study revealed two major themes: “Nurse communication and patient information” and “Care compromise”, with three and four sub-themes, respectively. These
findings are used to illustrate how, and why, nurses’ experiences of caring for patients with dementia contribute a discontentment and negative preconceived perception by some nurses towards their acute care of patients with chronic dementia. The results are discussed in the context of Interactional Nursing Practice theory, and describe the challenges experienced by acute care orthopaedic nurses who care for patients with dementia.

Conclusion: Orthopaedic nurses find it challenging and professionally difficult to provide person-centred care for patients with dementia during an acute orthopaedic hospital admission.

Summary statement of implications for practice

What does this research add to existing knowledge in gerontology?

- Electronic patient records do not convey sufficient relevant information for the complex combination care requirements for acute orthopaedic care and chronic dementia care.
- The allocation of nursing workload of patients with dementia in the orthopaedic clinical setting based on criteria such as nurse personality and sentiment may be at odds to allocation based on clinical competence, safety and quality criteria.
- Orthopaedic nurses exhibited an unspoken and invisible division of work allocation between those nurses who excelled and those who defined themselves as novices regarding dementia care in the acute setting.

What are the implications of this new knowledge for nursing care with older people?

- Person-centred care can be enhanced if the pre-conceived ideas and frustrations about dementia care in the acute orthopaedic care setting can be openly discussed in the clinical environment within a non-judgemental context.
- The findings of this study have implications for hospital managers about how to reduce healthcare workforce stigma towards nurses who care for people with dementia. Enabling an open and authentic dialogue about the complexities and nuances involved in dementia care within the orthopaedic setting will enhance problem solving capacity, quality and safety in the recovery phase.
How could the findings be used to influence policy or practice or research or education?

- Improving effective documentation in electronic patient records to include dementia-friendly practical information will enhance the hospitalised acute care experiences for people with dementia.
- False and stigmatised pre-conceptions held by nurses and other health care professionals about people with dementia in the acute orthopaedic care setting should be the focus of workforce integrated learning for both graduate and undergraduate nurses in the future.

Introduction

Individuals with dementia, their families, and society generally experience the negative disruption to the personal practicalities of independent lifestyle in the context of an unplanned hospitalisation for an acute condition (Alzheimer’s Society, 2014). Over the last decade dementia awareness has grown to prominence in the public domain with wider focus across political, societal and health sectors. It is estimated that 47.5 million people worldwide are currently affected by dementia, with forecasts that this figure is expected to double by 2030 (WHO, 2012). The same proportions apply in Denmark, where an increase of people with dementia is expected to double by 2025 (Demenshandlingsplan 2025, 2017). The UK’s 2009 Alzheimer Society report documented the economic and personal impacts associated with acute care hospitalisation of people with dementia. In it, they also recognised the self-reports of acute care clinicians who suggested that they were under-prepared to care for patients with dementia in the acute hospital setting.

The complexity of caring for people with dual chronic and acute conditions simultaneously conflicts with the traditional medically organised systems approach to care delivery. One recent systematic literature review provides some guidance about suitable care delivery for older people with dementia during episodes of general hospital admissions (Dewing & Dijk, 2016). In it they describe a number of characteristics that frame the hospitalised experience for patients with dementia and of the nursing staff working to assist them in the acute ward setting, such as: the health care environment, cultures of care, staff attitudes, the contribution of volunteers, varied service models in-hospital care, and challenges for people with dementia, their carers, and health care staff (Dewing & Dijk, 2016).
Initiatives such as Dementia Action Alliances, with a Dementia-Friendly Hospital Charter (Dementia Action Alliance, 2015), have assisted hospitals to transform their services so that patients with dementia receive similar service access and quality to their non-dementia counterparts (OECD, 2015). A recent dementia audit across UK hospitals showed some progress has occurred, however considerable further improvement remains necessary (Royal College of Psychiatrists, 2017).

The term ‘dementia’ incorporates a number of chronic forms of dementia, such as; Alzheimer’s diseases, vascular dementia, frontal-temporal dementia and Lewy body dementia. Studies have shown that a significant number of patients with dementia who are admitted to hospital, also have a superimposed delirium, underscoring the importance of screening for delirium in caring for a patient with dementia in the acute setting (Reynish, 2017). The similar symptomology between some elements of dementia and delirium can make it difficult to distinguish between these two conditions; however, a critical taxonomic aspect is that recovery from an episode of delirium is likely if the underlying cause(s) are treated.

There is a high prevalence for orthopaedic hip and femur fracture among people with dementia. Some studies have reported that as many as 42% of patients can be expected to have dementia with only half diagnosed with dementia prior to admission (Sampson, Blanchard, Jones, Tookman, & King, 2009). A Danish study investigated all hospital admissions for a column fracture of the femur over the course of a year and revealed 19.2 % of the admissions either had a diagnosis of Alzheimer disease or received a medication from the NO6 psychoanaleptics (NO6-psychoanaleptics, 2018) group of drugs for the management of dementia symptoms (Jensen-Dahm, 2016). People with dementia are three times more likely than other citizens to be hospitalised for hip fracture (Baker, Cook, Arrighi, & Bullock, 2010). Thus, the significance of undertaking research about the experiences of people with dementia in acute orthopaedic care settings is particularly relevant, if the quality of health care experiences, and the effectiveness of service delivery, is to improve for this specific group of patients.

The acute trajectory of a hospital admission for a person with dementia, following a hip fracture, together with the likely possibility of discomfort related to uncontrolled pain, and/or distress related to the possible development of delirium, leads to a requirement for complex clinical care management by health professionals. Hip fractures are associated with severe pre and post-
operative pain (Foss, Kristensen, & Palm, 2009), and the use of opioid-based medication for patients with dementia has been shown to be lower during hospitalisation compared with patients without dementia (Jensen-Dahm, Palm, Gasse, Dahl, & Waldemar, 2016; Morrison and Siu, 2000). Whereas, insufficient pain relief, or untreated pain, increases the risk for lengthy hospital stays, reduced mobilization and superimposed delirium (Morrison & Siu, 2000).

The significance of this study is the investigation of the admission of patients with Alzheimer’s disease to an orthopaedic ward following fall incidents resulting in an orthopaedic injury, because this group of patients’ is expected to increase in the near future. The focus will include the clinical experiences of nursing staff who deliver care to patients with dementia in acute an orthopaedic setting.

**Background**

In general, patients with dementia are more vulnerable than patients without dementia during an acute care hospital admission. They are more likely to experience pain, thirst, fear and over-stimulation, partly due to a difficulty in communication with the staff (Bridges & Wilkinson, 2011). There is evidence to suggest that health professionals often fail to interpret the nonverbal communication cues to adequately meet the needs of acute care patients with dementia, and this group of patients with dementia-related cognitive impairment often experience heightened distress, fear and are unable to verbalise their needs effectively (Dewing, 2009; Heath, Sturdy, & Wilcock, 2010; McCorkell et al., 2017). Additionally, health professionals are noted to misinterpret agitation by the patient with dementia as a disruptive behaviour, rather than a means of communicating pain or thirst (Elliot and Adams, 2011).

Similarly, Kang, Moyle, and Venturato (2011) recognised that the holistic needs of patients with dementia are frequently overlooked in the acute care setting because the somatic condition that resulted in acute hospital admission is prioritised as the main focus for care. This has also been linked to the lack of attention by managers in health care organisations about the synthesis of holistic care of patients with dementia (Care Quality Commission, 2013). This critique shows that patients with dementia generally do not receive care that demonstrates their person-centred value and emotional well-being in the acute hospital setting (Cowdell, 2010a, 2010b).
Acute hospital environments are generally not purposely designed for patients with dementia. Impersonal and busy hospital wards can be difficult contexts for patients with dementia to interpret and navigate if they are unfamiliar with the setting, staff and routines within them (Moyle et al., 2008; Nolan, 2007; McCorkell, 2017). However, the challenging setting and circumstance can be alleviated with some practical measures such as, improving lighting and signage, ensuring purposeful activity opportunities exist and the provision of personal objects can contribute positively to the hospital stay (Keenan et al., 2011; Moyle et al., 2008). Edvardsson, Sandman, and Rasmussen (2011) point out that good hospital design alone is not a solution for creating dementia friendly hospitals, noting that the contribution of a visible presence of a warmly engaged and friendly staff in the acute care setting also contributes to a positive practical impact for patients with dementia, and helps them to feel a sense of ease, as if they were in a home-like environment. While McCorkell et al., (2017) suggests that nurses have an important role in the harnessing and inclusion of information collected from the patient’s family about the patient’s usual routines for hygiene, meals, calming influences and agitation triggers as well as dislikes, discomfort and pain behaviours. These can be communicated to the health care team in the form of a dementia-friendly toolkit to equip health care professionals, families and the patient to achieve optimal care outcomes (McCorkell et al., 2017).

The results of a Korean survey determined that the negative sentiment of nurses towards patients with dementia adversely influences the delivery of quality care within the acute setting. Nurses who held positive attitudes towards people with dementia were linked to positive care experiences for patients (Kang et al., 2011). Nurses on medical wards demonstrated a propensity for more positive attitudes towards caring for patients with dementia when compared to nurses working in surgical wards (Kang et al., 2011). A Japanese study was able to link the negative attitudes by nurses towards patients with dementia with the higher administration levels of pro re nata sedatives, or the use of physical restraint in this patient group (Nakahira, Moyle, Creedy, and Hitomi., 2009).

Norman (2006) conducted a Grounded Theory study and found that where patients exhibit behaviours that nurses interpret as “difficult behaviours”, this leads to the formation of negative attitudes among the nurses towards this group of patients. Nurses caring for patients with dementia within the acute setting frequently report managing patients with dementia behaviours
such as calling out, agitation, wandering and non-compliance during the administration of nursing care generally as challenging (Alzheimer’s Society, 2009; Bateman, 2012; Gladman et al., 2012). Nurses report a lack of competence and insufficient health service resources, such as, time allocation and staff ratios to deliver suitable care for this subgroup of patients (Alzheimer’s Society, 2009). This results in expression of frustration, guilt and exhaustion among acute care nurses who are frequently involved in caring for patients with dementia (Burgess & Page, 2003; Byers & France, 2008; Gladman et al., 2012).

Lastly, a wide array of education programmes for nurses involved in acute dementia care have succeeded with a range of positive clinical outcomes, raising the awareness of dementia and encouraging a positive shift in perceptions and attitudes towards patients with dementia (Banks et al., 2013; Wesson and Chapman, 2010; Anthony et al. 2016; McCorkell et al., 2017). Thus, while it has been established that nurses’ negative perceptions about people with dementia results in poor person-centred care for people with dementia, these attitudes are amenable to change through education, adequate staffing and sufficient time to deliver care to people with dementia.

Nurse-to-patient ratios have been investigated in several studies and found to be important; with a low patient-to-nurse ratio contributing to some of the challenges in the acute care of people with dementia (Alzheimer’s Society, 2009; Byers & France, 2008; Gladman et al., 2012). The notion that a doubling of staffing results in twice-as-good care in acute dementia care has been challenged by Edvardsson et al. (2011), because these ideas are based on nursing staff focusing on tasks, rather than meaningful and necessary interactions as a mediator for successful patient care of people with dementia. Cowdell (2010a, 2010b) concluded that the culture of care in a hospital is usually focused on physical needs, reducing the patient to an “object of care” and resulting in a minimal interaction dynamic that is insufficient alone to adequately support the person-centred recovery experience for the patient with dementia. The standardised care regime adhered to in acute hospitals led Clissett (2013) to observe that many opportunities are overlooked and missed and fail to provide person-centred care for people with dementia.

There is some evidence to support the notion that a managerial focus on financial and productivity targets negatively influence the capacity of nurses to conduct person-centred dementia care in the acute care setting (Clissett et al. (2013). The flow of information about individual patient needs
and preferences, has been stressed as an important aspect in caring for people with dementia in the acute clinical setting (McCorkell et al., 2017), but where health and well-being communication and documentation are poorly implemented in the clinical setting, then this exacerbates the challenges that are experienced for nurses, and for patients with dementia (Chater & Hughes, 2012; Gladman et al., 2012).

Houghton et al., (2016) conducted a qualitative evidence synthesis investigating nurses’ experiences of caring for people with dementia in the acute setting. Their study used the VIPS framework developed by Brooker and Latham (2016) to guide the synthesis of evidence (Brooker & Latham, 2016), and is designed to assist care providers at all levels to deliver person-centred care. VIPS is an acronym for the four following attributes: Values people, Individual’s needs, Perspective of service user and Supportive social psychology. The results of the Houghton et al., (2016) analysis reveals the following sub-themes that describe nurses’ experiences of caring for people with dementia in the acute setting. In particular, the pathways of care; culture of care; pieces of the puzzle; barriers to person-centred care; interactions and impact on other patients; the built environment; forming relationships; and, family involvement (Houghton et al., 2016). The study identified areas policymakers should act on to improve the experiences of hospitalisation of people with dementia including the ineffective pathways of care, unsuitable environments, inadequate resources and staffing levels with a lack of emphasis on education and training, that exist in some acute settings at present. The review emphasised the need for a managerial commitment to instilling a person-centred set of values in the organisation, in order to achieve the end goal of improving hospital stays for patients with dementia (Houghton, Murphy, Brooker, & Casey, 2016).

In parallel to Houghton et al., (2016), Moonga and Likupe (2016) conducted a literature review to explore nurses’ experiences of caring for people with dementia in orthopaedic wards (Moonga & Likupe, 2016). They found 14 relevant articles about caring for patients with dementia in the acute setting, none of which described care on an orthopaedic ward. Focusing more specifically on caregiver experiences in the acute setting, Moonga & Likupe (2016) found the following dominant themes: challenging behaviour and unsuitable care environment; lack of education on dementia; strain from nursing patients with dementia; and, ethical dilemmas arising from caring for people with dementia. The findings described by Moonga et al. (2016) and Houghton et al. (2016) are
compatible and suggest that while there is a general understanding of the challenges experienced by nurses in acute dementia care based in medical care wards. However, there remains a paucity of knowledge specifically about the experiences of nurses who care for people with dementia following orthopaedic surgery.

Aim
The aim of this study is to investigate nurses’ experiences of caring for people with dementia, who are recovering from an orthopaedic surgery in an acute orthopaedic hospital ward setting.

Method
Qualitative interviews were conducted to capture orthopaedic nurses’ experiences of caring for patients with dementia in an acute clinical setting. A phenomenological-hermeneutic approach, inspired by Ricoeur’s theory of narrative interpretation, was used for data analysis because this technique enabled the researchers to distil the most meaningful aspects of the phenomenon under investigation (Ricoeur, 1976; Dreyer & Pedersen, 2009).

A hip fracture unit within an orthopaedic ward of an acute hospital in Denmark was selected as the recruitment site for the study. Specifically, the unit consisted of two four-bed, and five single-bed rooms, with a total of 13 beds at its disposal. Staff involved in caring for the patients consisted of nurses and social and healthcare assistants (SOSA) trained to European Qualifications Framework (EQF) levels 6 and 4, respectively (European Union, 2017). The SOSA para-profession in Denmark is a assistants in nursing who have obtained a nursing qualification and practice under the supervision of a registered nurse. For the purpose of clear communication in this paper, registered nurses, nurse managers and SOSA’s are collectively referred to as nurses, because it is the experiences of all of these types of nurses that is relevant to addressing the topic under investigation.

Participants
The nurses invited to the group interviews were purposefully selected because they were identified as frequently involved in caring for patients with dementia during the previous patient observational study (XXX., 20XX). Therefore, the number of nurses with relevant experiences for this study are few, however their experiences provide rich data relevant to the topic under investigation. While the interviewer for the qualitative group interviews was not a part of the
management, medical or nursing staff for the ward, the nurses were well acquainted with the interviewer following the preceding observation research phase.

Prior to invitation and selection of participants for the group interviews, the ward manager was contacted to request permission to interview four nurses, two SOSAs, the head nurse and the leader nurse, thus eight nurse participants in total. The request was granted, and all invited nurses willingly accepted and participated in the group interviews.

**Ethical considerations**
The head nurse of the orthopaedic ward where the study took place, informed potential participants about this study together with information in the form of a flyer posted on the noticeboard in the staff room, and at the nursing station. The flyer contained information about the research participant rights and made explicit an option to withdraw from the study without prejudice at any time.

Anonymity was ensured for the participants, and data recordings/field nodes, and the subsequently transcribed interviews, were stored in accordance with Danish Data Protection Agency guidelines (Danish Data Protection Agency, 2017). The study had obtained approval from all relevant authorities in relation to Danish law on ethics and data protection.

**Data collection**
The nurse participants agreed to be interviewed in small-paired groups, resulting in two groups of two nurses, one group of two SOSA’s, and one group containing the two nurse managers. The paired approach was convenient because it enabled the participants to attend the interview that corresponded with their work schedule and ensured that the least possible disruption to workflow occurred in the clinical setting. Qualitative open-ended interviews was used for understanding the real-life experiences and the personally constructed meanings people develop to make sense of their world, in this case their work-life, and the experiences and meanings the nurses have derived from a specific clinical setting. Participants were provided with information about the study, reminded of their right to withdraw without prejudice at any time, and given the opportunity to ask any questions prior to providing consent before the interviews began. The first author of this article conducted the interviews.
An opening question was used to facilitate a dialogue (Kvale, 1996) inviting the nurses to raise any experiences of caring for patients with dementia that they would like to talk about. The opening question was as follows; “What can you tell me about your experiences of caring for patients with dementia while working in an orthopaedic ward?” The remainder of the interview was conducted as a conversation where the interviewer ensured that all participants had the opportunity to openly express their opinions without any value judgments imposed upon them. Nurses were asked to limit their comments to instances they were certain included a patient with dementia, in an attempt to eliminate nurses’ experiences of patients who may have only had delirium, or other cognitive or psychiatric conditions. The interviews were performed in a quiet and private room in the orthopaedic ward setting for the study. Interviews were held either before or at the beginning of the nurse’s regular shift for the convenience of the participants, and with the agreement of hospital management. Interviews were digitally recorded and transcribed verbatim after the interview.

**Data analysis**

The analysis consisted of iterative phases of analysis: a naïve reading, structural analysis and a critical interpretation and discussion (Ricoeur, 1976; Dreyer & Pedersen, 2009). Data was imported into NVivo 11 to assist with accurately handling large quantities of text generated from the group interviews (NVivo 11).

The naïve reading of the text data allows the reader to become acquainted with the raw text, and generate a first impression about what the text is conveying about caring for patients with dementia according to Ricoeur (1976).

During the structural analysis phase, direct quotes from the text constitute units of meaning, that when grouped together, form units of significance. The concise wording of the units of significance summarise commonality across multiple data quotes, and carry forward to form the basis for the generation of themes and sub-themes, as a preliminary result in the analytic process. This is a cyclical process involving multiple readings of the whole data material, and reviewing the results with the co-investigators several times (Dreyer & Pedersen, 2009). The interpretation is represented by the development of themes and sub-themes that were derived and further analysed during subsequent critical interpretation and discussion (Pedersen, 1999).
To strengthen the integrity interview data was read and discussed by all in the research team. The first author conducted the primary structural analysis.

**Theoretical frameworks**

A combination of theoretical frames was selected to examine the findings of this study. Firstly, Kitwood’s (1997) perspectives about person-centred care suggest that a focus on the individual with recognition of personal values, choices, preferences in life, and needs are central, rather than the routines and tasks that are prioritised in an acute hospital ward setting (Kitwood, 1997).

Secondly, the VIPS framework was selected because it was developed specifically as a guide to implementing the concept of person-centered care settings where a person has dementia (Brooker & Latham, 2016). The use of Kitwood and VIP theories translates the nurses’ experiences of a holistic approach to caring and enables exploration of a narrative that prioritises the person (or the patient).

Lastly, to better understand the elements of caring from a nursing perspective, we selected the Scheel et al., Interactional Nursing Practice theory to consider the findings (Scheel, Pedersen, & Rosenkrands, 2008). Scheel et al., (2008) used Haberma’s (1981) model for interpreting forms of knowledge: cognitive-instrumental, aesthetic-expressive and moral-practical knowledge, to underpin an interactional nursing practice theory and this enabled us to derive knowledge from the experiences of nurses’ who provide direct clinical acute care to people with dementia. Scheel et al., (2008) suggests that cognitive-instrumental actions are proactive, interventional and problem-solving strategies, while the aesthetic-expressive actions deal with self-reflection, self-understanding and self-interpretation together with an understanding of the environment. The moral-practical modes of action deal with a nurses’ sensitivity towards the ethical challenges, and knowledge of ethical norms. These aspects of knowledge are applied to understanding nursing praxis as it occurs within real-life clinical experiences of nurses where they make practical meaning in the clinical setting of rigid hospital pathways. Interactional Nursing Practice is concerned with how nurses’ personal experiences of adapting to a particular individual caring situation, by involving the patient, relatives and colleagues in decision making about any given applied practical care situation assists them in their work roles (Scheel et al., 2008). Interactional Nursing Practice theory (Scheel et al., 2008) is therefore complimentary to both the Kitwood (1997) and the VIP
framework (Brooker & Latham, 2016) with concepts about person-centeredness and individualised care, specifically for people with dementia and understanding the nurses’ experiences who care for them. Combined, these frameworks form a cohesive and tailored comprehensive theoretical framework that is ideally suited for interrogating the data in this study, and proposing findings relevant to the topic under investigation.

Results
Eight nurses from an orthopaedic ward of a Danish hospital were selected and agreed to participate in qualitative semi-structured small groups interviews with the purpose to understand their perspectives about caring for people with dementia in the acute orthopaedic care setting. A profile of study participants is located in Table 1 and outlines information about the category of nursing role, gender, year of graduation, and years of employment in the orthopaedic ward. Participants were all employees in permanent nursing positions at the hospital study site. The participants were interviewed in pairs resulting in four Small Group Interviews (SGI). The average length of the interviews lasted 49 minutes.

Naive reading
The naive reading phase of the analysis process revealed mixed perspectives with nurses identifying with both difficult and rewarding clinical experiences in regard to caring for patients with dementia. The difficult aspects arose from insufficient time allocation to carry out the complex dimensions of care required by a person with dementia in an acute care setting. However, nurses’ sense of personal satisfaction increased when they felt they had gathered more knowledge, competence and prior clinical experience in caring for people with dementia generally.

The range of opinion was polarised among the nurse participants with some of the view that adequate dementia care could adequately be integrated within the acute care setting. However, others considered that it would be impossible to create a dementia-friendly experience in an acute care setting. The diversity of views about the suitability of the acute care environment for people with dementia suggests that nurses who have enough time, and a background of knowledge and practical experience in caring for people with dementia are able to adapt these skills and apply them in the acute context. These attributes are necessary components to achieve a satisfying
experience as compassionate and safe care providers for the nurses, and for a safe recovery experience for the patient with dementia.

Structural analysis
During the structural analytical phase, the following major two themes emerged: “Nurse communication and patient information”, and “Care compromise”. Table 2, presents the themes and corresponding sub-themes, and the following sections report the study results in relation to these themes and sub-themes. Data excerpts are presented from each of the four small group interviews (SGI1; SGI2; SGI3 and SGI4).

Nurse communication and patient information
The first theme to arise from the data describes the directions of information and communication flow as the nurse participants described them. They identified difficulties integrating the rigid electronic patient record algorithm with the complex holistic needs of a patient with both chronic and acute conditions, in the context of a busy hospital ward, where the acute physical health needs of the patients are prioritised ahead of the chronic conditions that pre-exist the acute condition.

Drowning in the electronic patient record
The analysis showed that the electronic patient record system used in the orthopaedic setting does not accommodate sufficient information, tailored care plans or contemptuous information about the current care needs for patients with dementia. The chronological and quantitative nature of recording and reading patient data in an acute short-stay ward is counter-intuitive to the usual business and operation of the acute care setting for people with dementia. The workplace culture reinforces a rapid and specific communication style, which primarily aims to succinctly relay specific markers of recovery and deterioration related to physical health conditions. This context in which documentation of patient status occurs inadvertently forms a barrier to the rich description of the other important patient information that is of particular relevance to the best care provision for patients with dementia. Nurse participants in this study referred to “reading up on a patient” (SGI2), as a process of scanning and scrolling back through the chronological listed data in the electronic patient record for the purpose of gaining an overview of information pertaining to the immediate needs for caring for the patient. In the event of a lengthy patient stay,
relevant information that may have been entered at the beginning of the admission period, may be missed later in the stay due to the nature of the computer program which requires copious page views to revise a full patient history, and thus tends not to be read at a later point by future staff. Participant’s referred to this process as:

... information drowning in the electronic patient record (SGI3).

Nurses in this study reported that it is usual to commence every shift by reading the electronic documentation to obtain the most relevant contemptuous information about patients’ status and care needs, so that nursing planning and care management can be undertaken to progress patient recovery during that shift. In the instance of caring for people with dementia in the acute orthopaedic setting, this can be challenging, because richer description of care dynamics and responses are harder to convey in text forms, with the need for more time requirements for the commencing shift staff to read and comprehend the patient information. To counteract the difficulty of locating and comprehending information in the electronic patient record, nurses used a work-around strategy of oral dissemination about caring for the patient to supplement the electronic patient record, despite no time allocation within the usual work routine to undertake this activity. Alternatively, participants reported writing ad hoc pertinent information about the patients with dementia on paper-based notes and physically carrying these in their pockets for quick reference during their shift to guide the nurse about particular person-specific intricacies, as a ‘better than nothing’ strategy. Thus, willing nurses solved the problem with a work-around strategy to supplement the less than adequate usual practice by modifying the communication methods and tailoring them to specific patient, despite a lack of organisational support to do so.

This practice relies on the goodwill of nurses, rather than the sound policy of nursing management. The following excerpt from the data illustrates the tension about the inadequacy of the electronic patient record to capture all the necessary components of the nursing process:

You report your observations about standardised caring tasks, without getting a prompt in your (electronic patient record) documentation, if the standard trajectory proves difficult (SGI3).

As an alternative, nurse participants suggested that an electronic patient record system based on inclusion of “areas of concern in care” (SGI3) would assist nurses and other health care
professionals to find information of relevance for patients with dementia in the acute orthopaedic clinical setting.

**Somatic priority**

According to the participants in this study, nursing care for a patient with dementia in an acute hospital setting was associated with a conflict between treatment orientated tasks aligned with standardised care pathways, rather than a tailored holistic person-centred approach to care, as demonstrated in the following quote from the data:

*The priority is on giving the patient the right medication... if they get their coffee with or without sugar... that is not important* (SGI1).

While physical recovery goals are not improper; participants noted that a prioritised goal of orthopaedic recovery outweighed holistic well-being, and compromised the capacity of nurses, and the hospital, to provide the best possible quality care for people with dementia. Participants described a hierarchal cascade of care priority commencing with a primary focus on the patient’s recovery following surgery, and closely followed by other medical complications the patient had before the admission. All other aspects of care related to relief of distress, confusion and promotion of psychological comfort in relation to the patient with dementia were considered secondary to core care. Nurses in the study indicated that a specific clinical knowledge about differential dementia diagnoses was not considered important, despite the presentation of complex clinical care circumstances represented in providing quality nursing care to people with dementia. Nurse participants noted that it is “*nice to know information*” (SGI1) in relation to the nursing management of a person with dementia, but even so, nurses in the orthopaedic ward are not inclined towards additional effort, beyond their usual clinical routines, to seek extra information that might serve to better support the care of the person with dementia in an acute orthopaedic ward.

Nurse participants varied in regard to their levels of understanding of and/or interest in the psychosocial aspects of care related to people dementia. Interestingly, even those who deemed it of little importance in the acute orthopaedic context were able to provide examples of care situations where paying attention to the psychosocial needs of the patients with dementia was applied successfully to enhance the person-centred care of the orthopaedic patient.
Nurses reported examples of strategies they used and believed had been successful such as calming techniques by playing along in the way the patient understands the world, instead of confronting the patient with reality:

_Telling them that there is someone that is taking care of the children at home, even though we know that the children are adults now. ... it is a solution (SGI1)._  

In this way, the nurses felt that they were able to manage the short-term discomforts of the patient for the duration of the nursing shift or across the anticipated short-stay. They considered it was unnecessary to explore the patient history, their triggers and behaviours related to expression of discomfort, anxiety or cognitive confusion as the following data excerpt indicates:

_We do not need to put all that effort into getting to know the patients, because the nursing home patients are hopefully home again in two days (SGI1)._  

On the other hand, participants recognised that information about the patient’s life history was highly prized by nurses as something that would help them in caring for the patient, and it was also a source of frustration if the life history was not available for the patient. However, it seemed that the work culture of the orthopaedic ward precluded nurses from collecting organised and helpful information, and so it was gathered in an ad hoc manner with a just-enough, and just-in-time approach to the psycho-social aspects of person-centred care. This leads to point-of-care communication stress between the nurse and the patient where questions require logical answers and instructions need to be followed to complete personal care or treatment administration tasks, as the following quote indicates:

_We stress them with all our questions. They cannot take it... and get angry in different ways (SGI4)._  

The quote expresses how an otherwise ordinary patient-nurse exchange can become complicated if the patient is not able to cooperate to the extent anticipated by the nurse, and in the context of a busy ward, where physical care is the main focus. Further frustrations by the nurse participants were evident in the data where they indicated that all nurses should be able to administer basic competent care for people with dementia, yet failed to complete basic nursing care in this regard. There was a view that all nurses will have undertaken educational training to do so at all levels of
the nursing profession, thus nurses accused each other of poor general communication skills, if information had not been obtained and passed on to others, in the type and quality perceived as helpful, despite the lack of workplace organisational structure to support the information collection and exchange. A culture of blame, together with ambiguity about the type of information required to promote person-centred clinical care reinforces a stigma about nurses’ preparedness to care for people with dementia.

A stigma was apparent where the psychosocial aspects of dementia care were perceived as lesser priorities and more suitable for “nursing home activities” by some nurses; however, in contrast other nurses described their preparedness and attention to the psychosocial care of patients with dementia as a core feature, but still considered it as something extraordinary compared to the usual workplace culture of the orthopaedic acute care setting.

**Hospital environment**

Nurses in this study were adamant that the physical environment of the orthopaedic ward was sub-optimal for the patient with dementia. The ward environment contains busy thoroughfare corridors containing high volumes of foot traffic and equipment transport, generating noise and creating a confusing unfamiliar physical environment for any patients who experience cognitive compromise. The new environment is stressful for the patient with dementia, and one way that the participants reported alleviating this stress was a ward-based prioritisation for patients with dementia to be cared for in a single-bed room, so they are not further disturbed by the care activities and presence of other patients. Broader reflections about suitable environments were also mentioned, such as:

*The best scenario for a patient with dementia would be if they went straight home from the operating table (SG1)*.

The nurses acknowledged that it is not ideal for the patient with dementia to be admitted to the orthopaedic ward, but also recognised the need for a patient with dementia to recover after an operation in some form of acute post-surgical hospital environment, with access to specialist somatic recovery care. An attempt to accelerate care in hospital was described as a useful strategy for patients with dementia but also represented a challenge because the intensity of the strategy required ‘too much, too soon’ of patients. Meanwhile, lengthy hospital stays for people with
dementia in the stressful hospital environment can be counterproductive to recovery as well. Nurses experienced a dilemma trying to determine the best way to plan and deliver acute orthopaedic care to a person with dementia that would be in the best interests of holistic patient care.

Participants in this study had little confidence that it would be possible to create an acute orthopaedic hospital environment suitable for patients with dementia and they believed that the costs associated with an attempt to do so would preclude the option for hospitals to consider such a proposal. In light of these limitations they suggested that the most suitable action in the best interests of the patient was to attempt to make the hospital stay as short as possible for patients with dementia.

**Care Compromises**

Theme two draws together findings that suggest ways in which nurses noted vulnerabilities in their work practices and teams that could compromise the care provided to patients with dementia in the orthopaedic setting. The compromises related to their preconceived ideas and frustrations, preparedness to adapt their personal approach to caring specifically for people with dementia, their attitudes and willingness to learn, and lastly the rigidity of usual care plans that where not flexible enough to incorporate the holistic care needs of the patients who require a variation to standardised care. Taken together these characteristics highlight the tensions that exist for best practice person-centred care of patients with dementia in an acute care setting.

**Preconceived ideas and frustrations**

The preconceived ideas of nurses about people with dementia influenced the ways that they conceptualised working in an acute orthopaedic ward with people who had a pre-existing condition of dementia. Nurses used informal verbal labelling as a ward-based communication strategy to convey the classification of patient types across the nursing care team. For example:

> *It is just a label that makes it easy to communicate about the patient’s behaviour* (SG12).

While the term ‘demented’ was used to refer to patients with dementia in the acute orthopaedic setting, in the Danish language context this should not be misconstrued as a negative connotation in the way the term may suggest in an English language context. This term, in Danish language
context does not carry the stigma associated with its use in English language context. It is regarded more simply as a generic informal classification of patients to assist with communication across shift rotations of staff and in verbal reports. However, the use of informal labelling of patient by condition illustrates a communication emphasis where the illness, disease and dysfunction information are prioritised, ahead of the person and the person’s physical and psychological responses to these conditions. This was apparent in the way that participant’s suggested that the shift coordinators allocated nurse-patient workloads, based on the assumption that a nurse allocated to a patient with dementia will encounter difficulties and challenges in the delivery of care to these patients. One participant categorised patients with dementia in the following way to indicate the sub-type of patient, and the nurse’s sentiment about the corresponding level of difficulty likely to be experienced in delivering care:

*Oh no – I hope it’s not one of them that calls out and is confused all the time.*

The quiet and smiley ones we can handle (SGI1).

Nurse participants noted that they preferred to have more time to focus on the patient with dementia, and suggested that it would make it possible to care for patients with dementia more effectively. But enough time was not available to them to provide the extra support and care required for a patient with dementia in an orthopaedic ward, and this was a particular source of frustration to them, as the following quote indicates:

*Sometimes I get frustrated as they are so unpredictable, and then I reflect on the way I behaved... and then I become even more frustrated. It is like a dog chasing his own tail* (SGI2).

In an attempt, to summarise the care situation for a patient with dementia, one nurse participant responded:

*They are in essence a nuisance... but I know that I just as well can take my time in the beginning to establish contact with them, instead of running in and out of the room all the time* (SGI4).

The nurse participants expressed a high level of frustration that related to their lack of familiarity with the practical aspects of caring for a person with dementia, together with an underlying
preference and familiarity for working with patients with orthopaedic needs. Their limited familiarity with, and interest in, caring for people with dementia resulted in their recognition of their limitation of competency to do so. They articulated this as ‘uncertainty’ about what to expect in regard to communication, behavioural and cognitive needs and expressions of people with dementia. They reported often being in a situation where they had to make a clinical decision where they were uncertain if the outcome was most appropriate for the patient primarily because they lacked information and/or could not communicate adequately with the patient. One nurse participant describes her experiences in this way:

“I don’t like it... it makes me often wonder if have made wrong decisions”

(SGI2).

The combination of dementia care and orthopaedic care in the context of an acute ward, prompts nurses to predict that the forthcoming shift is likely to be a difficult one for them. The impending sense of personal frustration experienced by nurses about caring for a patient with dementia in the acute orthopaedic clinical setting adversely affected the development of a therapeutic relationship with the patient and reinforced a widespread negative sentiment among nurses within the clinical setting overall.

Calm and adaptive
The decision by the shift co-ordinator to assign a particular nurse to the care of a specific patient is influenced by a number of factors to ensure the most suitable care of all patients in the ward is balanced against the workplace skills and resources available to meet the clinical demands. Usually, patient acuity is matched to clinical expertise. In this study, nurses suggested that a further criterion was the personality traits of a nurse, whereby nurses with a calm demeanour, were more likely to be allocated to the care of a patient with dementia in the orthopaedic ward, as the following participant quote indicates:

‘.. complexity in the recovery is primary in determining how gets the patient - but ideally personality is also taken into consideration (SIG3).

Some nurses indicated that they were less adaptable to caring for a patient with dementia and became anxious as the clinical circumstance escalated in challenging complexity with the dual needs for dementia and orthopaedic care, blaming themselves if their efforts failed in some
respects. These nurses were less flexible in coping with the limitation of time and personal agency to care for a person with dementia where they considered that the quality of care was compromised because of the complex dual morbidities they were required to accommodate with less than optimal resources. Shift coordinators explained that they considered these personal factors carefully, but at times, it was unavoidable and they had to allocate nurses with more limited attributes to the care of a person with dementia, as the following quote indicates:

*It is not ideal, and I feel both for the patient, and my colleagues.* (SIG1)

It was apparent that a set of informal criteria was used to delegate nursing care to patients with dementia in the orthopaedic setting. In particular, nurses with a calm demeanour and who were able to adapt their practice to the dual care needs of the patient were more likely to be allocated to dementia care.

**Sentiment and willingness to learn**

Positive and negative sentiment exhibited by nurses towards patients with dementia in the orthopaedic ward influenced intent to willingly and collegially work together to collaborate in caring for patients with dementia. Some nurses stated that they found it easy working with patients with dementia, but at times felt frustrated by their colleague’s attitudes who did not share their enthusiasm. They reported their colleague’s negative attitude towards caring for patients with dementia in statements such as:

*... I don’t understand why – that way they will never learn ... they think it’s boring.* (SGI4)

One participant suggested that a knowledge deficit was a factor for nursing colleagues who found it difficult to care for patients with dementia, she said:

*I think they lack knowledge about what it is like having dementia. They come directly from school – and perhaps have never worked with it before – and all of a sudden they stand there powerless and with no ideas to work with* (SGI4).

Nurses with a positive attitude towards people with dementia indicated that they found it rewarding to connect with the person rather than to be focussed on the dementia behaviours.
These nurses described caring for patients with dementia as a positive challenge, and they were aware that their nursing colleagues appreciated their efforts and the associated patient outcomes. When asked if they thought their colleagues would like to learn to improve their ability to perform dementia care, the response was “no – they are happy if I do it” (SGI4).

There were two categorisations of nurses that were apparent: on the one hand participants suggested that there was limited willingness to compromise clinical preferences for orthopaedic acute care for some nurses and that this perpetuated a negative sentiment towards patients with dementia. Alternatively, those nurses who exhibited willingness and positive sentiment in caring for people with dementia took on the task in addition to their usual orthopaedic interests, with the unreciprocated interest of their colleagues. This distinction is unspoken of in everyday practice but all staff members are aware who excelled and those who defined themselves as novices regarding dementia care.

Variations to standardised care

Best practice nursing care of people recovering from orthopaedic surgery follows standardised pathways for care, designed to reduce the risk of deterioration and to maximise the potential for a full orthopaedic recovery. Nurse participants described situations where they had to make clinical decisions to adapt the standardised orthopaedic pathways of care, because they had to accommodate the needs of a person with dementia as part of a complex recovery plan. However, in doing so, they worried that some compromises to recovery may result in detrimental outcomes for the patients. For example, a priority for nursing care of orthopaedic patients is to promote mobilisation on the first post-operative day. A variation to this standard pathway of care is usually acceptable and approved by hospital clinical and administrative managers; however, nurses remain concerned that complications may arise from these types of care compromises. As one nurse describes:

...what if the patient catches pneumonia... then I’ll start to bring guilt into the equation (SGI2).

The nurses proposed a solution to the rigid compliance to standardised treatment regimes whereby individualised treatment plans should be developed for patients who do not fit specifically within the standard treatment regime parameters. They considered that development
of a more flexible treatment plan would assist them in providing optimal care for people with dementia. The nurses felt conflicted in their clinical decision making, as the following excerpt shows:

If I fail in one aspect of care – I can live with that – but if I fail on all of them, then I start to get frustrated, and that often happens with patients with dementia (SGI2).

Nurse participants in this study indicated that they required variations to support clinical planning guidance for patients with dementia who they cared for in an orthopaedic setting to optimise person-centred recovery.

**Discussion**

The aim of this study was to investigate nurses clinical experiences of providing orthopaedic recovery care to patients with dementia in an acute orthopaedic ward setting. The results revealed two major themes: “Nurse communication and patient information” and “Care compromise”.

Documenting and retrieving relevant information about patients with dementia in the electronic patient record proved to be a point of tension for nurses, because information related to dementia care was swamped in the vast quantity of acute health data related to the patient’s somatic condition. This rendered relevant information inaccessible when, and where, it was needed and resulted in nurses devising ad hoc ‘work-around’ information sharing strategies. This aligns in parallel with findings by Chater et al. (2012) and Gladman et al. (2012) who described the practical gaps in patient information exchange processes in the general clinical setting in regard to people with dementia.

The somatic aspects of recovery were dominated by a focus on acute care delivery and this demonstrated the difficulty associated with integrating psychosocial aspects of care into routine acute care orthopaedic nursing care activities. Nurses indicated that their direct communication with patients who have dementia, together with their information sharing strategies about the patient with other relevant health professionals, were particularly challenging for holistic health care provision. Our findings are similar to the of findings of Dewing (2009) and Heath et al., (2010), who concluded that these factors, combined with the overall environment and design of the acute
clinical ward, are not ideal for patients with dementia; a notion further supported by similar studies conducted by Moyle et. al., (2008) and Nolan (2007).

The preconceived ideas of nurses towards patients with dementia as being difficult to care for led to frustration and negative sentiment among the nursing teams with regard to their ability to adequately support the holistic recovery of these patients. An informal distinction between nurses was made up of those who had positive sentiment and willingness to care for patients with dementia, and other nurses who had less interest, negative sentiment and were unwilling to learn more about caring for people with dementia. As such, the results of this study show a more nuanced understanding of nurse’s attitudes about being involved in caring for patients with dementia in an acute orthopaedic setting than had previously been described (Kang et al. 2011). Additionally, the decision-making process related to the allocation of particular nurses to specific patients serves to further broaden a gap of knowledge and practical skills in dementia care, and to reinforce the status quo of compromises that make up work-around routine care planning to find unique ways to provide person-centred care to people with dementia.

The main finding of this study describes the difficulty acute orthopaedic nurses experience in adequately caring for patients with dementia because the orthopaedic hospital environment, informal orthopaedic nursing peer support systems, electronic patient record platforms, and standardised orthopaedic clinical work routines do not accommodate the complex needs of people with dementia who have concurrent acute orthopaedic care needs. As such, the nurses in this study considered that patients, and nurses, experienced associated disadvantages and they were particularly concerned that this circumstance would lead to poorer outcomes for patients with dementia. The nurses held a view that patients with dementia should not be admitted to orthopaedic acute settings; however, they acknowledged the paradox that patients with dementia who require acute orthopaedic care needed accommodation in an acute somatic care clinical setting. This dualism is explored and explained using Interactional Nursing Practice theory (Scheel et al., 2008), and the concept of person-centred dementia care (Kitwood, 1997) (Brooker & Latham, 2016).

In the 1990s, Kitwood (1997) advocated for a holistic view of people with dementia suggesting that the symptoms of dementia should to be understood as a combination of personality, life
history, somatic condition, environmental stressor and/or a support, in addition to the neurological damage to the brain. Kitwood (1997) suggested that behaviour alone is insufficient as a descriptor for a person with dementia because behaviour is influenced by a combination of multiple components that cannot be adequately interpreted in isolation from one another. Scheel et al., (2008) further developed a theoretical perspective that suggested that the patient life-world experiences help to describe the complexity of experiences of patients with dementia.

In this study, the nurses prioritised their focus on somatic orthopaedic health, yet they conceded that it was difficult to achieve somatic outcomes for the patient because of their dementia condition. In drawing this distinction, it appeared that nurses attempt to understand and cope with the paradox of care requirements by attempting to isolate characteristics that are inseparable as individual elements within the patient’s actual life-world experience and in contrast to their aspiration of providing person-centred care (Scheel et al., 2008). This circumstance led to a counterproductive recovery environment for patients with dementia, and to dissatisfaction among the nursing workforce in the orthopaedic setting. As a result, a conflict of care ideals and care outcomes were evident, as such: nurses experienced a personal professional conflict in their provision of nursing care towards patients with orthopaedic and dementia care needs because they were unable to deliver a standard of care that satisfied their professional sense of duty of care for patients. This resulted in them experiencing feelings of inadequacy in caring for their patient/s and reinforcing a negative sentiment about caring for people with dementia in the acute orthopaedic setting and reducing their capacity to deliver person-centred holistic care.

The study was able to highlight the importance of understanding the consequences of orthopaedic nurses dividing the elements of somatic care and dementia care in a way that disrupts the capacity for person-centred care and as such, contributes important new knowledge for the discipline. This was further reinforced by the structural limitation of the orthopaedic electronic patient record pathway that did not sufficiently support nurses’ intentions to deliver person-centred holistic care. Rather, it forced them to adopt task-based work completion, and to abandon accommodating the patient life-world sensibility within their nursing care as they attempted to manage the prescribed workload in their acute setting, and this led to heightened nurse and patient dissatisfaction.
The findings in the orthopaedic setting concur with Cowdell (2010) who demonstrated that improving health professional’s awareness of the experiences of patients with dementia in acute care is an important step towards improving a culture of dementia-friendly change in the general acute hospital setting. Cowdell (2010) proposed that workplace professional development should include opportunities for hospital staff to meet people with dementia who do not have acute conditions to help improve staff cognitive and affective intelligence about the experience of living with a dementia condition. The findings suggest that orthopaedic nurses who have pre-conceived beliefs about anticipating difficulty when they care for people with dementia are less inclined to be interested to work with patients with dementia in a holistic manner. This finding compliments other studies that have investigated attitudes of other acute care staff about caring for patients with dementia (Alzheimer’s Society, 2009), with some suggesting that an origin for negative attitudes may exist because nursing students’ have little exposure to knowledge about geriatrics in general, and few plan to work with people who are older in the future (Øster, Munk, & Henriksen, 2017).

Capability and willingness to care for patients with dementia is increasingly a general competency requirement for orthopaedic nurses. A Danish study demonstrated that 19% of all patients admitted to an orthopaedic ward either had a dementia diagnosis, or were receiving dementia-related medications (Jensen-Dahm et al., 2016). In addition, a large number of hospitalised acute care patients are known to either be undiagnosed or experience drug induced delirium (Reynish et al., 2017). While a Maltese study found that using appreciative inquiry techniques assisted staff to improve their dementia practice development (Scerri, Innes, & Scerri, 2015). Another study showed success when using dementia care mapping concepts to design dementia-friendly changes and an inform care improvement initiatives (Innes, Kelly, Scerri, & Abela, 2016). The findings, together with other studies about this topic, indicate that the acute care environment is likely to be a more supportive recovery environment for patients with dementia if a focus on change in the care culture facilitates a person-centred approach to care for people with dementia (Brooker & Latham, 2016).

The findings are able to translate relevant implications for practice using specific nursing theories to do so. The sub-themes from the study can be compared to the three modes of action from Interactional Nursing Practice as presented in Table 3.
This highlighting that nurses experience difficulty to provide holistic person-centred life-world relevant orthopaedic care to people with dementia in the acute hospital setting due to the structural workplace constraints of the electronic patient record and the orthopaedic clinical environment, compounded by their sentiment to engage meaningfully with the disparate conditions (Scheel et al., 2008). Further, it validates the notion that nurses should be supported to undertake practice development training and adopt person-centred workplace routines to provide suitable care to people with dementia in the acute orthopaedic care setting (Alzheimer's Society, 2009). Finally, it is important that nursing students are prepared cognitively and affectively to enhance their willingness and interest to engage with patients with dementia in all clinical settings, including the orthopaedic setting, given the increasing prevalence of dementia in future society and the increasing need for nursing competency in this regard across diverse acute and non-acute clinical and sub-clinical settings.

Limitations
The group selected for interviews had in common that they often were selected on the basis of their experience with direct acute orthopaedic care of patients with dementia in one clinical setting. This could result in experiences and opinions being skewed in the direction of a more positive perspective about providing acute care for people with dementia. If this was the case, then the results of the study will emphasise the even more profound need to address the acute orthopaedic recovery care provision for people with dementia because it is possible that we have collected the most favourable sentiment and opinion in the data set, with strong negative sentiment not adequately represented in the small sample of agreeable participants available in one setting.

The sample of eight people from three nursing groups (nurses, SOSAs and ward management) meant that distinction and comparison between the groups was not done in order to preserve anonymity. The study does not attempt to suggest any differences between categories of nurse participants, or to suggest how this might compare or contrast with the perspectives of other health professionals.

This study was embedded within a wider study (XXX., 20XX). While it is possible that our prior knowledge derived from other study phases may have influenced analysis, we consider that this is
mitigated with the primary investigator and data collector for the study who was from the public health discipline. Our multidisciplinary team of investigators (some nurses) provided us with an opportunity to strengthen the study with a diversity of disciplinary perspective, enabling us to interrogate the data fairly and completely without undue bias.

**Conclusion and implications for practice**

Orthopaedic nurses find it challenging and professionally difficult to provide person-centred care for patients with dementia during an acute orthopaedic hospital admission. It can be concluded that disruptions in communication flows and accessing relevant information in the electronic patient record hampered the quality and extent of person-centred care that nurses were able to provide. Nurses also expressed concern with the impact that the hospital environment and health management systems had on the patient, and described the orthopaedic injury and repair as a higher priority than any of the other needs a patient with dementia experienced related to emotional distress and behavioural unrest. The findings describe the compromise of care that people with dementia experience in the acute orthopaedic clinical setting. In particular, the results have been able to determine that nurses in the acute setting report their frustrations in caring for people with dementia stemming from their preconceived ideas about people with dementia generally. This factor influences their sentiment, readiness and willingness to calmly adapt to providing the person-centred and life-world inclusive nursing practices that are able to support the patient with dementia more effectively. The study has identified the variations that are required in the orthopaedic clinical workplace for nurses to effectively access and utilise electronic patient record, clinical pathway information and other clinical documentation together with improving the environment to enhance the extent and quality for person-centred nursing care of patients with dementia who are undergoing orthopaedic treatment and recovery.

The clinical implication arising from this study is that acute nurses working in the orthopaedic setting should work to adopt a positive attitude towards dementia care because it is an integrated and relatively common aspect of acute orthopaedic nursing. A person-centred approach to the integrated dementia and orthopaedic care of patients with the dual conditions of chronic dementia and acute orthopaedic injury and repair is required overall, and it is recommended that this should be a focus for nursing education and practice development generally. It is also
recommended that the electronic patient record should be supplemented by oral dissemination to some extent, as information, plans of action and knowledge about the care situation for patients with dementia has a tendency to drown in chronological data sets that prioritise a focus on standardised somatic care.

It is envisaged that if future adaptions to the orthopaedic electronic patient records and care protocols can be developed to include dementia characteristics, in conjunction with dementia-centred professional development opportunities and enhancements to improve nurse sentiment and time allocation for patients with dementia, then person-centred care for people with the dementia in the orthopaedic setting can more readily be achieved. It is likely that these types of improvements will further enhance quality and safety for patients, and work satisfaction levels for orthopaedic nurses assisting in the retention of experienced and capable nursing workforce in the context of an aging population and an increasing prevalence for both conditions.

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Http://Www.Datatilsynet.Dk/English/The-Danish-Data-Protection-Agency/Introduction-To-The-Danish-Data-Protection-Agency/.


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Table 1: Participant profile

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Table 2: Themes and sub-themes

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Table 3: Comparison of modes of action interactional nursing practice (Scheel et al., 2008) with sub-themes arising from study