

RESEARCH ARTICLE

A qualitative focus group discussion study on the experiences of Certified Nurses in Dementia Nursing related to effective staff education

Hiromi Taneichi¹  | Ryoko Rokkaku²

¹Department of Makuhari Human Care, School of Nursing, Tohto University, Chiba, Japan

²Mie Prefectural College of Nursing, Mie, Japan

Correspondence

Hiromi Taneichi, Department of Makuhari Human Care, School of Nursing, Tohto University, 1-1, Hibino, Mihama-ku, Chiba, 261-0021, Japan.
Email: hiromi.taneichi@tohto.ac.jp

Abstract

Aim: To explore the experiences of Certified Nurses in Dementia Nursing (DCNs) concerning the effective education of staff in acute hospitals.

Background: In Japan, the number of inpatients with dementia who need medical care continues to increase. DCNs play an important role in educating medical staff about dementia care in acute hospitals. However, there is a lack of a clear understanding in this regard.

Design: A qualitative design using a thematic analysis.

Methods: Data were extracted from a focus group discussion conducted with 10 DCNs working in 10 different acute hospitals in central Japan. Participants answered semi-structured, open-ended questions about their experiences related to effective staff education. Categories, subcategories and themes were created. This study complied with the Standards for Reporting Qualitative Research.

Results: The two themes identified were “building a foundation for dementia care education” and “continuous support based on practical processes.”

KEYWORDS

acute care, certified nurses in dementia nursing, dementia patient, focus groups, qualitative study, staff education

1 | INTRODUCTION

Dementia has a physical, psychological, social and economic impact on people with the disease, their carers, their families and society at large. At present, the number of people living with dementia worldwide is estimated to be 47 million (approximately 5% of older people) and is expected to almost triple by 2050 (World Health Organization, 2017a).

In 2013, the “Dementia Summit” was held by the G8 (Group of Eight) in London. The summit aimed to agree on what could be done to stimulate greater investment and innovation in dementia research and to improve the prevention and treatment of dementia, as well as the quality of life (QOL) of people with dementia. Moreover, in 2017,

a global action plan was adopted by the World Health Organization (WHO). In the action plan, the importance of training health and social care personnel to provide evidence-based treatment and care was highlighted (WHO, 2017b). Additionally, the importance of education for medical staff was emphasized.

Japan has one of the highest overall life expectancies in the world. In 2017, the percentage of older people in Japan was 27.7%. By 2065, 1 in 2.6 people will be 65 years old and over (Cabinet Office & Government of Japan, 2018). Accordingly, the number of patients with dementia is estimated to sharply increase to 7 million (about one-fifth of the total older population) by 2025 (Ministry of Health, Labour, & Welfare, 2016).

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In hospitals, the number of inpatients with dementia who need medical care will increase. Japan has the highest number of hospital beds among OECD (Organisation for Economic Co-operation and Development) countries with 13.1 beds per 1,000 of the population (OECD, 2018). The reasons include professional or cultural norms, differing payment schemes and access to long-term care facilities (Tiessen et al., 2013). It is important to support patients with dementia in Japan, which has the longest hospital stay duration and very low hospital discharge rates compared with other OECD countries. Patients with dementia are admitted for different reasons and appear to have longer stays than patients without dementia, which leads to higher hospital costs per capita (Lyketsos, Sheppard, & Rabins, 2000).

In Japan, all residents are required by law to have medical insurance coverage (Ministry of Health, Labour, & Welfare, 2015). Depending on familial income and the age of the insured, patients are responsible for paying 10%, 20% or 30% of their medical fees, with the government paying the remaining fee. If appropriate and effective dementia care can be provided, then the QOL and activities of daily living (ADL) of dementia patients can be enhanced and both their length of stay in hospital and their medical expenditures can be lowered (Tanajewski et al., 2015; Tay et al., 2017).

In 2016, the Japanese government began a new trial, which involved a medical fee revision process whereby the government covered some of the medical fees needed for appropriate and effective dementia care in acute wards (Ministry of Health, Labour, & Welfare, 2016). Furthermore, a system of "Dementia Certified Nurses" (DCNs) to function in a dementia nursing and educational capacity in hospitals was started in 2004 (Japanese Nursing Association, 2016). DCNs must possess the following abilities:

1. Ability to perform high-level nursing practices to support patients with dementia and their families;
2. Ability to teach and consult nursing professionals, making full use of the specialized knowledge and techniques of dementia nursing; and
3. Ability to provide care that respects life, QOL and the dignity of patients with dementia, in cooperation with nurses and other medical professionals.

A DCN works mainly as a dementia care practitioner, instructor and counsellor (Japanese Nursing Association, 2018). DCNs are mostly expected to bear the responsibility of the occurrences related to dementia care in specialized facilities; hence, they must take on several roles, such as educator, coordinator and adviser. For instance, DCNs establish education plans, conduct staff training workshops and are involved in the discharge planning process from the point of admission to the point of discharge for patients with dementia. Furthermore, some DCNs work as members of their hospital's Psychiatric Liaison Team. Individuals involved in DCNs' activities are patients with dementia, their caregivers and medical staff, which includes nurses and other non-specialists. Moreover, the activities of DCNs are continuously expanding and

since these duties exist in both the hospital and community settings, it is clear that DCNs will have more opportunities based on these responsibilities (Maeda & Kajita, 2016).

However, as of 2018 and over 10 years since the establishment of the DCN system, there are only 1,259 qualified DCNs in Japan (Japanese Nursing Association, 2018). Since the number of general hospitals in Japan is 7,353, there is clearly a shortage in the number of DCNs available to these hospitals (Ministry of Health, Labour, & Welfare, 2017) and, unfortunately, this shortage has led to the uneven distribution of DCNs across regions and institutions in Japan. This shortage is compounded by the fact that 85.6% of DCNs belong to hospitals (Japanese Nursing Association, 2018), which leaves other institutions understaffed and DCNs being forced to assume the leading role in their hospitals as the only specialists providing education to medical staff about dementia care. Finally, it is reasonable to imagine that there are many challenges in educating nurses and other medical staff in hospitals, especially in acute hospitals where treatment is a priority; however, there are no clear data in this regard.

2 | BACKGROUND

In the global trend of dementia care education, there is a need for better education and training for both dementia professionals and hospital staff members (Department of Health & Social Care, 2009). Education for medical staff is provided by the multidisciplinary Liaison Psychiatry Team and includes training on how to care for the medically ill with co-existing mental health problems, which has a positive impact on patient care in hospitals (Koli & Filippidou, 2017). Regular consultations and training by outreach liaison teams for healthcare professionals in acute hospitals that provide care for people with dementia have been validated (Mukaetova-Ladinska, 2016), and the effectiveness of specialized wards that focus on treatment through environmental adjustment and behaviour therapy with highly specialized experts who receive educational training has been demonstrated (Saidlitz, Sourdet, Voisin, & Vellas, 2017); however, this model is difficult to apply in acute wards. A dementia behavioural management advisory service that provides appropriate advice to all people involved in dementia care plays an educational role (Dementia Support Australia, 2019). Yet despite various attempts, a knowledge gap regarding dementia care among hospital nurses still exists (Baumbusch et al., 2017; Lin, Hsieh, Chen, Yang, & Lin, 2018).

The Clinical Practice Guidelines recommend that health and aged care organizations ensure that all staff members working with people with dementia receive dementia care training, stating that the quality of evidence in this regard is low (National Health & Medical Research Council, 2016). This implies that education and programmes that suit each staff member's level and involvement may be more effective and significant than uniform education. Therefore, even if a country has the required educational programmes and systems in place, it may be difficult to ensure all staff members understand dementia care, especially in acute hospitals. It has been

suggested that dementia-specific education for professionals should be further developed (Naef, Ernst, Burgi, & Petry, 2018).

2.1 | Aim

This study aims to explore the experiences of DCNs related to the effective education of staff in acute hospitals. Additionally, DCNs in acute wards face challenges in educating staff and other individuals about dementia care and this study also aims to provide findings that suggest ways to address these challenges.

3 | THE STUDY

3.1 | Design

We conducted a qualitative study using a single focus group discussion (FGD) that was held in October of 2017. An FGD is frequently used as a qualitative approach to gain data and an in-depth understanding of social issues from a purposefully selected group of individuals, rather than from a statistically representative sample of a broader population. An FGD can generate discussion or debate about a research topic that requires collective views and identifies the meanings that lie behind those views (Nyumba, Wilson, Derrick, & Mukherjee, 2018). Therefore, to gather informative data in our FGD, we focused on recruiting study participants based on their experiences and willingness to engage in a candid discussion to explore DCNs' experiences related to dementia education for staff in acute hospitals.

3.2 | Sampling strategies

A total of 10 DCNs (one male and nine females) working in 10 different acute hospitals in central Japan were selected using a purposeful sampling method. They were recruited from a Dokkyo Medical University-sponsored DCN exchange seminar whose participants were comprised of DCNs who had reacted to the seminar announcement that had been sent to all DCNs two years previously. The seminar aimed to exchange views and problem-solving techniques. Forty DCNs proactively participated in this study, and they were interested in sharing their experiences.

3.3 | Data collection

An FGD was held to discuss participants' experiences related to dementia education. The discussion took place in a meeting room at the university and lasted approximately two hours. Two researchers were also involved in the discussion, which was led by an experienced moderator who was a researcher in geriatric nursing and who was assisted by one observer. The discussion was recorded with permission using an IC recorder, and the observer made brief notes about the comments of each participant, who answered semi-structured, open-ended questions. The interview included introductory questions such

as (a) "recall your educational experiences in your hospital," (b) "How was your experience regarding effective practical support and consultations?," (c) "What were the specific situations of the cases that you experienced?" and (d) "How effective were the interventions in the given cases?".

3.4 | Methods of analysis

The discussion was transcribed verbatim, and a content analysis was performed on the Japanese transcripts before translation. Based on Graneheim and Lundman's (2004) method, the analysis process consisted of the following steps:

1. The recorded interviews were transcribed and read to gain an overall understanding.
2. The text was divided into meaningful units.
3. The meaningful units were extracted and encoded.
4. Based on their similarities and differences, the initial codes were classified into subcategories.
5. The subcategories were sorted and abstracted into categories.
6. Themes were created to link the underlying meanings together in the categories.

During the open coding stage, all transcripts were thoroughly read several times and participants' experiences regarding effective dementia care education for staff were noted. The basic codes were obtained and compared with all extracted data to identify existing similarities and differences. Subsequently, the categories, subcategories and themes were created.

3.5 | Methods of quality assurance

Member checking, peer questioning and cross-examination were used to ensure the trustworthiness, dependability and credibility of the data. For member checking, each participant was provided with the transcript of their coded interview and was asked whether the codes matched their experiences. Peer checking of the transcripts was carried out by two researchers who had been conducting DCN exchange seminars for two years, which enabled them to earn the participants' trust and develop strong communication links. This facilitated precise data collection.

3.6 | Ethics

The study protocol was approved by the Institutional Review Board. Before the study commenced, participants were informed about the aim and procedure of the study and their right to withdraw their participation at any time. Moreover, they were assured of their anonymity by the researchers and written informed consent was obtained from each participant and their hospital managers. Participation was strictly voluntary. This study complies with the Standards for Reporting Qualitative Research (See Appendix S1).

4 | RESULTS

Participant details are shown in Table 1. A total of eight categories and two themes were extracted from the data on DCNs' experiences related to effective dementia care education. The two themes were "building a foundation for dementia care education" and "continuous support based on practical processes" (Table 2).

The theme of "building a foundation for dementia care education" included the following subcategories: (a) establishing a system for dementia care education; (b) discussing patients', families' and staff feelings to support them; and (c) establishing a cooperation system with mutual understanding. All participants were working

as the only DCN in their respective facilities, so they needed to understand their roles and abilities in dementia care education concerning the directors, staff, patients and their families. Their understanding helped them develop an environment where they were able to play an active role.

One DCN tried to involve a person in a managerial or administrative position to improve the nurses' working environment:

I have no power to control personnel placement, so I talked to a head nurse who said, 'you should talk to the director about the extremely busy conditions and ask to establish a relief system that can send nurses to your ward whenever necessary.'

Conversely, the DCN supported nurses when they were too busy to care for patients with behavioural and psychological symptoms of dementia (BPSD), saying: "I joined patients' care willingly to lighten the burden imposed on nurses."

The DCNs tried to learn more about the patients, their families and the staff involved in their care. This was important for DCNs because they needed to sympathize with nurses' circumstances to support them educationally:

TABLE 1 Description of participants

N	10
Female (%)	9 (90%)
Average age (SD)	45.3 years (1.6)
Average number of years in nursing (SD)	24.0 years (1.9)
Average number of years as DCN (SD)	3.2 years (0.3)

Abbreviations: SD, standard deviation; DCN, certified nurses in dementia nursing.

TABLE 2 Experiences of Certified Nurses in Dementia Nursing related to effective education

Theme	Category	Sub-Category
Building a foundation for dementia care education	Establishing a system for dementia care education	Involving person who was in a managerial or administrative position to improve nurses' working environment
		Supporting nurses indirectly who were too busy to care for the patient with BPSD
	Discussing patients', families' and staff's feelings to support them	Trying to understand feelings of the patient with BPSD
		Communicating the family's feelings to staff
	Establishing a cooperation system with mutual understanding	Talking with staff who felt difficulty in dementia care personally or during work
		Answering volunteers' questions one by one to reduce their fear
Continuous support based on practical processes	Providing support to achieve the practical process	Establishing a foundation of cooperation with professional and non-professional staff
		Providing service considering each role and situation
	Showing nurses the viewpoints of dementia care	Delegating dementia care to nurses gradually to promote their independent practice
		Visiting the ward frequently to support and confirm the situation immediately after intervention
		Supporting as a specialist to bring nurses understanding and relief
		Making full use of methods to transmit important information to nurses
	Determining and practicing care with nurses	Showing providing care as a role model of the practice
		Keeping in mind listening to what happens to patients and explaining to nurses clearly for comprehensive understanding
	Visualizing the effects of dementia care	Discussing thoughtfully with nurses to create a comfortable place for a dementia patient
		Finding an improvement in the direction of care in conference
Encouraging growth through introspection of practice	Helping staff become capable of caring in a courageous manner	
	Showing nurses the qualitative and quantitative effects of dementia care to allow easy recognition	
		Prompting to look back on nurses' practice to draw on past experience

Abbreviation: BPSD, behavioural and psychological symptoms of depression.

I tried to find out and understand the feelings of patients with BPSD regarding what happened with them until now.

I talked about the feelings of the family who cared for the patient with many difficulties and then I communicated their experiences with the staff.

I tried to talk with the staff personally or during work, who found it difficult to care for patients with dementia.

In hospitals, professionals and non-professionals, such as volunteers, are involved with patients with dementia. Therefore, DCNs have helped both groups to establish an effective foundation for a cooperation system:

I planned 'expanded conferences' four times until discharge that included not only the staff in the hospital but also service providers in the community to know each other and promote effective cooperation.

Volunteers were often afraid of even talking with and touching patients with dementia because they had little knowledge of dementia.

The DCNs played different roles according to different situations for the assessment of dementia care:

I became a liaison officer as a representative of the dementia care team in the hospital in case of emergencies. I thought it was difficult for the hospital staff to cope with such patients due to their insufficient knowledge and experience.

The DCNs continuously supported the staff according to a practical educational process. Thus, under the theme of "continuous support based on practical processes," the following subcategories were extracted: (a) providing support to achieve the practical process; (b) showing nurses the viewpoints of dementia care; (c) determining and practicing care with nurses; (d) visualizing the effects of dementia care; and (e) encouraging growth by introspection of practices.

Based on educational assessment, the DCNs intervened in dementia care to carefully support nurses initially, but they gradually maintained distance to promote nurses' independent practice:

After the staff discussed the care for patients with BPSD in a conference, in the first three days, I went to the ward frequently.

However, some DCNs had two roles: staff and DCN, so they had to prioritize work in their wards circumstantially.

Nurses were sometimes uneasy about dementia care. Therefore, the DCN supported them by being a role model to enhance nurses' understanding and relief:

At the beginning, I told a nurse to stay behind me and observe me to learn how to care for a patient with dementia.

The DCN used different methods to show viewpoints of dementia:

When I obtained important information in the interview, I left the record for nurses that reminded them of a guideline of dementia care.

The DCNs aimed to enable nurses to provide dementia care autonomously; otherwise, nurses may have come to depend on DCNs or the dementia care team. The DCNs cared for patients with dementia, along with nurses while carrying out trial and error procedures:

In a conference, I told the nurses who feared that a lack of physical restriction could be dangerous for patients with dementia: 'If you are unable to manage yourself, you can bring it up in the upcoming meeting.'

In addition, the DCNs changed the working environment to raise awareness regarding dementia care:

The nurses and I discussed the ward environment. Due to that, they arranged the nurse station to be comfortable for patients with dementia.

The DCNs showed nurses the effects of dementia care to easily enable their recognition:

I carried out a briefing session indicating the effects of the activity program on patients with dementia.

I showed the ward nurses a video of patients in the daycare. They were surprised that the patients enjoyed it.

The DCNs verbalized what the nurses could apply to practice and provided advice when needed for their professional development:

For the nurse who felt that the practice did not go well, I gave a hint to assess her practices by herself.

I asked a nurse questions such as 'What is the patient's reason not to eat? What happens in the mouth?' To reflect on her past practices.

5 | DISCUSSION

In this study, the two themes of “building a foundation for dementia care education” and “continuous support based on practical processes” were found regarding DCNs’ role in effective dementia care education in acute hospitals.

This first theme is an important step for DCNs who provide dementia care education as the only dementia care specialists in hospitals. To provide effective and high-quality education in hospitals, the DCNs in our study sought help from their managers, who are legally and ethically bound to guarantee good care or improve the quality of care. These nursing managers are under pressure to maintain efficiency in acute hospitals (Andrews, 2012). Therefore, the DCNs in this study explained that their educational activities enabled them to prevent the aggravation of BPSD along with the loss of bodily functions. This means that patients can get discharged earlier, which will benefit the managers as well.

A previous study reported that the admission of patients with dementia to a general hospital did not lead to positive outcomes (Dewing & Dijk, 2016). Most older people with dementia who are hospitalized owing to illness progression have BPSD (Lyketsos et al., 2000), which requires more support and financial aid owing to the symptomatic aggravation that it causes (Woods & Dimond, 2002). As for the cause of BPSD aggravation, a previous review suggested that the tension between prioritization of acute care for existing co-morbidities and person-centred dementia care were the primary contributing factors (Dewing & Dijk, 2016). However, these factors are complicated, as there is insufficient understanding of what constitutes person-centred care and a lack of requisite knowledge and skills in healthcare practitioners (Dewing & Dijk, 2016). In addition, overworked nurses are generally desperate to end even basic patient care and they may be unable to focus on person-centred care as a result though previous research has reported that specialized care provided in dementia wards was effective for addressing the BPSD and ADL of patients (Taniguchi et al., 2013). It is possible that a liaison team, the placement of a specialized nurse, a specialized ward and a shared care ward can improve the quality of care and reduce the cost of care, the adverse effects of hospitalization and the length of hospitalization for these patients (Dewing & Dijk, 2016; Tay et al., 2017).

As the above results show, the provision of appropriate care in acute hospitals is effective for patients, nurses and hospitals. Therefore, if a hospital or a ward manager understands the importance of dementia care and ensures efficient staff placement and education of the clinical staff by an expert, then the provision of effective dementia care could be possible.

In this study, the DCNs mentioned that they aimed to improve dementia care and that managers who aimed for efficiency had the same interest; hence, the human resources and organizational structure of their hospital were such that there was a “relief system” and provision of dementia care to prevent the aggravation of BPSD. Additionally, the DCNs aimed to improve awareness of dementia care in the entire hospital.

Furthermore, various experts are concerned with dementia care. Several studies have found that the available care for dementia is not the best, especially given the nature of the illness and its symptoms (Fukuda, Shimizu, & Seto, 2015; Nilsson, Rasmussen, & Edvardsson, 2016). Care providers find it difficult to conduct care practices, even if they understand their roles; therefore, the DCNs always maintain personal, face-to-face relations through consultations and providing professional knowledge. One of the methods to reduce care providers’ feelings of difficulty is the acceptance of the difficulty in being honest during face-to-face interactions. However, the Japanese often make a social distinction between how they truly feel and what is considered appropriate to be said in public (Japan External Trade Organization, 1999). As a result, the hierarchy in the group is respected and employees sometimes do not share what they wish to say to their superiors. In such a cultural background, DCNs play the role of mediator between the managerial class and lower-level professionals to plan collaboration between the two involving honest sharing with each other. This is an important point in promoting the support system.

At the same time, the DCNs tried to engage volunteers in dementia care who had never cared for people with dementia before. The history of volunteers in Japanese hospitals is not as well understood as in Western European countries, and it is hypothesized that the education level and residential areas of these volunteers are different in each hospital (Nihon Hospital Volunteer Association, 2011). In the beginning, many volunteers felt anxious about spending time with people with dementia; thus, it is necessary to change the acceptance and awareness of dementia among volunteers. The DCNs delivered their explanations using words that were easy to understand and provided opportunities to spend time with patients with dementia who were calm while guaranteeing professional support at any time. In this way, the DCNs created the required foundation for dementia care. However, when a dementia care team does not exist, DCNs will have a difficult time fulfilling their role as educators.

Nurses in acute hospitals face great uncertainty when caring for patients with dementia (Pinkert et al., 2018). Acute care nurses tend to lack specific knowledge about dementia and may not understand the difference between acute and chronic confusion (Moyle, Borbasi, Wallis, Olorenshaw, & Gracia, 2011). Education is important for the professional development of staff, which is mostly obtained via workplace experience. Experience-based learning in hospitals, that is OJT (on-the-job training), is considered the most effective form of training. Knowledge and skills are obtained from advice, direct observation and imitation of a role model. Coffey (2004) found that responses to questions on the type of training that nurses prefer demonstrated an overwhelming interest in an “on-the-job” training model. This is because it reduces the burden of learning on busy nurses, who can learn what they need to know “on the spot.” Additionally, Kolb (1984) stated that learning is a process that depends on knowledge obtained through experiences, which suggests the effectiveness of the process of learning through experience. The

other type of learning is off-the-job training, such as a workshop. The DCNs in this study continuously provided education by skilfully mixing these elements.

As mentioned previously, the Japanese government introduced financial benefits in the form of paid medical fees for the appropriate and effective care of patients with dementia in acute care hospitals. However, many nurses feel that patients with dementia disrupt the normal hospital routine and create an obstacle in the delivery of medical care to other patients (Digby, Lee, & Williams, 2017). In acute hospitals in particular, where nurses need to address the needs of many patients simultaneously, the staff considers the care of patients with dementia to be “troublesome” (Featherstone, Northcott, & Bridges, 2019). The following two reasons could contribute to this attitude: first, despite having knowledge of dementia, nurses were unable to provide concrete and effective care in a busy ward; and second, appropriate investigation of the processes they followed and a consideration of whether they accepted dementia care were essential given their diverse backgrounds.

To enable nurses to provide dementia care themselves, the DCNs developed a process to promote nurses' growth gradually and to enable them to think and act on their own initiative. The DCNs visited the wards numerous times, monitored the care and waited for an opportunity for clinical intervention. In particular, the DCNs developed close relations with nurses early in the intervention step. They helped nurses to perceive their annoyance as a “new experience” and then convert that experience into learning. The DCNs seemed to understand that this early step of intervention is crucial and that learning is deepened from experience. In the clinical site, the DCNs asked nurses appropriate questions repeatedly and the nurses considered the care they provided and learned more about dementia care. Such repetition might help nurses better understand dementia care progressively.

Importantly, the DCNs provided care as role models to help nurses realize the progress being made in dementia care and what is important in its practice. Cruess, Cruess, and Steinert (2008) stated that learning from role models occurs through observation and reflection. In this way, the DCNs supported nurses in reflecting on their annoyance in the work setting and to view it from a different perspective to help them conceptualize dementia care. The DCNs also helped with “determining and practicing care with nurses,” and a new care method was planned and implemented based on the idea of conceptualization. The DCNs acted not only as supporters who provided advice but also as co-operators, who considered what could be done with nurses even if they were busy. Thus, DCNs should be regarded as supportive partners for effective education.

The DCNs also provided nurse support through “visualizing the effects of dementia care” and “encouraging growth by introspection of practices” after caring for a patient together.

Kolb's (1984) experiential learning cycle concept divides the learning process into a cycle of four basic theoretical components: concrete experience, reflective observation, abstract

conceptualization and active experimentation. In this study, five practices were found: (a) “providing support to achieve the practical process,” (b) “showing nurses the viewpoints of dementia care,” (c) “determining and practicing care with nurses,” (d) “visualizing the effects of dementia care” and (e) “encouraging growth by introspection of these care practices.” There are few differences and several commonalities with Kolb's (1984) theory that the impetus for the development of new concepts is provided by new experiences. Therefore, new consciousness of experience in the clinical site would be the first step to improving dementia care. However, DCNs lack sufficient time for educational activities. Some of the urgent challenges are to support nurses individually, establish a system that can have a ripple effect on the entire staff for learning about dementia care and increase the number of people involved in dementia care.

5.1 | Strengths and limitations

One of the strengths of this study is that honest opinions were obtained from the participants owing to their good relations with the present researchers. Further, this study used member checking by participants, which is effective in establishing credibility and trustworthiness.

There are also some limitations. First, there were only 10 participants; therefore, more data are needed to confirm the generalizability. Second, the differences in the types of facilities and positions of DCNs were not considered. These factors likely affected their experiences. In particular, there is a difference between DCNs who are members of dementia care teams and those who are not. However, this study was able to obtain results that reflected the present conditions of DCNs in a variety of situations. Third, analyses that remain so close to the text might restrict transferability; however, imagining effective practices could help with the application of such interventions to clinical sites. Last, the familiarity between researcher and participants might imperil analytical distance; hence, using methods of quality assurance might be effective in avoiding arbitrary analysis.

6 | CONCLUSION

The present study showed that the practices of DCNs related to effective education in acute hospitals consisted of two themes: “building a foundation for dementia care education” and “continuous support based on practical processes.” Getting involved with managers and seeking their help, as well as other professionals and non-professionals, such as volunteers, was considered effective in building a foundation for dementia care education. The results of this study also suggested that DCNs' continuous support based on practical processes led to nurses providing independent dementia care. Furthermore, the existence of a dementia care team was important for carrying out effective educational activities related to dementia care.

7 | RELEVANCE TO CLINICAL PRACTICE

Many DCNs in acute wards face challenges in educating staff and other people related to dementia care. This study provides some suggestions to address these challenges:

- Becoming acquainted with the clinical site and providing education in a timely and concrete manner.
- Getting help from co-operators such as specialists, staff, people in managerial or administrative positions and volunteers.
- Creating an optimal multidisciplinary environment for collaboration with the dementia care team.
- Ensuring a multidisciplinary environment, along with a cooperative manager, is necessary to provide education in acute wards.

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CONFLICT OF INTEREST

The authors declare no conflicts of interest.

ORCID

Hiroimi Taneichi  <https://orcid.org/0000-0003-4818-3056>

REFERENCES

- Andrews, J. (2012). How acute care managers can support patients with dementia. *Nursing Management*, 19(2), 18–20. <https://doi.org/10.7748/nm2012.05.19.2.18.c9062>
- Baumbusch, J., Shaw, M., Leblanc, M.-E., Kjørven, M., Kwon, J.-Y., Blackburn, L., ... Wolff, A. C. (2017). Workplace continuing education for nurses caring for hospitalised older people. *International Journal of Older People Nursing*, 12(4), e12161–<https://doi.org/10.1111/opn.12161>
- Cabinet Office, Government of Japan (2018). *Annual report on the aging society 2018*. Retrieved from: <https://www8.cao.go.jp/kourei/whitepaper/w-2018/html/gaiyou/index.html>
- Coffey, A. (2004). Perceptions of training for care attendants employed in the care of older people. *Journal of Nursing Management*, 12(5), 322–328. <https://doi.org/10.1111/j.1365-2834.2004.00442.x>
- Cruess, S. R., Cruess, R. L., & Steinert, Y. (2008). Role modelling—making the most of a powerful teaching strategy. *BMJ*, 336(7646), 718–721. <https://doi.org/10.1136/bmj.39503.757847.BE>
- Dementia Support Australia (DSA) (2019). *Responding to changes in behaviour, enhancing quality of life*. Retrieved from <https://www.dementia.com.au/>
- Department of Health and Social Care (2009). *Living well with dementia: A national dementia strategy*. Retrieved from https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/168221/dh_094052.pdf
- Dewing, J., & Dijk, S. (2016). What is the current state of care for older people with dementia in general hospitals? A literature review. *Dementia*, 15(1), 106–124. <https://doi.org/10.1177/1471301213520172>
- Digby, R., Lee, S., & Williams, A. (2017). The experience of people with dementia and nurses in hospital: An integrative review. *Journal of Clinical Nursing*, 26(9–10), 1152–1171. <https://doi.org/10.1111/jocn.13429>
- Featherstone, K., Northcott, A., & Bridges, J. (2019). Routines of resistance: An ethnography of the care of people living with dementia in acute hospital wards and its consequences. *International Journal of Nursing Studies*, 96, 53–60. <https://doi.org/10.1016/j.ijnurstu.2018.12.018>
- Fukuda, R., Shimizu, Y., & Seto, N. (2015). Issues experienced while administering care to patients with dementia in acute care hospitals: A study based on focus group interviews. *International Journal of Qualitative Studies on Health and Well-being*, 10, 25828. <https://doi.org/10.3402/qhw.v10.25828>
- Graneheim, U. H., & Lundman, B. (2004). Qualitative content analysis in nursing research: Concepts, procedures and measures to achieve trustworthiness. *Nurse Education Today*, 24(2), 105–112. <https://doi.org/10.1016/j.nedt.2003.10.001>
- Japan External Trade Organization (JETRO) (1999). *Communicating with Japanese in business*. Retrieved from <https://www.jetro.go.jp/costarica/mercadeo/communicationwith.pdf>
- Japanese Nursing Association (2016). *Nursing in Japan*. Retrieved from <https://www.nurse.or.jp/jna/english/pdf/nursing-in-japan2016.pdf>
- Japanese Nursing Association (2018). *Nursing education in Japan*. Retrieved from <https://www.nurse.or.jp/jna/english/nursing/education.html>
- Kolb, D. A. (1984). *Experiential learning: Experience as the source of learning and development*. Englewood Cliffs, NJ: Prentice-Hall Inc.
- Koli, T., & Filippidou, M. (2017). Audit on the quality of handovers of a psychiatric liaison team in the UK: A short report. *Psychiatry Danubina*, 29(Suppl 3), 536–540.
- Lin, P. C., Hsieh, M. H., Chen, M. C., Yang, Y. M., & Lin, L. C. (2018). Knowledge gap regarding dementia care among nurses in Taiwanese acute care hospitals: A cross-sectional study. *Geriatrics & Gerontology International*, 18(2), 276–285. <https://doi.org/10.1111/ggi.13178>
- Lyketsos, C. G., Sheppard, J. M., & Rabins, P. V. (2000). Dementia in elderly persons in a general hospital. *The American Journal of Psychiatry*, 157(5), 704–707. <https://doi.org/10.1176/appi.ajp.157.5.704>
- Maeda, K., & Kajita, H. (2016). Issues in initial-phase intensive support team for dementia experience in Kobe city. *Seishin Shinkeigaku Zasshi = Psychiatria Et Neurologia Japonica*, 118(2), 90–96.
- Ministry of Health, Labour and Welfare (2015). *Health and medical services*. Retrieved from <http://www.mhlw.go.jp/english/wp/wp-hw9/dl/02e.pdf>
- Ministry of Health, Labour and Welfare (2016). *Long-term care insurance system of Japan*. Retrieved from https://www.mhlw.go.jp/english/policy/care-welfare/care-welfare-elderly/dl/ltcisj_e.pdf
- Ministry of Health, Labour and Welfare (2017). *Survey of medical facilities (in Japanese)*. Retrieved from <https://www.mhlw.go.jp/toukei/saikin/hw/iryosd/17/dl/02sisetu29-1.pdf>
- Moyle, W., Borbasi, S., Wallis, M., Olorenshaw, R., & Gracia, N. (2011). Acute care management of older people with dementia: A qualitative perspective. *Journal of Clinical Nursing*, 20(3–4), 420–428. <https://doi.org/10.1111/j.1365-2702.2010.03521.x>
- Mukaetova-Ladinska, E. (2016). Current and future perspectives of liaison psychiatry services: Relevance for older People's care. *Geriatrics*, 1(7), 1–9. <https://doi.org/10.3390/geriatrics1010007>
- Naef, R., Ernst, J., Burgi, C., & Petry, H. (2018). Quality of acute care for persons with cognitive impairment and their families: A scoping review. *International Journal of Nursing Studies*, 85, 80–89. <https://doi.org/10.1016/j.ijnurstu.2018.12.018>
- National Health and Medical Research Council (2016). *Clinical practice guidelines for dementia in Australia recommendations*. Retrieved

- from [https://sydney.edu.au/medicine/cdpc/documents/resources/LAVER_Dementia_Guidelines_recommendations_PRVW%20\(4\).pdf](https://sydney.edu.au/medicine/cdpc/documents/resources/LAVER_Dementia_Guidelines_recommendations_PRVW%20(4).pdf)
- Nihon Hospital Volunteer Association (2011). *The history of Nihon hospital volunteer association*. Retrieved from <https://www.nhva.com/english/nihon-hospital-volunteer-association/>
- Nilsson, A., Rasmussen, B. H., & Edvardsson, D. (2016). A threat to our integrity—meanings of providing nursing care for older patients with cognitive impairment in acute care settings. *Scandinavian Journal of Caring Sciences*, 30(1), 48–56. <https://doi.org/10.1111/scs.12220>
- Nyumba, T. O., Wilson, K., Derrick, C. J., & Mukherjee, N. (2018). The use of focus group discussion methodology: Insights from two decades of application in conservation. *British Ecological Society*, 9(1), 20–32. <https://doi.org/10.1111/2041-210X.12860>
- OECD (2018). *OECD health statistics 2018*. Retrieved from <http://www.oecd.org/els/health-systems/health-data.htm>
- Pinkert, C., Faul, E., Saxer, S., Burgstaller, M., Kamleitner, D., & Mayer, H. (2018). Experiences of nurses with the care of patients with dementia in acute hospitals: A secondary analysis. *Journal of Clinical Nursing*, 27(1–2), 162–172. <https://doi.org/10.1111/jocn.13864>
- Saidlitz, P., Sourdet, S., Voisin, T., & Vellas, B. (2017). Management of behavioural symptoms of dementia in a specialized unit care. *Psychogeriatrics*, 17(2), 81–88. <https://doi.org/10.1111/psyg.12193>
- Tanajewski, L., Franklin, M., Gkountouras, G., Berdunov, V., Harwood, R. H., Goldberg, S. E., ... Elliott, R. A. (2015). Economic evaluation of a general hospital unit for older people with delirium and dementia (TEAM randomised controlled trial). *PLoS ONE*, 10(12), e0140662. <https://doi.org/10.1371/journal.pone.0140662>
- Taniguchi, S., Narumoto, J., Shibata, K., Ayani, N., Matsuoka, T., Okamura, A., ... Fukui, K. (2013). Treatment in a ward for elderly patients with dementia in Japan. *Neuropsychiatric Disease and Treatment*, 9, 357–363. <https://doi.org/10.2147/NDT.S41581>
- Tay, F. H. E., Thompson, C. L., Nieh, C. M., Nieh, C. C., Koh, H. M., Tan, J. J. C., & Yap, P. L. K. (2017). Person-centered care for older people with dementia in the acute hospital. *Alzheimer's & Dementia: Translational Research & Clinical Interventions*, 4, 19–27. <https://doi.org/10.1016/j.trci.2017.11.003>
- Tiessen, J., Kambara, H., Sakai, T., Kato, K., Yamauchi, K., & McMillan, C. (2013). What causes international variations in length of stay: A comparative analysis for two inpatient conditions in Japanese and Canadian hospitals. *Health Services Management Research*, 26(2–3), 86–94. <https://doi.org/10.1177/0951484813512287>
- Woods, D. L., & Dimond, M. (2002). The effect of therapeutic touch on agitated behavior and cortisol in persons with Alzheimer's disease. *Biological Research for Nursing*, 4(2), 104–114. <https://doi.org/10.1177/1099800402238331>
- World Health Organization (2017a). *10 facts on dementia*. Retrieved from <https://www.who.int/features/factfiles/dementia/en/>
- World Health Organization (2017b). *Global action plan on the public health response to dementia 2017–2025*. Retrieved from https://www.who.int/mental_health/neurology/dementia/action_plan_2017_2025/en/

SUPPORTING INFORMATION

Additional supporting information may be found online in the Supporting Information section.

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