DEMENTIA CARE

Care of patients with dementia in an acute trauma and orthopaedics unit


Abstract

Aim To increase awareness of the needs of patients with dementia in the trauma and orthopaedics unit of one acute hospital, and to collaborate with staff on the unit to identify ways of improving the care experienced by these patients and their families.

Method An action research approach was used and three action research cycles were completed. Data were obtained retrospectively for 20 patients with dementia who were admitted to the unit for treatment. Deficiencies in the care of these patients were identified and related to communication, pain management and the recognition of delirium. In response, a dementia toolkit was developed by nurses and implemented on the unit to improve the care of patients with dementia.

Findings Comparison of pre-implementation and post-implementation audit results indicated a significant improvement in all aspects of care for patients with dementia in the trauma and orthopaedics unit, as a result of the implementation of the dementia toolkit. Education and training were provided to staff on the ward to ensure the toolkit was implemented appropriately.

Conclusion It is important to consider the specific needs of patients with dementia in acute care settings, not only the primary reason for their admission. The involvement and inclusion of staff in determining what change was needed on the unit, how change would be undertaken and the positive effects of change, demonstrates how action research can inform and improve clinical practice.

Keywords action research, acute care, communication, delirium, dementia, older people, research, trauma

THE TERM ‘DEMENTIA’ is used to describe a syndrome that may be caused by a range of illnesses in which there is progressive decline in multiple areas of the individual’s functioning, including memory, reasoning, communication skills and the ability to carry out daily activities (Wilson et al 2011). Alongside this decline, people with dementia may develop behavioural and psychological symptoms that might complicate care delivery, such as depression, psychosis and aggression, and that can occur at any stage of the illness (Department of Health 2009).

The most common types of dementia are Alzheimer’s disease and vascular dementia, while other forms of the disease include frontotemporal dementia and dementia with Lewy bodies (Takeda et al 2012). Dementia is a progressive condition, thus the symptoms are likely to worsen over time. The progression of symptoms and experience of dementia will vary between individuals. It is unclear why dementia develops, and once cognitive impairment begins, there is little that can be done to prevent its progression (Wilson et al 2011).

Background

Acute hospital wards are busy environments. Admission to hospital can be stressful for any patient, and can be particularly challenging for those with dementia because of their cognitive impairment. Patient distress and
confusion, and the challenges associated with meeting patients’ fundamental care needs often lead to suboptimal outcomes, such as increased length of stay in hospital. Patients with dementia often require additional time and specific attention when they are admitted to acute hospital settings (Van Hunen Bos 2011).

Up to 70% of acute hospital beds are occupied by older people, approximately 40% of whom have dementia (Alzheimer’s Society 2009). Although dementia might not be the primary reason for the patient’s admission, those who have dementia experience increased care complications, such as pressure ulcers, falls and incontinence (Royal College of Nursing (RCN) 2013). Studies also show that the average length of stay in an acute hospital for a person with dementia is greater than that for an individual without the condition (Johnston et al 2011). Overall, patients with dementia typically stay in hospital 25% longer – and in some acute hospital settings, up to 85% longer – than patients without dementia (CHKS 2013).

Patients with dementia are also at increased risk of delirium, with an estimated 90% of these individuals developing delirium following hip surgery (Björkelund et al 2009). All older patients should be assessed for delirium, especially those with dementia. If delirium is not treated, individuals can develop additional complications that may result in adverse outcomes, such as delayed discharge or death (Hasemann et al 2016).

In acute care settings, the focus is usually on the patient’s presenting condition, for example a fracture following a fall. Staff will have the knowledge, skills and expertise to treat the patient in relation to their respective specialty; however, the patient’s diagnosis of dementia is often overlooked (Alzheimer’s Society 2009). The care of patients with dementia can be challenging for generalist clinicians and evidence suggests that nurses in the acute care setting may lack the specialist knowledge, skills and confidence required to provide this care (Surr et al 2016). Issues relating to communication, nutrition and pain management have been identified as priority areas for improving the care of patients with dementia in the acute care setting (Alzheimer’s Society 2009, Department of Health, Social Services and Public Safety 2011).

**Aim**

To increases awareness of the needs of patients with dementia in the trauma and orthopaedics unit of one acute hospital, and to collaborate with staff to identify ways of improving the care experienced by these patients and their families.

**Method**

The study used an action research approach, which involves the systematic development of knowledge rooted in experience with the purpose of generating new forms of understanding among individuals (Williamson et al 2012). It is conducted by practitioners who are working in an area where they have recognised an issue, and is often referred to as practitioner research. Action research typically involves identifying an issue and engaging in action research cycles to overcome this issue (Koshy et al 2010). The four stages of an action research cycle are: planning, action, observing, and critical reflection.

One of the attributes of action research is the focus on day-to-day practice and the work context. Since it involves thinking about and reflecting on work, it is considered a form of self-reflective practice (McCormack 2009). Self-reflection was central to this research project, because staff on the trauma and orthopaedics unit had the potential to realise how their attitudes, values and behaviours might be hindering necessary changes to the care of patients with dementia on the unit.

**Findings**

Three action research cycles were completed. The first action cycle was undertaken to address the issue of suboptimal care of patients with dementia on the trauma and orthopaedics unit.

**Cycle 1: planning**

The first action research cycle began with the ‘planning’ stage. This involved exploring the issue of suboptimal care of...
patients with dementia on the trauma and orthopaedics unit and identifying possible solutions. During a clinical supervision session, two staff nurses observed that the patients with dementia admitted to the unit for acute trauma care were not receiving the regional standards of care aimed at improving the services and support available for people with dementia (Department of Health, Social Services and Public Safety 2011) (Box 1), and that staff on the unit felt stressed when caring for such patients. It was acknowledged that it can be challenging for staff to identify and provide additional assistance and support required by patients who are cognitively impaired on a busy ward. The manager of the trauma and orthopaedics unit supported the research project and encouraged staff in its application and implementation.

It was important to assess the extent of the issue, in other words the extent of suboptimal care of patients with dementia on the trauma and orthopaedics unit, because this informs the planning stage (Parahoo 2014). An audit was undertaken of the care of 20 patients admitted to the trauma and orthopaedics unit for orthopaedic treatment, but who also had a diagnosis of dementia. The purpose of the audit was to gather baseline data to determine the standard of care these patients received in relation to nutrition, communication, pain management and the recognition of delirium. The case notes were retrospectively selected at random for patients discharged during 2013.

The results of the audit indicated that:

» For 25% (n=5) of patients, there was no documentation to indicate the type of dementia with which they were diagnosed.

» Pain was not adequately assessed using an observational pain assessment tool, which meant that pain relief was not administered regularly or appropriately for any of the patients.

» There were minimal notes about communication with patients’ families. For example, information about patients’ individual needs was documented in 45% (n=9) of the case notes reviewed.

The audit indicated that improvement in communicating with patients with dementia and their families was required. It also showed that it was necessary to improve pain management and the identification of delirium in patients with dementia.

**Cycle 1: action**

The second stage of the action research cycle is action. The action stage involved two staff nurses requesting a meeting with other nursing staff on the unit to inform them of the audit results and to plan how care could be improved. The nursing team made suggestions about what would assist them when caring for patients with dementia. It was agreed that a dementia toolkit should be developed that would include information, charts, documents and advice to overcome the deficiencies in care that were identified by the audit. The two staff nurses took the lead and developed a dementia toolkit to increase awareness of dementia in patients, provide support and assistance to patients with dementia, and to communicate discreetly that a patient has dementia to all members of the multidisciplinary team.

On the trauma and orthopaedics unit, patient documentation such as fluid balance and clinical observation charts, are usually held in a black folder at the end of the patient’s bed. For patients with dementia, the colour of the folder was changed to purple, because this is the international colour representing dementia (Alzheimer’s Society 2016a). In addition to the standard ward documentation, the purple folder contains:

- a letter to the patient’s family members explaining that the unit is a dementia-friendly ward; advice about communicating with patients with dementia; a traffic-light communication sheet for patients with dementia; the Cognitive Impairment

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**BOX 1. Regional standards of care to improve the services and support available for people with dementia**

- Person-centred and multidisciplinary approach
- Provision of information to the patient and their family
- Improved staff knowledge and skills
- Preservation of patient function and skills, and prevention of decline
- Appropriate use of medication and other interventions
- Environmental design that is dementia-friendly

(Department of Health, Social Services and Public Safety 2011)
Pain Assessment Scale; and information about the assessment and management of delirium. This purple folder, with relevant documentation and information, was referred to as the dementia toolkit.

**Letter to the patient’s family members explaining that the unit is a dementia-friendly ward**

Having as much information as possible about the patient is essential to ensure person-centred care and communication (RCN 2013). It is important to learn how patients with dementia function best in everyday life, from their family and carers. The patient’s family often has valuable information about the patient that can support staff to make accurate assessments, provide care that meets the individual’s needs, and enable effective discharge planning. The letter included in the dementia toolkit enables the initiation of such conversations with families, and provides them with information and reassurance about the care their relative will receive on the ward.

**Advice about communicating with people with dementia**

Effective communication is essential to enhance the well-being of patients with dementia and prevent stressful situations from developing (RCN 2013). It may take patients with dementia additional time to understand what is being said to them, and unfamiliar people and hospital routines, along with the effects of acute illness, often exacerbate such difficulties. Patients with dementia in hospital may be unable to understand explanations, follow directions, report their symptoms and needs, ask for help, and develop and maintain relationships with staff. This may lead to miscommunication between healthcare professionals and patients and suboptimal care delivery (Eggenberger et al 2013).

In addition to assessing the patient’s communication difficulties and patterns, nurses should gather further information from their family or carers that will enable staff to communicate with the patient in a person-centred manner, resulting in improved interpretation of unclear vocalisations and improved anticipation of their needs. Such information may include: the patient’s preferred name and the names of their immediate family members; their daily routine, including eating, sleeping, leisure activity, and toileting patterns; potential situations they might find upsetting; potential calming interventions; how they might exhibit pain; and possible sources of comfort and reassurance. Advice about how to communicate effectively with patients who have dementia is included in the dementia toolkit (Box 2).

**Traffic-light communication sheet for patients with dementia**

Time spent in hospital can result in the deterioration of daily living skills, confidence and independence for any patient. Thus, it is essential for staff to acknowledge the multiple abilities and needs of patients with dementia (RCN 2013). To prevent compounding issues associated with functioning, care should proactively promote re-enablement and rehabilitation to achieve the patient’s optimal level of function. The traffic-light communication sheet focuses on nutrition, continence and mobility, and has a section where family members may include further relevant information about the patient (Figure 1). This is completed on the patient’s admission to the unit, using information gained from their family members, to ensure an accurate record of the patient’s ability to carry out activities of daily living, such as eating and drinking, mobilisation and elimination. The assessment

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**BOX 2. Advice about how to communicate effectively with patients who have dementia**

- Approach the patient from the front, where possible
- Ensure you have the patient’s attention by minimising other distractions
- Encourage the patient to focus by maintaining eye contact. Try to be at the patient’s eye level, since standing over them can be intimidating
- Recognise the importance of non-verbal communication. As much as 90% of communication is non-verbal. The patient with dementia will most likely be aware of your body language
- Speak clearly and calmly. Make sentences short and simple. Make one point at a time
- Avoid asking the patient questions that require complicated answers
- Ensure you give the patient adequate time to process information
- Listen carefully and be aware of the patient’s body language
- Avoid contradicting or arguing with the patient with dementia, since they can become confused
- Do not speak down to or over the patient with dementia, or treat them like a child

(Adapted from Alzheimer’s Society 2016b)
depends on knowing not only what the patient’s present functional ability is, but also what it was before their hospital admission. The aim is to restore and maintain the patient’s optimal level of function before they are discharged from the unit.

Use of the Cognitive Impairment Pain Assessment Scale
In the trauma and orthopaedics unit, most patients will experience pain during their stay. Suboptimal pain management for patients with dementia may lead to unnecessary pain, difficulty mobilising, increased agitation, increased risk of developing delirium and increased length of stay in hospital (Achterberg et al 2013). Patients with dementia are particularly vulnerable to unmanaged pain as a result of their difficulty in communicating (Regnard et al 2003), which may mean they are unable to report pain. Despite being equally susceptible to painful conditions, patients with dementia often receive fewer analgesics than patients who are not cognitively impaired (McLachlan et al 2011). Pain assessment tools, particularly observational or behavioural tools, such as the Abbey Pain Scale (Abbey et al 2004) or the Pain Assessment in Advanced Dementia scale (PAINAD) (Warden et al 2003), can assist the identification of pain-related behaviour. However, these tools are more effective in long-term care settings than in acute care settings.

The Bolton Pain Assessment Scale (BPAS) (Gregory 2011) was developed for use in an acute hospital setting, and was therefore considered the most appropriate pain assessment tool for use on the trauma and orthopaedics unit. The BPAS (Gregory 2011) is a combination of the Abbey Pain Scale.
(Abbey et al 2004) and the PAINAD scale
(Warden et al 2003), and has an additional
section for the patient’s family to provide
pain behaviour information about the
patient with dementia. This tool enables
staff on the unit to undertake an extensive
assessment of the patient, rather than simply
asking the individual: ‘are you in pain?’ As
with other observational pain assessment
tools, the healthcare professional observes
for visual signs of pain in the patient’s facial
expressions and speech, for example if they
are tense, groaning or crying out.

The BPAS (Gregory 2011) includes other
physical signs of pain, such as fidgeting, fist
clenching or changes in the patient’s usual
eating patterns. The patient’s reactions to
other people, including pulling, pushing
away and striking out is also assessed as
possible manifestations of pain and/or
discomfort. These signs are scored from
0 (absent) to 3 (severe), and the scores
are totalled to give an overall pain score,
which indicates whether the patient is
experiencing no pain, mild pain, moderate
pain or severe pain. Analgesics are
prescribed and administered accordingly.

Permission was received from the specialist
pain team at the royal Bolton Hospital NHS
Foundation Trust to adapt the BPAS for use
on the trauma and orthopaedics unit and
other wards in the trust. Figure 2 shows the
Cognitive Impairment Pain Assessment Scale,
which was adapted from the BPAS (Gregory
2011) by the authors and included in the
dementia toolkit.

Information about the assessment and
management of delirium
Delirium is the sudden deterioration
in mental functioning, which is caused
by acute illness, acute injury or drug
intoxication (Siddiqi 2011). As many as
one in eight patients in hospital may
be affected by delirium, and it is the most
common complication experienced by older
people in hospital (Siddiqi 2011). Delirium
can be caused by various factors, such as
unfamiliar surroundings, pain, dehydration,
electrolyte imbalances, constipation and
infection. By recognising the difference
between dementia and delirium, as well
as managing delirium promptly and
appropriately, the patient experience can be
improved significantly. To assist with the
recognition and management of delirium,
a flow chart was included in the dementia
toolkit, which was based on the National
Institute for Health and Care Excellence’s
(2010) recommended interventions to
prevent delirium.

Cycle 1: observing
The next stage of the action research cycle
involves observing the effects of the action,
in this case the use of the dementia toolkit
on the unit. On an agreed date, the first
version of the toolkit was introduced and
used in practice. However, while the toolkit
was used in the care of some patients with
dementia, it was not applied appropriately
by some nurses on the unit. In the fourth
stage of the action research cycle, critical
reflection, it was felt that staff required
further education on the use of the
dementia toolkit. This led to the second
action research cycle.

Cycle 2: staff education
One issue identified from the first action
research cycle was the lack of staff education
about the effects of dementia, the onset
of delirium and the use of the dementia
toolkit; therefore, a second action research cycle
commenced. The planning stage of this cycle
related to providing further education for
staff to enable the changes to care to become
embedded in everyday practice. Staff on
the trauma and orthopaedics unit required
information about what practices were to
change, as well as how best to implement
the changes. It was important for staff on
the unit to be aware of the rationale for the
contents of the dementia toolkit to enhance
its effectiveness. This is an ongoing process
because the ward environment is dynamic.

The action stage of this cycle focused on
teaching and training sessions, supported
by the nurses who had developed the
dementia toolkit. These sessions were held
at lunchtime, or on an ad hoc individual
basis when the opportunity arose, with
all members of staff on the unit, with the
purpose of improving the care of patients
with dementia. Additional dementia toolkits
were made available to staff following this

KEY POINT
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education initiative and were to be used when a patient with dementia was admitted to the unit.

The third stage of this cycle, observing, involved undertaking a repeat audit six months after the dementia toolkit was introduced of 20 patients with dementia who were admitted to the trauma and orthopaedics unit. Comparison of the results pre-implementation and post-implementation of the dementia toolkit indicated significant improvements in all aspects of care of patients with dementia on the unit (Table 1). Pre-implementation data found that a recognised dementia pain assessment tool was not used for any of the patients with dementia, whereas post-implementation data found that the Cognitive Impairment Pain Assessment Scale was used in 95% ($n=19$) of patients. Evidence that regular pain relief was prescribed was documented in 30% ($n=6$) of patients pre-implementation of the dementia toolkit, whereas this increased to 90% ($n=18$) of patients post-implementation.

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**Figure 2. Cognitive Impairment Pain Assessment Scale**

Cognitive Impairment Pain Assessment Scale  
Adapted from the bolton pain assessment scale  

<table>
<thead>
<tr>
<th>Score</th>
<th>Absent (0)</th>
<th>Mild (1)</th>
<th>Moderate (2)</th>
<th>Severe (3)</th>
<th>Date</th>
<th>Time</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vocalisation</td>
<td>None</td>
<td>Occasional moan or groan</td>
<td>Low level speech with a negative or disapproving quality</td>
<td>Repeatedly crying out loud, moaning or crying</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Facial expression</td>
<td>Smiling or relaxed</td>
<td>Looking tense</td>
<td>Sad, frowning</td>
<td>Grimacing and looking frightened</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Change in body language</td>
<td>None</td>
<td>Tense, fidgeting</td>
<td>Guarding part of the body</td>
<td>Withdrawn, rigid, fists clenched, knees pulled up</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Behavioural change</td>
<td>None</td>
<td>Increased confusion</td>
<td>Refusing to eat, alterations in usual eating pattern</td>
<td>Pulling or pushing away, striking out</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physiological signs</td>
<td>Normal</td>
<td>Occasional laboured breaths, increased heart rate</td>
<td>Hyperventilation, increased heart rate and blood pressure</td>
<td>Changes in pulse, blood pressure or respiratory rate, and perspiring, flushed or pallor</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical changes</td>
<td>None</td>
<td>Skin tears</td>
<td>Pressure ulcers, arthritis</td>
<td>Pre-operative trauma or less than four days after surgery</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pain on movement / physiotherapy</td>
<td>None</td>
<td>Mild</td>
<td>Moderate</td>
<td>Severe</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

0-2 = No pain  
2-6 = Mild pain  
9-14 = Moderate pain  
15+ = Severe pain  

Total score and signature  
Name:  
Date of birth:  
Health and Care Number:  
Action taken and time to review
Cycle 3 – sustainability
To ensure that the changes to the care of patients with dementia on the trauma and orthopaedics unit were sustained, several members of staff on the unit were selected to become dementia champions, attending The Best Practice in Dementia Care learning programme provided by the University of Sterling in Scotland (Dementia Services Development Centre 2007). These dementia champions have been equipped with workbooks and resources and have facilitated the development of up to eight further dementia champions on the unit over six months. This cycle continues, but preliminary results and feedback from staff and families are positive. It is envisaged that the dementia toolkit will eventually be implemented in all acute and older adult wards in the trust.

Discussion
The dementia toolkit is a discreet, subtle and inexpensive way of improving care for patients with dementia and their families, and supports the development of a person-centred culture on the unit. It is evident from the results of the pre-implementation and post-implementation dementia toolkit audits that use of the dementia toolkit has resulted in significant changes to the care of patients with dementia on the trauma and orthopaedics unit.

Effective communication is essential to ensure optimal care for patients with dementia. It is also important for staff to consider that the unfamiliar hospital environment can be overwhelming for patients with dementia. Previous studies have established that for these patients, their dementia is often seen as secondary to the primary reason for their admission to hospital, thus meeting dementia-related needs may be considered a low priority that requires additional time and diverts nurses attention from their primary purpose of delivering acute medical or surgical care (Moyle et al 2011). In addition, staff on acute hospital wards may have an acute care ‘mindset’ that does not consider the specific needs of patients with cognitive impairment (Eriksson and Saveman 2002).

Table: Audit results for the care of patients with dementia admitted to the trauma and orthopaedics unit (n=20)

<table>
<thead>
<tr>
<th>Category</th>
<th>Patients before implementation of the dementia toolkit % (No.)</th>
<th>Patients after implementation of the dementia toolkit % (No.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type of dementia documented</td>
<td>25 (5)</td>
<td>55 (11)</td>
</tr>
<tr>
<td>Communication sheet completed</td>
<td>45 (9)</td>
<td>100 (20)</td>
</tr>
<tr>
<td>Recognised dementia pain assessment tool used</td>
<td>0 (0)</td>
<td>95 (19)</td>
</tr>
<tr>
<td>Evidence that regular pain relief was prescribed from the point of patient admission</td>
<td>25 (5)</td>
<td>95 (19)</td>
</tr>
<tr>
<td>Evidence that analgesics were prescribed when required</td>
<td>70 (14)</td>
<td>100 (20)</td>
</tr>
<tr>
<td>Regular pain relief administered from the point of patient admission</td>
<td>30 (6)</td>
<td>90 (18)</td>
</tr>
<tr>
<td>Evidence that family members were updated on the progress of the patient</td>
<td>0 (0)</td>
<td>80 (16)</td>
</tr>
</tbody>
</table>

Part of the complexity of caring for people with dementia in acute hospital wards results from an acute care focus on the patient’s physical diagnosis, whereas patients with dementia require highly skilled assessment and care planning designed to coordinate their physical and mental health needs (Bezzant 2008). Caring for these patients may be physically and mentally demanding (Eriksson and Saveman 2002), and often takes place in areas with high workloads, insufficient staffing levels and inappropriate physical environments (Dean 2011). The dementia toolkit has enabled staff on the trauma and orthopaedics unit to address suboptimal care of patients with dementia in relation to issues around communication, managing pain and recognising delirium (Alzheimer’s Society 2009).
to ensure effective communication, pain assessment and pain relief for patients with dementia has been paramount. Effective communication techniques are essential when assessing pain. The nurse has a central role in identifying and appropriately assessing pain to provide effective treatment (Buchanan et al 2014). Pain is often not recognised and undertreated in patients with dementia (Reynolds et al 2008), since they may not be able to report pain (Herr et al 2006). According to Riva et al (2011), unrelieved pain can result in an individual experiencing disorientation, confusion and reduced concentration. For individuals with dementia, the experience of pain can manifest as behavioural disturbances, such as agitation and aggression (Cohen-Mansfield 2014).

Morrison and Siu (2000) found that following surgery for hip fracture, patients who were cognitively impaired received one third of the opioid analgesics administered to patients who were not cognitively impaired. These results are comparable to the data collected before the use of the Cognitive Impairment Pain Assessment Scale in the dementia toolkit. Overall, effective management of undiagnosed pain can reduce behavioural disturbances and distress (Ahn and Horgas 2013). Staff on the trauma and orthopaedics unit are aware that they cannot rely on usual pain assessment tools when caring for patients with dementia; instead, they should consider pain indicators, such as changes in mood and behaviour, to provide an accurate assessment of pain and to distinguish between pain and other issues such as delirium.

**Staff training**

It has been suggested that conventional didactic classroom approaches to training do not improve knowledge sufficiently to support changes to clinical practice (Ballard and Aarsland 2009, Smythe et al 2015). Staff often have little opportunity to leave the clinical environment for training, or to meet as a team to reflect and learn together (Smythe et al 2015). Therefore, training delivered in the clinical setting may be more feasible and might have greater potential to enhance practice.

It was necessary to involve and include staff on the unit to determine what change was needed, how change would be undertaken and the positive effects of the change, demonstrating how an action research approach can inform and enhance clinical practice.

**Conclusion**

When a patient with a diagnosis of dementia is admitted to an acute hospital ward, all members of the healthcare team should be made aware of their condition, because the patient will often require additional time and specific attention (Van Hunen Bos 2011). On a busy acute hospital ward, it can be challenging for staff to identify the patient’s need for additional assistance and support because of the cognitive impairment associated with dementia. The dementia toolkit includes information and advice to ensure that the patient’s dementia-related needs are recognised, documented and met, alongside the primary reason for their admission.

While an acute care setting is not ideal for patients with dementia, many of these individuals will require this type of admission when presenting with acute trauma or acute comorbid conditions; therefore, effective training for staff in the care of these patients is essential. Staff in acute care settings should have appropriate knowledge and skills to meet the needs of patients with dementia.

**IMPLICATIONS FOR PRACTICE**

» It is important that healthcare professionals consider the specific needs of patients with dementia in acute care settings, not only the primary reason for their admission. Part of the complexity of caring for people with dementia in acute hospital wards results from an acute care focus on the patient’s physical diagnosis, whereas patients with dementia require highly skilled assessment and care planning designed to coordinate their physical and mental health needs.

» In additional to standard ward documentation, the dementia toolkit includes a letter to the patient’s family members explaining that the unit is a dementia-friendly ward; advice about communicating with patients with dementia; a traffic-light
communication sheet for patients with dementia; the Cognitive Impairment Pain Assessment Scale; and information about the assessment and management of delirium. The toolkit has been used successfully in one acute trauma and orthopaedics ward to promote person-centred care and enhance the care experience for patients with dementia and their families.

- It is essential that healthcare professionals receive appropriate education and training to ensure they have the knowledge and skills to meet the needs of patients with dementia, irrespective of the healthcare setting.

References


Ballard C, Aarsland D (2009) Person-centred care and enhance the care of delirium. The toolkit has been used successfully in one acute trauma and orthopaedics ward to promote person-centred care and enhance the care experience for patients with dementia and their families.

- It is essential that healthcare professionals receive appropriate education and training to ensure they have the knowledge and skills to meet the needs of patients with dementia, irrespective of the healthcare setting.