Low investment non-pharmacological approaches implemented for older people experiencing responsive behaviours of dementia

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Abstract

Introduction: The acute care setting is not ideal for older people with dementia; responsive behaviours may be triggered when care is delivered within a strange environment by staff with limited knowledge of life history and personal preferences. Responsive behaviours (e.g., yelling, hitting, restlessness) are used by older people with dementia to communicate their needs and concerns. It is unknown whether non-pharmacological approaches used by nurses support the development of a meaningful interpersonal relationship between nurses and older people with dementia.

Aims: The aims of this study were to explore: (a) the types of low investment non-pharmacological approaches (e.g., music, social activities) used by nurses caring for older people experiencing responsive behaviours of dementia in acute medical settings and (b) the factors that influence the decisions of these nurses to implement these approaches.

Methods: We present a qualitative secondary analysis of data from a primary study using Thorne's interpretive description approach. Interviews were conducted with 11 nurses and four allied health professionals from acute medical settings in Canada. A qualitative secondary data analytic approach was used, specifically analytic expansion, and experiential thematic analysis.

Findings: Regardless of the educational preparation of nurses, the decision to use specific types of low investment non-pharmacological approaches were influenced by the perfunctory development of the interpersonal relationships in acute care hospitals. The factors that led nurses to use limited approaches (e.g., turning on the TV and providing a newspaper) were lack of dementia care education and attending to other acutely ill clients.

Conclusions: This study revealed that nurses in acute medical settings require greater practice growth to deliver relational care which is crucial to supporting older people with dementia. Nurses need education and knowledge translation support to use creative low investment non-pharmacological approaches with the intent on upholding the quality of life older people with dementia.

Keywords

dementia care, mental health, qualitative methodology, geriatrics

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Introduction

The estimated number of older people with dementia worldwide is 50 million (World Health Organization, 2019). Over half a million Canadians are affected by dementia (Alzheimer's Society of Canada, 2016). Approximately 25% of hospital beds are occupied by older people with dementia seeking care for acute illnesses (Hynninen et al., 2016). Compared to the general population, people with dementia in hospitals experience

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poorer nutrition and function, higher risk of death and delirium, and increased risk of falls related to responsive behaviours (Mukadam & Sampson, 2010; Sampson et al., 2009, 2014; Zhu et al., 2015). Approximately 75% of people with dementia who receive care in the hospital will experience responsive behaviours (Sampson et al., 2014). Responsive behaviours (e.g., yelling, hitting, restlessness, repetitive questioning) are words or actions exhibited by people with dementia in an effort to communicate their needs. These behaviours are present in response to pain, fear, hunger, or thirst. The hospital environment may trigger responsive behaviours for people with dementia due to an unfamiliar environment (Sampson et al., 2014) and cause feelings of distress, insecurity, anxiety, and fear (Hynninen et al., 2016).

Many providers perceive a lack of education in providing non-pharmacological approaches to address responsive behaviours (Schindel Martin et al., 2016). Examples of evidence-based non-pharmacological approaches are aromatherapy, multisensory stimulation, structured care routines, reminiscence therapy, and music therapy (Scales et al., 2018). These approaches often require structured education and knowledge translation support for nurses which is not always provided in an acute care environment. In working with resources at hand, nurses have been found to use perfunctory non-pharmacological strategies (e.g., distraction techniques, asking what is bothering a client, turning on the TV) to address responsive behaviours in surgical settings (Hynninen et al., 2016). These types of activities are not personally meaningful to an individual compared to tailored therapeutic activities. In an emergency department older adults and families have been found to be provided with additional care through tailored therapeutic activities including social visits and supplied activities (e.g., books, puzzles, crosswords, magazines) (Ellis et al., 2020). Despite the promising potential of therapeutic activities in acute care settings, many barriers in acute care settings exist (e.g., inadequate staffing, lack of dementia care education) leading to some nurses to resort to administering chemical or physical restraints (Digby et al., 2016).

Evidence-based non-pharmacological approaches are considered person-centred and selected to address the unmet needs of people with dementia (e.g., loneliness, boredom, and discomfort) that result in responsive behaviours (Canadian Gerontological Nursing Association, in press; Registered Nurses' Association of Ontario [RNAO], 2016; Scales et al., 2018). Low investment non-pharmacological approaches (e.g., bathing, mouthcare, and validation therapy) require: (a) less than one hour of education, (b) less than 15 minutes to implement, (c) no specialized knowledge, (d) less than $100 in materials with no ongoing cost and need for

environmental changes, (e) little tailoring to individualized needs prior to implementation, and (f) little need to assess carefully for risk-benefit to ensure safety (Scales et al., 2018). These approaches decrease agitation, anxiety, physical discomfort, apathy, and resistance to care. Moderate to high investment non-pharmacological approaches (e.g., multisensory stimulation, bright light therapy) may require more than four hours of provider education and greater than one hour to implement, have ongoing costs, and necessitate extensive environmental modifications or access to special equipment (Scales et al., 2018).

The discussion of evidence-based non-pharmacological approaches in the current literature is limited in terms of meaningful outcomes. The main objective of therapeutic interventions is to 'manage' responsive behaviours by implementing environmental, mechanical, and/or chemical restraints (Maust et al., 2015). When leisure activities are implemented such as music and reading these are often regarded as non-pharmacological 'interventions' or 'treatments' that can lead to a variety of clinically-oriented outcomes (e.g., decrease anxiety, reduced pain) (Dupuis et al., 2012; Genoe & Whyte, 2015). Low investment non-pharmacological approaches should be valued as means to enhance the quality of life of older people with dementia and build therapeutic relationships between nurses and clients. This can be achieved through relational caring practices which focuses on nurturing healthy relationships and supporting another person's well-being (Dupuis et al., 2016). Through this type of practice providers will experience a shift from a narrow lens on body and care management to understanding how to support human flourishing within complex relationships (Mitchell et al., 2020).

It is important to note that nurses, pragmatic clinicians, will need help to identify and apply specific interpersonal strategies that reflect and sustain relational care. Acute care nurses would require support in developing strategies that recognize mundane acts of care as a way to create some form of normalcy in an unfamiliar environment for older people with dementia. Mundane acts of care, defined as very ordinary or everyday acts and interactions of help and support, are viewed as achievements (Anderson et al., 2015) that can help to retain dignity in persons receiving care and promote a sense of continuity (Brownlie & Spandler, 2018). Examples include helping someone dress, supporting hygiene care, providing familiar objects, and continuing leisure activities. Mundane practices are used as a 'best basic practice' in long-term care settings to support personhood and identity among people with dementia (Buse & Twigg, 2014). In an acute care setting however mundane practices are limited by constraining factors such as the architectural and system design of hospitals focused

on financial profit (Buse et al., 2018). The materialistic culture and consumerist approaches to care in hospitals are reflected through small hospital rooms, push for discharges, and lack of personalized care.

Whether one chooses to implement low or high investment approaches, it is important to incorporate person-centred care into these approaches so that building positive relationships is valued as much as meeting physical/medical needs and task completion in acute care (Clissett et al., 2013). Person-centred care is a holistic approach that maintains the wellbeing of people with dementia. Kitwood (1997) defined personhood as the status assigned to individuals by others through respect, trust, and recognition. An example of a person-centred approach that can be used in acute care is listening to music with people with dementia (RNAO, 2016). Nurses caring for people with dementia in acute care have been found to often associate task-based approaches with person-centred ones and missed opportunities to implement care (Clissett et al., 2013) that will promote self-mastery, enjoyment and feelings of security of such individuals and their families.

In an acute care environment, which is fast paced with increasing demands placed on nurses, low investment non-pharmacological approaches are often implemented rather than high investment ones (Yous, Ploeg, Kaasalainen, Schindel Martin, & 2019). At present, the types of low investment non-pharmacological approaches implemented by nurses in acute medical settings are not well understood. It is unknown whether such approaches can be considered therapeutic and still support the development of an interpersonal relationship between nurses and older people with dementia. Improved understanding is necessary as acute medical units (i.e., general internal medicine) provide services to many older people with dementia who are at risk for experiencing responsive behaviour (Sampson et al., 2009, 2014). The factors that lead nurses to implement low investment non-pharmacological approaches in acute medical settings are also unknown.

The aims of the study were to explore: (a) the types of low investment non-pharmacological approaches used by nurses in caring for older people experiencing responsive behaviours of dementia in acute medical settings, and (b) the factors that influence the decisions of nurses to implement these approaches. In this paper low investment non-pharmacological approaches include both evidence-based approaches and personal strategies. The extended research questions were: (a) What types of low investment approaches are nurses using to care for older people experiencing responsive behaviours of dementia in acute medical settings? and (b) What are the influencing factors that inform the decisions of nurses to implement low investment non-pharmacological approaches? We present findings from a qualitative secondary data analysis of a primary study that explored nursing perceptions in caring for older people experiencing responsive behaviours of dementia in acute medical settings (Yous et al., 2019).

Methods

This section consists of an overview of the methods that were used in the study. The descriptions of the setting, sampling, recruitment, and data collection are reflective of the methods that were used in the primary study and are discussed within that context.

Design

This study used secondary analysis of qualitative data from a primary study (Yous et al., 2019) using Thorne's (2016) interpretive description approach to explore a clinical practice issue (i.e., nursing care delivery for older people experiencing responsive behaviours). Thorne (2016) indicates that a secondary analysis is appropriate to revisit data guided by a new or extended research question and further elaborate on findings within an expanded clinical context, if the new question aligns with the data. When researchers are immersed in primary data, this opens new lines of inquiry that merit attention. During the process of analyzing data collected during the primary study, the researchers realized participants were describing their experiences with 'everyday' approaches used to address responsive behaviours as part of their practice repertoire. The researchers identified this phenomenon to be distinct from yet aligned with the primary questions and agreed that a secondary analysis would contribute to a richer understanding of the concept of low investment non-pharmacological interventions, and the factors that might influence their use in acute care settings.

Primary Study: Setting, Sampling and Recruitment

The primary study was conducted in four acute medical units (i.e., three clinical teaching units and a cardiology unit) in a hospital in Ontario, Canada housing approximately 130 acute medical beds (Yous et al., 2019). Participants were registered nurses, registered practical nurses, a nurse educator, and allied health professionals (e.g., occupational therapists, a social worker, a physiotherapist). We sought to explore how the experiences of allied health professionals witnessing nursing care delivery in the context of responsive behaviour contributed to the descriptions of the nurses themselves.

Purposive sampling was used including criterion and maximum variation sampling (Patton, 1990). Nurse participants met the following criteria: (a) a registered nurse or registered practical nurse, (b) work in an acute

medical setting, and (c) cared for at least one person with dementia experiencing responsive behaviours in an acute medical setting within the past two years. Allied health professionals also had to have experience in interacting with or caring for older people experiencing responsive behaviours. Maximum variation sampling (Patton, 1990) was used to locate participants with varied work experience, education levels, and dementia care preparation. A behavioural specialist sent an email invitation to all eligible participants. Nursing managers shared study information during rounds. The first author provided in-person introductions for nurses and placed recruitment posters in staff rooms and at nursing stations. An incentive (i.e., $25 gift card) was offered to participants to promote participation.

Primary Study: Data Collection

The first author conducted individual face-to-face semi-structured interviews from December 2017 to March 2018 and audio-recorded and transcribed interviews (Yous et al., 2019). Participants were asked about their day-to-day experiences in supporting older people experiencing responsive behaviours. For example, participants were asked about the strategies they use to learn more about the life story and capabilities of clients (see Yous et al., 2019 for interview questions). All interviews, ranging from 25 to 45 minutes, took place at a time and workplace area chosen by participants (e.g., unoccupied staff and conference rooms). Participants were interviewed once. Reflective field notes were made after the interviews by the first author to capture actions and personal reactions. Interviews continued until recurrent themes emerged that addressed the research questions, while recognizing that it is not possible to capture all experiences at a single timepoint (Thorne, 2016).

Secondary Data Analysis

A qualitative secondary data analytic approach was used in this study, specifically analytic expansion, as we conducted a secondary interpretation of our own data source from the parent study (Yous et al., 2019) to answer extended research questions (Thorne, 1994). Through the analytic expansion process, we formed revised research questions and conducted an in-depth review of our own database to determine whether our data could provide answers to the extended questions. Thematic analysis was used in this study to guide the creation of themes as it was consistent with Thorne's (2016) design. Specifically, experiential thematic analysis, a form of thematic analysis, was used as it focuses on the viewpoints of participants and their experiences (Braun & Clarke, 2013). The actual words of the participants are recognized as narrative data that supports the naming of themes. Data obtained from the nurses were analyzed separately from data obtained from allied health professionals. Secondary data analysis was conducted independently by the first author and all team members reviewed the themes to achieve consensus. NVivo Version 12 was used to organize data.

Rigour and Trustworthiness

For interpretive description, credibility criteria consist of "epistemological integrity, representative credibility, analytic logic, and interpretive authority" (Thorne, 2016, p. 96). For epistemological integrity, we ensured that our line of reasoning was aligned with the extended research questions. For representative credibility we used triangulation of two data sources, data from nurses and allied health professionals, to support claims and offer an alternative perspective on caring for people with dementia. Credibility was maintained by ensuring that the words of participants were embedded in the themes. For analytic logic, we ensured that the study process description was detailed and sound. A comprehensive review of the literature was conducted to ensure it was supported by recent evidence and reflected the current gaps. In considering interpretive authority, we displayed honesty in findings by reflecting participants' actual words.

Ethical Considerations

Ethics approval for the parent study was granted by the Hamilton Integrated Research Ethics Board (HiREB #4101). Written informed consent was obtained prior to interviews.

Findings

A brief description of the participants is provided before going on to discuss the two main categories of themes consisting of types of low investment non-pharmacological approaches used by nurses and the factors impacting their decision to use them.

Demographic Characteristics

A total of 15 healthcare professionals participated in the parent study (i.e., 10 nurses, one nurse educator, and four allied health professionals) (see Table 1). Most participants were female (87%) and had a bachelor's degree (73%). Participants worked in various roles and almost half were registered nurses (47%). Most participants had 10 or more years of experience in their current role (60%). All except one participant had received dementia care education in the past five years.

Table 1. Demographic Characteristics of Participants (N = 15).

Characteristics	n (%)
Age in years [mean (SD)]	42.9 (12.9)
20–29	4 (26.7%)
30–39	1 (6.7%)
40–49	5 (33.3%)
50 and above	5 (33.3%)
Gender	
Female	13 (86.7%)
Male	2 (13.3%)
Highest education completed	
College diploma	4 (26.7%)
Bachelor's degree	11 (73.3%)
Employment status	
Regular full time	9 (60.0%)
Regular part time	6 (40.0%)
Number of years of experience in an acute medical unit	
≤1	2 (13.3%)
1–2	1 (6.7%)
3–4	5 (33.3%)
5–9	3 (20.0%)
10–14	2 (13.3%)
15 and up	2 (13.3%)
Current role(s)	
Registered nurse	7 (46.7%)
Registered practical nurse	3 (20.0%)
Nurse educator	1 (6.7%)
P.I.E.C.E.S. educator/behaviour specialist/ Psychogeriatric resource consultant	2 (13.3%)
Physiotherapist	1 (6.7%)
Occupational therapist/geriatric case manager	1 (6.7%)
Number of years of experience in current role(s)	
≤2	2 (13.3%)
3–4	3 (20.0%)
5–9	1 (6.7%)
10 and up	9 (60.0%)
Completed a dementia care education program within the past 5 years	
Yes	14 (93.3%)
No	1 (6.7%)

Note. The total percentages for the number of years of experience in an acute medical unit and current role do not equal 100% due to rounding of values.

Themes

Themes were categorized under two main categories. The first category consisted of types of low investment non-pharmacological approaches used by nurses to care for older people experiencing responsive behaviours of dementia. The second category consisted of factors influencing the implementation of low investment approaches. Participant quotes are labelled with an N for nurse and AHP for allied health professional. The emergent themes are distinct from those of the primary study in that they are specific to the use of low investment non-pharmacological strategies and influencing factors for their use.

Types of Low Investment Non-Pharmacological Approaches Used by Nurses

Themes of types of low investment non-pharmacological approaches used were: (a) involving families and healthcare providers: *"getting everyone involved makes for a greater success,"* (b) implementing sensory activities without being present: *"they're by themselves and they're occupied,"* (c) engaging clients in a social activity: *"I engage with the patient,"* (d) using an authority figure: *"seeing a big security guy will calm them down,"* and (e) modifying the environment: *"we isolated him in the far room."*

Involving families and healthcare providers: *"getting everyone involved makes for a greater success."* Due to the complex nature of responsive behaviours, nurses involved healthcare providers and families to help meet the physical, psychological, and emotional needs of clients. When allied health professionals engaged clients in arts and crafts and exercises, nurses reported having more time to fulfil other tasks. Involving personal support workers ensured the safety of clients through monitoring if they were at risk of harming themselves or others. Nurses reported seeking information about client preferences and life stories from families. Clients were perceived to be more willing to accept care (e.g., vital sign assessments, hygiene care) when family members were present.

> *Because when they recognize that family, they trust that family and it's a big thing trying to get that family involved which is hard on an acute medicine floor but, it does really help. If you involve them in their care, the family's happy, the patient's happy and just having that reassurance of the family sitting with them when they are acting up kind of helps.* (N-07)

Involving others in the care of older people with dementia made care delivery easier as it allowed nurses to share care with others to promote success in addressing responsive behaviours.

Allied health professionals perceived that they collaborated with nurses to gain more information about the functional abilities of clients, however most of the discussions between nurses and allied health professionals did not focus on the interests or preferences of clients.

> *I do actually rely on the nurses sometimes to say you know "if the son comes in, can you find*
>
> *out…?" But, that's usually more very functional things like "how many stairs do they have?",*

"were they using a walker at home?" So you know there are examples of where I do work

with the nurses that way to get some information because obviously they're there all day and they might encounter a family member. I would take that into consideration if somebody tells me, "At home they never slept in a bed, they were always in their lounging chair and they really always liked being around music." That's really rare though to hear those kinds of life experience things. (AHP-02)

Discussions between nurses and healthcare providers were often task-focused such as ensuring that older people were provided with a walker and delegating tasks to personal support workers.

Implementing sensory activities without being present: "they're by themselves and they're occupied." Nurses recognized that clients exhibited responsive behaviours of dementia due to boredom and loneliness. They therefore implemented sensory activities such as playing music in a client's room, turning on the TV, offering a newspaper, and asking a client to fold face cloths. "*We had one gentleman who loved to read the newspaper so we get the newspaper and if he gets agitated we'll have him sit at the table in the lounge and have the newspaper in front of him*" (N-01). These activities were intended to keep clients occupied without the nurse having to remain with them and were perceived as simple to implement. These types of activities were not always reflective of the interests of older people as nurses used whatever resource was at hand. Approaches implemented reflected those everyday objects such as a radio, TV, and newspaper, immediately available.

Engaging clients in a social activity: "*I engage with the patient.*" Nurses reported that they engaged clients experiencing responsive behaviours in therapeutic social activities where nurses were expected to participate in the activities. Nurses would take walks with clients and engage them in conversations about their lives during care. Nurses also shared their own stories.

During that shower we chatted. Talked about their young children. Their children are all grown, right? And in their 60's but, talking about young children and my children and schools and engaging them to keep their minds off of things. (N-06)

One nurse reported that she would sing or hum a tune with clients experiencing responsive behaviours to lift their spirits. "*Sometimes I sing with the patient. If they love to sing. I don't know what they like to sing but humming with them makes them happy*" (N-09). Other types of activities nurses used were offering snacks, conversing with them, and participating in arts and crafts: "*We have*

one particular patient in there now, he has paintings, he has colouring things…we're always finding ways to keep him occupied" (N-04). Nurses reported implementing activities to persuade clients to take medications and agree to receive a shower. A nurse educator perceived that distraction was commonly used by nurses to care for clients.

There's one patient who does have the responsive behaviour of not wanting to take his medications and actually pushing the nurse away. She [nurse] has worked with this patient and he's been able to take the medication since. And distraction was a key factor. (N-11)

Activities were used to encourage compliance with routines. Clients were not given the choice to agree to care as some activities (e.g., hygiene care) were perceived as essential by nurses.

Using an authority figure: "*seeing a big security guy will calm them down.*" Nurses sought the assistance of security personnel when clients exhibited responsive behaviours. Security personnel served as an authority figure by instilling intimidation to persuade clients to return to their rooms and prevent responsive behaviours of a physical nature from occurring. Clients were more likely to comply with the requests of security personnel than of nurses. Having male security personnel present was perceived by nurses as increasing safety on the unit. Nurses recognized that having security personnel and multiple staff members surround a client can trigger responsive behaviours, but with limited resources on an acute medical unit nurses perceived that this was warranted to enforce safety when episodes of responsive behaviour escalated to a level of risk because of physicality.

I personally wouldn't feel comfortable handling that if they were to become physically aggressive so I would feel more comfortable if security personnel were present. But, at the same time I feel that it's a little bit contradictory simply because the more people there are surrounding the patient, I feel like that would be a trigger too. It doesn't really help with their behaviour but, honestly that's all I can really try to do in an acute care setting. (N-05)

Nurses used discretion in calling security personnel and this was often done as a last resort after they had tried other non-pharmacological strategies. "*I try to distract them. See what could distract them to kind of bring them over to what you want them to do. If that doesn't work, you gotta call security*" (N-03). The extent as to how much effort was spent by nurses to implement other non-pharmacological strategies prior to calling security personnel was unknown.

Modifying the environment: *"we isolated him in the far room."* Nurses tried to create a low stimulus environment for persons with responsive behaviours on the acute medical unit. Some nurses would offer clients a quiet private room to limit stimulation and these rooms were located far away from high traffic areas such as the nursing station. *"We isolated him in the far room. Quieter environment"* (N-07). Nurses would create physical barriers by closing doors so that clients experiencing responsive behaviours did not wander from the unit. One nurse placed a sign outside of a client's room to alert visitors and staff to potential responsive behaviours. *"Closing the doors, having barriers, there's a sign in front of their doors to notify visitors, allied health, kitchen staff, cleaning staff that this patient can be responsive in behaviours and to limit that stimulation"* (N-02). Nurses modified the environment to prevent responsive behaviours.

Factors Influencing the Use of Low Investment Non-Pharmacological Approaches

Themes related to the factors that led nurses to use low investment non-pharmacological approaches were the following: (a) lack of dementia care education: *"I don't think we have enough,"* (b) numerous nursing responsibilities: *"there's a lot of paperwork and other things,"* (c) inadequate staffing: *"it is the lack of staff,"* (d) attending to acutely ill clients: *"there's so many unstable patients,"* and (e) preoccupation with safety: keeping clients *"out of trouble."*

Lack of dementia care education: *"I don't think we have enough."* Nurses on acute medical units perceived that they did not receive enough education on dementia care and were therefore not aware of diverse evidence-based non-pharmacological approaches. They did not feel prepared to care for clients exhibiting responsive behaviours of dementia. *"I don't feel very prepared all the time especially if someone is more combative and they're trying to hit you"* (N-03). Nurses expressed interest in learning about more practical non-pharmacological strategies in caring for people experiencing responsive behaviours of dementia, which was often not stressed enough in acute care. *"More knowledge-based or case-based [education]. Like what works good, actual examples. I think that would be more helpful because sometimes when you read research, they're so general and not always relevant to what you're doing"* (N-08). Allied health professionals perceived that nurses used more pharmacological approaches than non-pharmacological approaches for clients with dementia.

> They're [nurses] quite fine to jump to quick solutions. That's why they're delighted when you start talking

about medications as an option because… *"Yes! Perfect! I can do that! I can administer medications."* So they tend to gravitate towards those discussions. When it comes to a shift in their practice and maybe doing things differently, that's when it becomes very challenging. (AHP-04)

Numerous nursing responsibilities: *"there's a lot of paperwork and other things."* Nurses in acute medical settings reported that they had a heavy workload in terms of the number of clients assigned to their care and the expected nursing tasks to complete. They perceived that they lacked time to attend to the needs of clients experiencing responsive behaviours.

> There's a lot of paperwork and other things and with any patient having dementia or not, I find that we don't have time to sit and talk with our patients like we used to years ago. So we are always in a hurry to finish all our care. (N-01)

Nursing expectations in acute medical settings such as providing medications on time and documenting care were perceived as impacting the delivery of person-centred care. Allied health professionals also perceived that nurses and other healthcare providers were very busy with having to meet their work demands.

> Everybody's pushed. Nursing staff, PSWs, even on acute health, medicine. All the physios, I think the doctors are pushed to rush between you know different units. It feels like everybody is really busy now. (AHP-02)

Inadequate staffing: *"it is the lack of staff."* Nurses perceived that they did not have enough staff available to care for clients experiencing responsive behaviours. The lack of staffing led nurses to use simple approaches as they did not have time to interact with clients with dementia, provide them with comfort, and strengthen their therapeutic relationship.

> Unfortunately, on acute medicine floors, it's [interaction] not always available especially when we're short staffed. Everyone's running around. So at times the patient-nurse relationship really declines which is a sad effect. (N-02)

Attending to acutely ill clients: *"there's so many unstable patients."* Nurses cared for acutely ill clients and were confronted with medical emergency situations. They therefore did not have the perceived time or resources to invest in higher level approaches in caring for older people with dementia and often sought quick solutions.

All the patients that we have, they're medically unstable. Sometimes they require medical attention from the nurses and it's hard to juggle that when you are having a patient that's exhibiting responsive behaviours and one patient who requires medical attention. (N-04)

Nurses were often faced with tensions in deciding who to attend to first, clients experiencing responsive behaviours or medically unstable clients.

Preoccupation with safety: keeping clients "*out of trouble*." Low investment strategies were used as quick solutions to keep clients experiencing responsive behaviours occupied so that they did not wander out of their rooms and to ensure their safety. Turning on the TV or playing music may not engage clients for long periods, but these activities required little resources and time to implement. When clients experiencing responsive behaviours participated in activities provided by nurses, this allowed nurses to care for other clients and helped them feel reassured that clients with dementia and other clients were safe while they attend to other duties. Keeping clients occupied as a distraction technique was nurse-directed and reflects the tension in acute medical settings between safety and person-centredness.

So to keep them out of trouble, we will give them some tasks like folding the face cloths too. That way they're gonna sit at the table you know they're gonna do that, we could go ahead and look after the patients. (N-01)

Nurses had little access to equipment such as radios or dolls that would be useful to engage clients. Some but not all families brought belongings from home to promote person-centred care.

Pictures of his family…and then we then we start talking about his family and then when his family would come in, we would have them write their name when they visited. (N-07)

Discussion

The emergent finding of the study was that regardless of the formal care delivery or educational model, it is up to the individual nurse to support the needs of older people with dementia, regardless of the sector within which that person is receiving care. Most of the nurses in the study had received dementia care education, however low investment non-pharmacological approaches used by nurses were not always reflective of their educational preparation. Findings suggest instead that the types of low-investment non-pharmacological approaches used by nurses to meet the physical, emotional, and psychological needs of older people experiencing responsive

behaviours are influenced by the perfunctory development of interpersonal relationships in acute care hospitals. Previous research has shown that although busy acute care environments can act as a barrier to developing interpersonal relationships, staff still recognize the need to learn about clients with dementia and build therapeutic relationships (Baillie et al., 2016). The current study findings point to the growing understanding that dementia care is so complex that it requires a combination of educational interventions targeting relationship-building skills, attitudes, and knowledge; a one-stop education approach and a one-stop care delivery model are not sufficient.

Nurses in the study were found to act in some ways that reflected relational caring and provided some therapeutic activities such as asking persons with dementia or families about his or her life story and sharing their own personal stories and respecting personal preferences (Dupuis et al., 2016). Nurses engaged clients in social activities such as walking and talking. Although walks are not categorized under traditional forms of non-pharmacological approaches, the act of 'walking with' another person represents companionship and a shared goal towards wellbeing and happiness (Doughty, 2013). Findings however mostly pointed towards the revelation that acute care nurses require more practice growth in the area of relational care and building meaningful interpersonal relationships as they would take actions that can negatively impact interpersonal relationships such as instilling intimidation through security personnel and limiting interactions with clients. Relational care is especially important for older people with dementia to honour their full citizenship in spite of a decline in cognitive and physical abilities (Mitchell et al., 2020). In order for staff nurses in a busy acute care unit to provide more meaningful activities targeting relational care they would need access to equipment such as painting materials, playing cards, and photo albums, which are often provided when delivering care using Montessori methods for persons with dementia (Sheppard et al., 2016).

In the present study nurses used authority figures such as security personnel as an intimidation tactic when responsive behaviours occurred. Similarly, Ashton and Manthorpe (2019) found that security staff were involved in addressing responsive behaviours of dementia due to staff shortages. Intimidation is a concept found in Kitwood's (1997) malignant social psychology theory that undermines a person with dementia's wellbeing by instilling fear related to threat or physical power. Strong concerns for safety and security led nurses to exert power in situations when older people were experiencing responsive behaviours. By enacting power in the therapeutic relationship, this could

undermine the actions that were previously taken to build a relationship built on trust and respect.

Few of the approaches that were used by nurses in the study were evidence-based or aligned with expected gerontological nursing standards of practice or expected guidelines (Canadian Gerontological Nursing Association, in press; RNAO, 2016). Strategies (e.g., asking clients to fold face cloths, involving security personnel) used reflected an outdated and punitive approach. This is not to say that nurses were operating below standards in all cases. Rather, there were also instances when they were not recognizing and highlighting the 'mundane' aspects of practice that they do not yet see as a necessary part of the entire model of person-centred care delivery (Brownlie & Spandler, 2018). For example, in the current study nurses supported mundane acts of care by helping with showers, playing music, turning on the TV, and offering the newspaper. These types of acts were used to create familiarity for older people with dementia and promote their wellbeing. Albeit they were not often consciously or purposefully applied for a therapeutic purpose and were not evaluated for impact using a systematic approach. This equate with the notion of 'token' or 'cursory' acts that further undermine their important clinical value.

We also found multiple factors (e.g., lack of dementia care education, inadequate staffing, preoccupation with safety, attending to medically unstable clients, limited access to equipment such as books, puzzles and art supplies) that led nurses in acute medical settings to resort to low investment non-pharmacological approaches. There was limited permission for acute care nurses to use creativity in implementing approaches. The acute care environment itself can trigger responsive behaviours (Schindel Martin et al., 2016) and access to low stimulus environments is limited in acute care. There is a strong relationship between quality of life of people with dementia and the quality of the built environment (Dijkstra et al., 2006; Fleming et al., 2016). The acute care environment triggers responsive behaviours due to an imbalance between necessary stimulation (e.g., social activities) and unnecessary stimulation (e.g., high noise levels), and lack of safe space for walking to facilitate large muscle energy expenditure. Hospital staff face time pressures in meeting the needs of all clients and are better prepared to care for people with acute illnesses (Yous et al., 2019; Dewing & Dijk, 2016). Time pressures and the structure of the acute care environment, in turn, impact the interpersonal relationship between clients and nurses.

There are many studies that highlight what evidence-based non-pharmacological approaches entail (e.g., music therapy, meaningful activities, massage) and the effects of these in preventing or reducing responsive behaviours of dementia (Legere et al., 2018; RNAO,

2016; Scales et al., 2018; White et al., 2017). Despite what is known regarding evidence-based strategies, the present study offers a unique contribution that revealed types of approaches that nurses were actually using in acute medical settings and how these were at times different than what is currently considered as evidence-based strategies. This suggests that perhaps there is a need to broaden the definition of evidence-based non-pharmacological approaches to ensure that strategies (e.g., involving families, engaging clients in mundane activities) that impact relationships and quality of life of older people with dementia are also being considered.

Strengths and Limitations

The strengths of the present study were the inclusion of nurses and allied health professionals to expand findings and a broad definition of low investment non-pharmacological approaches was used. The limitations were that only one hospital site in Canada was included in the study, limiting the transferability of findings and the potential overuse of datasets which may lead to biases in findings (Thorne, 2016). The primary study was not conducted to specifically collect findings on the use of low investment non-pharmacological approaches and factors influencing their use, however this was a strong theme that emerged during interviews and were therefore explored with participants. The exploration of low investment non-pharmacological approaches required further in-depth investigation separate from the primary study.

Implications for Practice

Given that people with dementia have multiple co-morbidities and seek acute care services for conditions other than dementia, there is a need to ensure that nurses are supported in applying evidence-based approaches that involve non-pharmacological strategies to reflect best-practices expectations. Expectations include being able to differentiate and address dementia, delirium, and depression by implementing appropriate interventions for each condition (RNAO, 2016). Dementia care education and easily accessible equipment should be provided for acute care nurses to implement creative non-pharmacological interventions as a first line approach and as an adjunct to leverage those pharmacological treatments when the inter-professional health team agrees that medications are warranted. Healthcare organizations have a responsibility to equip nurses with non-pharmacological approaches tailored to individual needs, the context of care and equipment and resources available. Organizational commitment will serve to reinforce non-pharmacological interventions as

an expected nursing intervention in the acute care setting, aligned with best practice expectations.

In supporting nurses to develop their repertoire of evidence-based non-pharmacological interventions there are also potential positive outcomes for older people, families, and nursing staff. These include the reduction of pain and agitation and greater success in completing activities of daily living for older people experiencing responsive behaviours (RNAO, 2016). Nurse-client relationships can be strengthened by implementing therapeutic activities with the intent on improving the quality of life of people with dementia. There is the potential to increase family satisfaction with the care being provided for older people with dementia and reduce conflicts between nursing staff and families. Research has shown that addressing responsive behaviours perceived as physically or verbally threatening negatively impacts employment satisfaction and influence the decision of nurses to change professions (Costello et al., 2019; Public Services Health and Safety Association, 2007). The implications of this study therefore reveal the need to enhance nursing successes in being able to safely provide care for older people experiencing responsive behaviours to help retain a healthy nursing workforce in acute care.

Regulated and non-regulated point-of-care staff have been educated to use a robust set of Montessori-type interventions in the long-term care setting with some success (Ducak et al., 2018). Both registered nurses and registered practical nurses in acute care settings also require this same level of preparedness to identify and apply to older people with responsive behaviours. In addition, future research studies are needed to implement and evaluate a formal education intervention where acute hospital nurses receive ongoing knowledge translation mentoring so that an expanded repertoire of creative non-pharmacological interventions is built and sustained over time.

Conclusions

This study revealed that nurses caring for older people experiencing responsive behaviours in acute medical units used low investment non-pharmacological approaches that were influenced by the perfunctory development of interpersonal relationships in acute care hospitals. There is a need to provide dementia care education focused on relational caring so that nurses from acute medical settings adopt more person-centred and a variety of creative, meaningful, evidence-based non-pharmacological approaches in practice. Without education on how to provide non-pharmacological interventions, the wellbeing of clients in acute care settings will be bleak. Nurses need support to use non-pharmacological approaches that are not only efficient, but effective because of their creative and innovative potential and potential to address the psychosocial needs and remaining capabilities of older people with dementia. Since some approaches that are relatively ineffective and detrimental to the nurse-client therapeutic relationship are being used in acute care, there is a need for more research in developing a variety of low investment non-pharmacological approaches. These approaches should still uphold the personhood of people with dementia and align with expected practice standards in the long-term care sector to provide consistency for non-pharmacological approaches across sectors.

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