Care provision for people with dementia in Maltese hospital wards: paradoxes between hospital staff perceptions and observational and audit data

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This study

Evaluated hospital care provision for people with dementia living in two wards in a hospital in Malta.

Focused on:

- Environmental design
- Psychosocial care delivery
- Staff understandings and practice of person-centred care

Study design

Comparative:

- Time 1 October 2011
- Time 2 October 2012

Participants:

2 hospital wards (W1 and W2) – ward staff (N=69) and people with dementia (N=16).

Methods

- Physical ward environment
  - *Environmental Audit Tool* (EAT) (Fleming and Forbes, 2003)
- Psychosocial care environment
  - *Dementia Care Mapping* (DCM) (Bradford Dementia Group, 2005)
- Staff views of the ward
  - *Person-centred Climate Questionnaire* – Staff version (PCQ-S) and *Person-centered care assessment tool (PCAT)* (Edvardsson et al., 2010a, b)

Analysis

Data sets – DCM, EAT, staff questionnaires x 2 time points were analysed according to operational rules.

Practice and environmental recommendations from T1 analysis fed back to hospital management.

Data from T2 were scrutinised and compared for change from T1 data.

Findings: environmental design

Total potential EAT score = 112

Time	Ward 1	Ward 2
October 2011	22/112	30/112
October 2012	28/112	40/112

Table 2: EAT scores on each ward at T1 and T2

Comparison of key design features T1 and T2: improved

Visual access – improved signposting using pictures of local landmarks and religious objects

Stimulus enhancement – signs on toilet, shower and bathrooms.

Privacy – slight improvement in ensuring privacy during intimate care

Community – provision of quiet seating area in one ward, but at end of a long corridor and unused

Community access – verandas more attractive to sit in.

Comparison of key design features T1 and T2: unchanged

Stimulus enhancement – excellent natural lighting from large veranda windows

Familiarity – some personal items on bedside lockers and some cultural objects in wards

Safety – low scores reflect hospital design of wards

Ward size – larger than recommended for optimal experience; 28 and 31 patients respectively

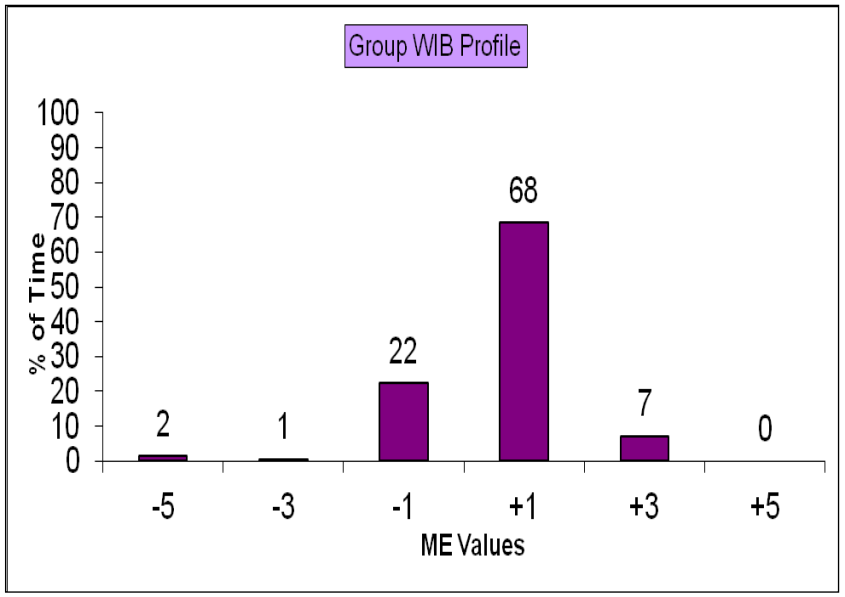
Stimulus reduction – very loud buzzers and door entry bell

Walking and access outside – poor access to outside spaces

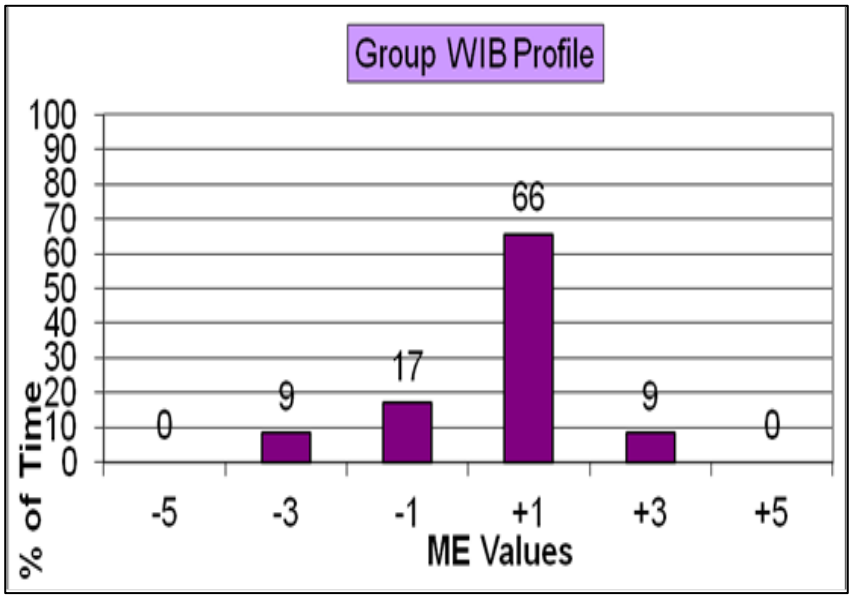
Community access – few areas for visitors to spend time with their relative/friend other than beside bed or in television room

Domestic activities – no opportunity or space to engage in domestic or meaningful activity.

DCM Findings: ward 1
T1 and T2

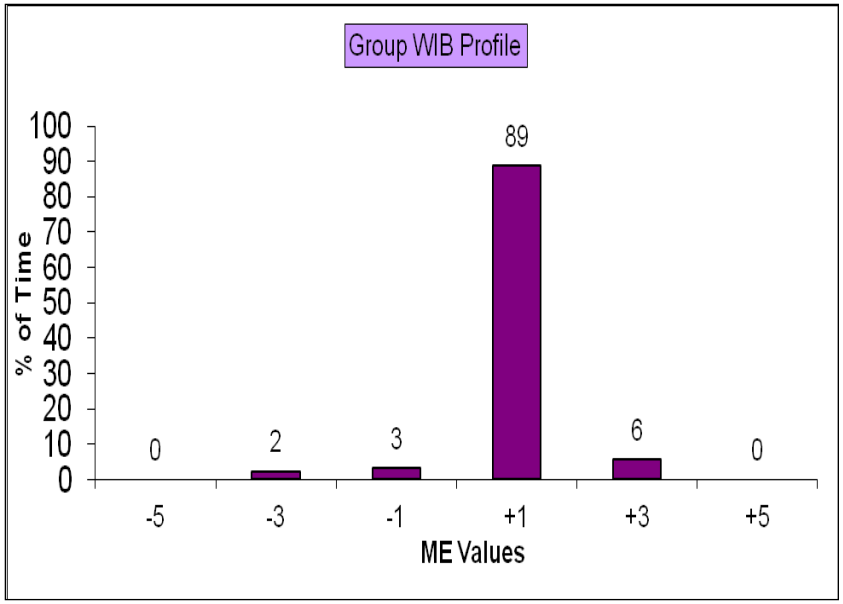


Group WIB profile 2011

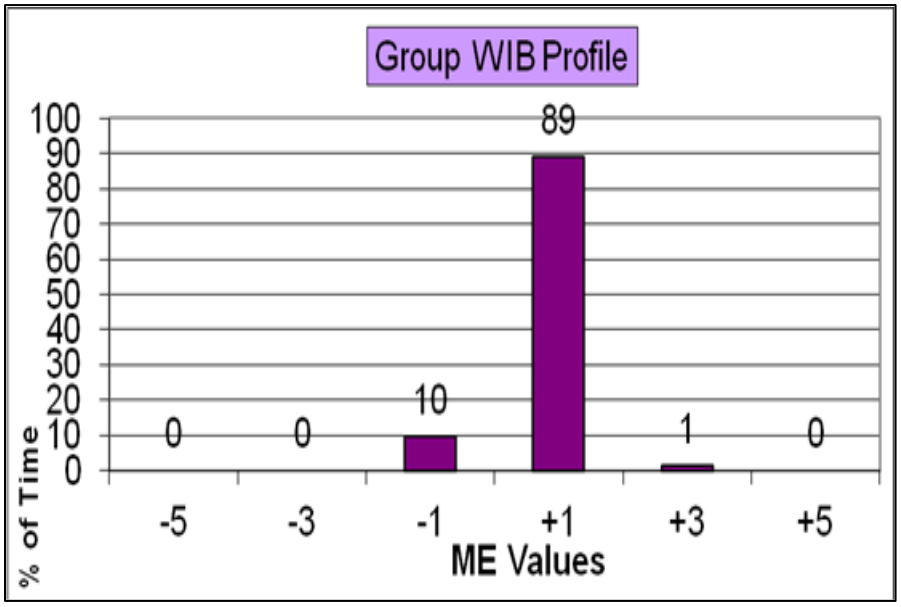


Group WIB profile 2012

DCM Findings: ward 2
T1 and T2



Group WIB profile 2011



Group WIB profile 2012

Comparison of DCM between T1 and T2: improved

- Slight improvement in attention to patient dignity
- In one ward more positive interactions between staff and residents
- Improved awareness of patient experience – ensuring television programmes are not potentially distressing.

Comparison of DCM between T1 and T2: unchanged

- Staff were kind and wanted to do a good job
- Despite high staffing levels, tasks rushed and patients disempowered or ignored
- Insufficient positive interaction between staff and patients
- Lack of insight into patient experience
- Poor continence promotion
- Inappropriate use of restraint.

Person Centred Care Assessment Tool – agree/strongly agree

	2011	2012
We often discuss how to give person-centred care.	89%	89%
We have formal team meetings to discuss residents' care.	89%	97%
The life history of the residents is formally used in the care plans we use.	75%	75%
The quality of the interaction between staff and residents is more important than getting the tasks done.	45%	51%
We are free to alter work routines based on residents' preferences.	54%	57%
Residents are offered the opportunity to be involved in individualised everyday activities.	72%	79%
Assessment of residents' needs is undertaken on a daily basis.	77%	79%
I simply do not have the time to provide person-centred care.	23%	18%
The environment feels chaotic.	10%	18%
We have to get the work done before we can worry about a homelike environment.	43%	56%
This organisation prevents me from providing person-centred care.	29%	43%
It is hard for residents in this facility to find their way around.	14%	15%
Residents are able to access outside space as they wish.	26%	28%

Person-centred Climate Questionnaire, staff version - agreement

	2011	2012
A place where I feel welcome.	94%	70%
A place where I feel acknowledged as a person.	91%	67%
A place where I feel I can be myself.	82%	61%
A place where the patients are in safe hands.	100%	94%
A place where the staff use a language that the patients can understand.	100%	79%
A place which feels homely even though it is in an institution.	86%	81%
A place where there is something nice to look at.	91%	74%
A place where it is quiet and peaceful.	73%	64%
A place where it is possible to get unpleasant thoughts out of your head.	66%	59%
A place which is neat and clean.	97%	85%
A place where it is easy for the patients to keep in contact with their loved ones.	100%	84%
A place where it is easy for the patients to receive visitors.	97%	97%
A place where it is easy for the patients to talk to the staff.	91%	91%
A place where the patients have someone to talk to if they so wish.	91%	90%

PCAT: congruence between staff views and observational data

- Staff reported discussing how to give person-centred care, suggesting a theory-based platform for practice. However, DCM data indicates there is much more work to be done.
- No change in recognition of the importance of life history in care plans, however DCM data indicated scant usage of this in practice.
- A slightly increased recognition of offering patients the opportunity to be involved in individualised everyday activities, however DCM data reveal the narrowness of activities patients engaged in.
- An increase in the view that the organisation prevents provision of person-centred care, however DCM data indicate high staffing levels.

PCQ-S: congruence between staff views and observational data

- Staff felt their practice was person-centred but DCM data indicated there is work to be done.

- Changing perception of the importance of communicating in a language patients can understand = decline in confidence in communication abilities, fewer English or Maltese speaking staff? Supported by DCM data.

- Changing perceptions of the environment suggests more awareness of the importance of making the hospital wards more dementia-friendly; EAT data supports slight improvements but PCAT data contradictory.

Concluding comments

- This study demonstrates the utility of taking a 3-pronged approach to assessing quality of dementia care and experience of living in hospital wards.
- Some increase in awareness of the principles of a person-centred approach and dementia friendly design.
- Applying this knowledge in practice takes commitment and effort from management and staff teams.
- Some changes to improve practice were easily implementable, others will take longer and will involve more sustained work.

Next steps

Recommendations to support continuing improvements in care for people with dementia in hospital
1. Training and mentoring of staff of all levels
2. Ensure patients' dignity and respect their rights
3. Ensure privacy when carrying out personal care
4. Formal team meetings and informal discussions to promote and recognise good practice
5. Recognise and respond to differing needs
6. Make the most of opportunities that present themselves
7. Promote meaningful interaction between staff and patients and between patients themselves
8. Promote a variety of activities for patients
9. Promote mobility
10. Ensure access to outside space
11. Staff to discuss and consider use of space to promote patient well-being and good practice
12. Promote continence
13. Provide objects that are interesting/stimulating
14. Involve families in ward life and decisions
15. Involve patients in ward life

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