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Dementia responsive behaviours

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Exploring nursing staff views of responsive behaviours of people with dementia in long-stay facilities

Abstract

Introduction: Caring for people with dementia and responsive behaviours can challenge nurses and little is known of their experiences.

Aim: To explore nurses views of supporting people with dementia and responsive behaviours in long-stay facilities.

Methods: A qualitative descriptive study utilising in-depth audio recorded interviews of 9 nurses, recruited from private and public care facilities. Qualitative content analyses conducted involving iterative comparisons of transcripts, summaries and memos; where coding, key quotes and tables were developed to determine themes.

Results:

Four themes emerged: recognising and understanding responsive behavior, resources and interventions to support people with dementia and responsive behavior, the impact of education on nursing practice, and the care environment.

Discussion:

Availability of staff, adequate time and financial restraints hinder nurses' ability to provide care. Access to ongoing education and being able to provide one-to-one care was valued as dementia specific education changed nursing practice.

Implications for practice:

Place of care was seen as dependent on; the type of responsive behaviour in question, the duration of the behaviour and the impact of the behaviour on the person, other residents and staff. Dementia education needs to be accessible to all staff and a collaborative approach is necessary in order to develop management guidelines and support strategies.

Key words: dementia, nurses views, older person, person-centered, responsive behavior

Relevance statement

This study highlights that nurses view of responsive behavior influences care provided and negative views can influence the quality of care and the person's quality of life. Nurses saw that to be person-centered they needed to enable personhood and see the person at the center of care. For this to occur nurses need to see responsive behaviours as the person's inability to communicate a need and that these behaviours were outside the person's control. Without such an understanding care providers run the risk of silencing and dehumanising the person through not affording them the opportunity to express their views and/or wishes and becoming focused on managing behaviours, assessing problems and labeling deficits.

Accessible Summary

What is known on the subject

- Caring for people with dementia and responsive behaviours is challenging however, little is known of nurses experiences of responsive behaviours.

What this paper adds to the existing knowledge

- To demonstrate understanding nurses need to be aware of their own actions, thoughts, attitudes and reactions.
- Time, education and management support are essential in enabling a person-centered approach.
- A decision regarding the place of care is difficult to come to and given the drive to a person-centered approach there is a need to consider the views of people with dementia.

What are the implications for practice

- Nursing staff supporting people with dementia should engage more frequently in reflective practice, ongoing education and decision making.
- Service providers/managers need to have an understanding of the complexities of caring for a person with dementia and responsive behaviours and provide their staff with relevant supports and education that is accessible to all staff.

INTRODUCTION

Responsive behaviour, is a relatively new term to describe what had been termed 'behavioural and psychological symptoms of dementia (BPSD)', 'behaviours of concern', 'problem behaviour', 'neuropsychiatric symptoms', 'disruptive behaviour' and 'challenging behaviour' and represent non-cognitive symptoms of dementia and include agitation, aggression, disturbed perception, thought context, mood or behavior (International Psychogeriatric Association 2015). The response of nursing staff to people with dementia and responsive behaviour can depend on their view of responsive behaviour. If the standard paradigm is applied then the nurse will believe the person with dementia is displaying random behaviours caused by damage to the brain by dementia or may be due to personality traits (Pulsford *et al.* 2011, Duxbury *et al.* 2013). If however, a Person-Centered Care (PCC) approach is followed, then nursing staff will look for meaning in the behaviour and understand that responsive behaviours are an attempt to communicate an unmet need (Kitwood 1997). Consequently, staff response will vary depending on which paradigm is favoured; to either treat the behaviour with medications, to sedate the person and stem the behaviour or to seek out biopsychosocial triggers for the responsive behaviours. This study focuses on nurses' views towards

people with responsive behaviours in long-stay care facilities in Ireland. Long-stay refers to wards and units providing care to people with dementia, receiving in-patient services on premises where nursing care is provided on a 24 hour basis (Health Service Executive 2011). This conceptual definition of long-stay care facilities encompasses all other terms describing relevant care facilities such as; nursing homes (public/private), extended care units, long-term care units and residential care units for older people. Little qualitative evidence exists regarding nurses experiences of responsive behaviours and given the focus and importance of person-centered care it is timely to highlight nurses' views of responsive behavior.

BACKGROUND

Dementia is an umbrella term used to describe a group of symptoms characterised by behavioural changes and loss of cognitive and social functioning (Cahill *et al.* 2014). There are several types of dementia, the most common being Alzheimer Type Dementia followed by Vascular Type, Multi-Infarct Dementia, Frontotemporal Dementia, Dementia with Lewy Bodies, other types of dementia include; Korsakoff's Disease, Creutzfeldt-Jakob Disease (CJD), HIV associated dementia and younger onset dementia (Alzheimer's Society of Ireland 2016).

Responsive behaviour is the preferred term of people with dementia to describe; how their actions, words and gestures are a response, often intentional, that express something important about their personal, social or physical environment (Alzheimer's Society of Ontario 2013). However, these behaviours can be viewed negatively and are often why families seek support resulting in people with dementia being admitted to long-stay care facilities (Zwijssen *et al.* 2014). With increasing numbers of people with dementia in long-stay care facilities; this increases the nurse's likelihood of experiencing responsive behaviours (MacDonald and Cooper 2007). Several factors have been identified as contributing to responsive behaviours such as; residents and caregiver characteristics, environment, workload, quality of the organisation and management of the facility (Isaksson *et al.* 2008).

Pulsford *et al.* (2011) highlight that 'responsive behaviours' are common in long-stay care facilities while Scott *et al.* (2011) indicate that 'workplace violence is a global phenomenon'. Both family and professional carers are often at the receiving end of threats, insults and at risk of injury from the people they are trying to support (Duxbury *et al.* 2013), this is often the case for people caring for people with dementia as neuropsychiatric symptoms are common (Zwijssen *et al.* 2014). 69% of staff report wandering and intrusiveness and 27% report physical aggression more than once a day (Cubit

et al. 2007). While staff attitudes have been examined in quantitative research, staffs' perspectives on patient aggression or response to people with dementia who are aggressive are under investigated within qualitative research (Pulsford *et al.* 2011, Duxbury *et al.* 2013). The evidence that exists stems from Lachs *et al.* (2012) examining 'verbal and physical aggression' from residents to nursing staff and Nakahira *et al.* (2008) review of 'attitudes towards dementia-related aggression' amongst staff in Japanese long-stay care facilities. However, while these studies do not examine the views of staff, they reveal that older more experienced staff with higher education levels and at higher grades had a more positive attitude towards patient related aggression (Nakahira *et al.* 2008, Lachs *et al.* 2012). With the growing numbers of people with dementia, prevalence of responsive behaviours, focus on person-centered care and governments internationally striving to implement strategies/policies, there is a need to highlight nurses' views of responsive behaviours to inform policy and management practices.

METHODS

Aim

To explore nursing staff views of supporting people with dementia and responsive behaviours in long-term care facilities.

Design

A qualitative descriptive design was used to gain a comprehensive description of participants' views through utilizing their own language to convey their thoughts, ideas, beliefs, and experiences (Sandelowski 2000). As it recognises the value of generating data based on personal viewpoints, contextual factors and reflexive interpretation to provide a comprehensive understanding (Sandelowski 2010). Although description rather than interpretation is the aim, interpretation is always present, and the researchers' own perspectives inevitably influence or transform the data (Sandelowski 1995).

Sample

Upon ethical approval, access was sought through the Directors of Nursing who acted as gatekeepers and distributed the invitation letter, information sheet and expression of interest form to participants. Purposive sampling was employed based on: participants having direct contact with people with dementia and responsive behaviours in a long-stay care setting, having at least one year experience caring for people with dementia with responsive behaviours and been a registered nurse.

To gain sample variance, seven sites in Ireland were selected allowing for a cross-section of nursing staff in both public and private long-stay facilities (public long-stay facilities include HSE nursing homes, geriatric hospitals and community nursing units, while private long-stay facilities are private nursing homes). In addition, nursing disciplines included intellectual disability, general and mental health. Within the sample 1 public and 8 private long-term facilities were represented within the sample. A target of 14 participants was set to allow for dropout and 5 people who expressed an interest to participate did not contribute due to work and personal commitments. However, as no new data were emerging it was decided not to recruit additional participants as data saturation was achieved. All who participated in this study were female.

Data collection

Semi-structured interviews were conducted to ensure all required information was obtained, provide participants the freedom to talk freely and the researcher to seek clarification where necessary (Doody & Noonan 2013). A pilot interview was carried out prior to the study to ensure the suitability of the interview guide and no changes were necessary (Doody & Doody 2015) with interviews conducted between March and June 2016. Interviews were audio-recorded, conducted by the first author and lasted between 26 and 78 minutes with an average of 46 minutes.

Ethical considerations

The study was approved by the Health Service Executive, South Eastern Area Research Ethics Committee prior to commencement. Throughout the study, attention was paid to participants' rights to: autonomy, dignity, informed consent, voluntariness and confidentiality. Interviews took place by mutual agreement of time and location with written consent obtained and participants informed that they could withdraw from the study at any time. Participants' confidentiality was ensured by assigning an identification number to their interview that was only known by the researcher.

Data analysis

Data analysis commenced after conducting the first interview, occurring simultaneously with data collection. The pilot interview was excluded from data analysis and each interview was transcribed by the first author and content analyses were performed to identify and explore patterns of

relationships within and between cases, following Elo & Kyngas (2008) framework: preparation, organising and reporting. An inductive approach to data analysis was undertaken by the researcher, where categories were elicited from the transcribed data, creating generalised statements from specific comments and remarks from the participants. As themes emerged from the data they were coded and then recoded, pre-set codes were not used. This allowed for the identification of common themes in the texts and a condensed broad description of participants views (Elo & Kyngas 2008).

Rigour

The reliability of the interview guide (Table 1) was established during the pilot interview. To ensure credibility a 'true' representation of participant's views are presented through descriptive quotes and statements. Through providing study information, quotations and reaching data saturation readers can draw on the transferability of this study and its findings. To support data analysis and formation of themes, each participant received their transcript for comment and both researchers analysed the data independently and met to discuss themes. In addition, a summary of themes/subthemes were sent to participants with a thank you letter seeking agreement that the themes reflected their views. Engaging in reflexivity and having an audit trail of decisions assisted the researcher in the research process. Reflexivity was essential as the researcher (first author) is professionally working in the field of dementia and this may have made participants feel uncomfortable. The researcher may have been known to participants in their capacity as having a lead role in dementia care in the region. However, no personal relationship existed between research and participants. However, this was addressed with participants directly by discussing with participants that there was no right or wrong answers as it is their view that is important both positive and negative. In addition, the study utilised the consolidated criteria for reporting qualitative research (Tong *et al.* 2007).

FINDINGS

Nine nurses (female) participated in this study and all gained their experience in dementia care in mixed care settings such as general nursing home facilities or in long-stay units in psychiatric hospitals. Participant details are identified in table 2. Through data analysis and abstraction four themes emerged; recognising and understanding responsive behaviour, resources and interventions to support people with dementia and responsive behaviour, the impact of education on nursing practice and the care environment.

Recognising and understanding responsive behaviour

Each participant commented on responsive behaviours in dementia and shared their understanding of these behaviours. While all participants were familiar with the term 'responsive behaviour', the level of recognition amongst participants varied. Where participants saw responsive behaviours as 'explaining behaviours that challenge', 'emotional feeling they are having, or a sign of depression', and 'notice something off with them, wasn't their normal behaviour'. Participants favoured the term responsive behaviour as they thought it to be a more positive description of how a person is presenting than the term challenging behaviour/s.

"Challenging behaviours has more negative connotations, responsive is more positive, it's more the way the persons reacts or responds to what is going on around them, whereas challenging, immediately your thinking that someone may need controlling" (P4).

The most common participants identified responsive behaviours tended to be more intrusive to care provision; behaviours such as 'hitting out/kicking', 'refusing care', 'scratching', 'spitting', 'aggression', 'biting', 'screaming' and 'swearing/cursing', but also there was an acknowledgement that people with dementia may exhibit responsive behaviours that are quieter such as 'low mood', 'withdrawn', and 'kneeling or lying'. Understanding of the reasons for responsive behaviours in people with dementia was evident amongst all participants. Where participants described responsive behaviour 'as a way of communicating' and they needed to interpret that communication.

"..the resident response or their way of responding to a need that needs to be met, it may be something simple as they need to go to the toilet, if they need a drink and they can't express the need, there may be shouting or calling or getting aggressive" (P6).

Understanding responsive behaviours as an unmet need and a way of expressing a need was highlighted by participants.

"Somebody who is feeling an emotion or not able to express themselves, they will start crying because they need the toilet or they have a pain" (P9).

This understanding is supported by staff been able to determine the triggers for responsive behaviours, this assists in supporting the person and reducing responsive behaviours.

"..watching for their trigger, you know when things are going to trigger and prevent the behaviour escalating" (P2).

In recognising and understanding responsive behaviours, participants comments on their own role from a personal perspective and the need to show empathy within their care and thinking.

“Stepping into someone’s shoes who has dementia and seeing their perception of things, that everyone is so different and each situation is so different and what might threaten one person doesn’t threaten the other and how I react to them” (P7).

Resources and interventions to support people with dementia and responsive behaviour

Resources that are needed to support the person with dementia and responsive behaviours and staff were highlighted by participants. Participants recognised how the availability or lack of resources can directly affect their ability to provide care. Staffing levels and being able to spend time with the person were highlighted as factors that affected participant’s ability to support a person with responsive behaviour. Staff mix was recognised as being important for dementia care provision where there are responsive behaviours ‘staffing should be probably a mixture of both general and psychiatric nurses’. However, underpinning staffing levels was the need for time to get to know the person with dementia and for managers to take time to get to know their staff and their needs.

“It’s time, it’s getting to know the individual, your staff and that they can look after the person, do they need anything, they could be scared themselves” (P4).

Participants described their frustration and feeling of ‘having your hands tied’ in relation to providing care when short staffed,

“When you are down staff, your hands are tied because you can’t provide the quality of care that you want and it’s frustrating because you know the other staff are going to get stressed” (P6).

Person-centered care was viewed by participants as needing time and having availability of staff. Barriers to person-centered care were highlighted; lack of funding and access to education on responsive behaviours in dementia. Evidence of this was when an intervention programme was discontinued due to cost.

“..it (the programme) finished because of the cost of the programme and the cost of care is not reflected in the fees that are negotiated through the National Treatment Purchase Fund” (P8).

Specific dementia and responsive behaviour focused interventions varied between facilities. The availability of one-to-one time with the person with dementia with responsive behaviours was deemed to be an important intervention in identifying and understanding ‘what exactly is causing them to have the responsive behaviours at that time’. The involvement and availability of an activity coordinator and an activity programme was seen as a significant resource by participants for the person with dementia with responsive behaviours. This was seen as ‘having a positive influence in

supporting the patient's needs'. Activities included reminiscence, doll and pet therapy, music, distraction, one-to-one time, hand massage and life story work. Collaboration between nurses and activities coordinator allowed for a more person-centered approach and integration of the activities within the persons care plan. An activities coordinator ensured the activities were conducted as they held the responsibility for the activities which was essential when nurses are caught with other caring activities. However, participants saw that even with the presence of an activity coordinator they had responsibility in supporting and carrying out these activities.

"While we have an activities coordinator we also do dementia specific activities, we do reminiscence, relaxation therapy, and we give each other feedback to say they enjoyed it" (P9).

Essential within the process of caring was 'getting to know the person', participants highlighted the importance of the resident's past life and the need for 'life story work' as;

"You need to get to know the person, to know their life, their history, to know everything about them, what they worked at, what they like to eat, their family, all their likes and dislikes" (P5).

A team approach and support was deemed important to participants in supporting the individual with dementia and responsive behaviours where; family contact, occupational therapist, physiotherapist, geriatrician, general practitioner and psychiatry of later life team were mentioned as positive supports to the nursing staff. However, not all facilities can avail of these support services.

The impact of education on nursing practice

Participants had a favourable and encouraging view of education on responsive behaviours in dementia. Six of the participants had completed the national dementia training programme(s) and participants who had dementia training highlighted the positive impact continuing education has on residents, staff, care provision and the environment.

"For someone that had no understanding of dementia care I learned from experience and interacting with people, going on day courses, but that three day course while intense, it gave a huge amount of tools to manage people with dementia, and to manage behaviours that are challenging and an overall view of how the person with dementia can act" (P8).

The value of experiential learning through working in dementia care was acknowledged by participants and this learning in conjunction with dementia education supported their practice.

"I must say much of it (information learned) would have been experience on the job, the study days have provided the tools and the mind-set so that you could go about it a different way" (P4).

While education and training were valued by participants, availability and access were issues for staff who highlighted the need for further education and training, for knowledge updates and to gain a better understanding of dementia and of how the person is experiencing living with dementia.

"It definitely would pay off for anyone working in dementia care to have some training in dementia and top up session, definitely a course or some documentation that they could sit down and actually read, just to understand what might be going on" (P9).

As part of the direct care delivery team, participants saw a need for education of other staff and highlighted the need for dementia education for health care assistants as a priority.

"Knowledge with nursing staff is at a level where they can understand, however, for the caring staff, mainly their knowledge isn't the same, some of them have attended training, sometime their knowledge lacks in ways that it makes it hard for them to respond to responsive behaviours or try to deal with a situation" (P9).

The care environment

The physical design of care environments for people with dementia was seen as a therapeutic resource, to promote wellbeing and maintain functioning. A positive care culture that recognised good communication and sharing of information was seen as an important aspect of dementia care. Concern in relation to what constitutes a suitable care environment for people with dementia with responsive behaviours was expressed by the participants. There was a variance in opinion as to which environment was most suitable to supporting the needs of people with dementia and responsive behaviours; a general nursing home setting versus a dementia specific unit.

"..definitely not in a hospital, they are not equipped to deal with them, especially at night when they can be a little bit more troublesome, they don't have the staff or the resources to sit (with them) and they may try to restrain them, we are maybe more equipped, we know more here to be able to try to talk to the person and try to orientate them, to make them happy and try to distract them" (P2).

"If they are violent in a way that they are going to be a threat to other residents or staff then I don't think a generalised nursing home is the place for them, I suppose ideally a dementia unit, where staff would be trained in dementia, because it is a very complex area" (P3).

Within the discussion with participants regarding dementia specific units participants' were concerned for each person's safety and for those who favored specific dementia units they were conscious of the fact that the person may lose the benefit of daily interactions and may become isolated.

"I feel it may become too institutionalise and then you have a group of people with dementia but they have no communication with fellow residents or patients that would have normal capacity and normal cognition, and I feel that sometimes they may be isolated in that sense, and staff might be too focused on dealing with dementia as opposed to bringing in normal every life and conversation" (P6).

The length of time the person with dementia has responsive behaviour and the level of associated aggression placed pressure on participants to support patients.

"we are used to dealing with people that strip or call out, or spit, but if it's ongoing, if it's constant every day, that puts too much pressure on and it's stressing for them and other residents" (P3).

Within the environment staffing levels and the mix of patients were seen as factors that can hinder care provision and could impact on the safety of all residents. Here participants' highlighted support from management is essential in delivering safe person-centered care and this support is only provided where managers have an understanding of the issues experienced by staff.

"Nursing management need to be on board, they need to understand, they wouldn't understand what it is you are trying to do for the patient, I don't think they understand why you are harping on about the compliment of staff and why you are constantly looking for (additional resources)" (P5).

Attitudes and being self-aware when caring for people with dementia and responsive behaviour can affect the care environment.

"You have to be calm, you have to monitor your own behaviour, you have to respect their space, what they want, what they don't want regardless of the fact that they might not be able to express it" (P6).

Participants also saw that attitudes also transcend beyond themselves and that attitudes affect staffs interactions and managers decisions to provide support by scapegoating,

"Management would say that if the resident needs behaviour management, that maybe here is not the best facility for them, should we consider special dementia care unit, so we don't get any support" (P1).

"I think my colleagues would think at times that the person is doing it out of spite, it's the person not the dementia's fault." (P5).

Within the care environment good communication, both with residents and colleagues was thought of as important by participants in providing care.

"..good communication skills, making sure you explain everything you are going to do, having regular meetings with staff that are looking after someone and discuss the care plan, discuss their care needs, discuss with the family more often" (P7).

Being able to assess a situation and recognise the affect the nurse's presence has on the person with dementia assists in communication as knowing where the challenge to care lies can at times be central to dementia care. Understanding of non-verbal communication and responding to situations appropriately, participants' believe came from experience, knowledge and knowing the person.

"I think sometimes we can all pose a challenge because with dementia a person can react to one negatively and not react to another, but it's about how each of us behave and how each of us manages the situation and how each of recognise our own limitations in dealing with the situation, and how each of us recognises how we might be the person or the problem, it's about stepping away, it's about we need to recognise that we need to be quiet and just stand, observe rather than trying to bring the person along and distract them, they might just need us to stand back and we need to be quiet, we don't always see that, sometimes we might react in panic, we have to sort them, we have to bring the person in from the door, instead of letting the person stand at the door and we stand with them" (P8).

Discussion

The key findings of this study highlight the importance of education, recognising and understanding responsive behavior and the availability of resources and specific interventions within the care environment. Participants were familiar with the term 'responsive behaviour' describing a wide range of responsive behaviours similar to that identified within the literature (Todd and Watts 2005, Cubit *et al.* 2007, Rosen *et al.* 2008). Socially disinhibited behaviours were identified by participants (e.g. stripping of clothes), however, behaviours such as being sexually inappropriate or sexually abusive (Cubit *et al.* 2007, Zwijsen *et al.* 2014) were either not mentioned or moderately considered by participants. Participants considered broad reasons for responsive behaviours however, physical reasons for responsive behaviour given by participants were few; with pain and sensory impairment being mentioned but dehydration, infection, cerebral events or metabolic disorders (Fong *et al.*

2009) being omitted. This highlights that while knowledge and understanding may be evident amongst participants, there is a need for continual education. Participants viewed people with dementia from a person-centered paradigm, searching for meaning in the responsive behaviours and not merely attributing responsive behaviours to symptoms of dementia or due to damage to the brain.

Within the study participants had a sense of frustration at the lack of time they could give to patients to establish a relationship, with time at a premium in modern, pressurised working environments, due to staffing levels. Lack of time prevented participants from being always able to determine what was driving the responsive behavior. Staffing levels and time are recognised within the wider literature as causing frustration (Skovdahl *et al.* 2003), higher rates of aggression (Isaksson *et al.* 2008) and staff finding caring particularly difficult (Zeller *et al.* 2011). Participants reported that having more time would enable them 'get to know' the patients, to provide a more comprehensive person-centered service. Essential within this process is the development of a relationship as interpersonal relationships are vital to successful care outcomes (Davies & Nolan 2008). This ability to create and maintain relationships is crucial for the person with dementia to sustain their sense of identity and feelings of personhood (Edvardsson *et al.* 2008). It is recognised that communication deficits and behavioural issues are barriers to relationships and given the likelihood of responsive behaviours in the dementia population it is important to consider a relationship-centered model for dementia care. Such a model has been proposed by Nolan *et al.* (2004) based on the SENSES framework where all parties involved in care experience relationships that promote a sense of; security, belonging, continuity, purpose, achievement and significance.

Participants indicated a wide range of interventions are currently being used to support people with dementia and responsive behaviours in long-stay care facilities. During episodes of aggression or agitation participants reported using distraction and one-to-one care, supporting literature findings that staff try to interrupt aggressive behaviour in a calm manner to prevent further aggression and respond in an interpersonal and non-physical way (Pulsford *et al.* 2011, Zeller *et al.* 2011). Within this study participants highlighted the availability of an activity coordinator as being a vital addition to supporting responsive behaviours, this role was not seen by participants as a nursing role, but a supportive role by care staff. While, literature supports interventions such as talking to the patient, distraction, providing reassurance, medication and restraint (Pulsford *et al.* 2011) participants favoured a PCC approach to care over the use of medication and restraint. However, participants recognised this was difficult to achieve due to time and staffing constraints. Participants preference for non-pharmacological interventions is in-line with research that highlights that responding to

responsive behaviour in a person-centered or interpersonal manner is favoured to maintain a person's dignity and personhood (Duxbury *et al.* 2013) and that these approaches are recommended as the most effective methods to prevent/reduce responsive behaviors (Azermai 2014). Only when these are proven ineffective, should other interventions be used in responding to responsive behaviours (Azermai, 2014). Within this study participants were upholding ethical standards of caring for patients with dementia by ensuring that care provided to persons with dementia was guided by compassion, honesty, and prudence (Hughes and Common 2015). In accepting a person-centered approach participants were avoiding the four kinds of restraint: a) chemical restraints or pharmaceuticals; b) emergency restraints used when the resident poses a risk to him/herself or others; c) environmental restraints or barriers to personal movement; and d) physical or mechanical restraints.

Dementia specific education and training was seen as essential by participants, both for themselves and for other staff working in dementia care. Education can have a positive impact on care in general, allowing nurses develop their skills and understanding of the dementia process and its effect on the person (Nakahira *et al.* 2008, Enmarker *et al.* 2011, Scott *et al.* 2011). However, participants suggested that education needs to be ongoing, specific and available, further increasing awareness of the person-centered approach, supporting positive interactions between patient and carer (Enmarker *et al.* 2011). This mirrors Scott *et al.* (2011) proposal; education specific to dementia care, nationally agreed skill standards to include standards for healthcare assistants and mentoring of inexperienced staff. The positive impact of dementia specific training was evident from participants, indicating that education had changed their views on dementia care provision and also on care environments. Participants reported a lack of support and guidance from managers in relation to; resources (time, staffing levels, activities, day-care, one-to-one care) and managing behavior, which is also recognised internationally (Josefsson *et al.* 2007, Nakahira *et al.* 2008, Rosen *et al.* 2008). Within this study participants identified that managers could offer support through continuing education programmes that are facility wide, which assist in maintaining professional competency and person-centeredness and increase professionals' ability to reduce and manage behaviours (Anderson *et al.* 2014, Livingston *et al.*, 2014).

Participants reported that the presence of violent and persistent responsive behaviours led them to consider if the person would be more suited in small dementia specific environment due to their concerns for patient and colleague safety, similar to previous research (Josefsson *et al.* 2007, Scott *et al.* 2011, Bostrom *et al.* 2011, Zeller *et al.* 2011). Participants awareness of responsive behaviours led them to be more aware of responsive behaviour triggers and mindful of identifying and avoiding

these triggers to evade causing upset or agitation (Isaksson *et al.* 2008, Zeller *et al.* 2011). However, this study highlights that to truly demonstrate understanding carers need to have self-awareness of their own actions, thoughts, attitudes and reactions and what was evident within this study was that participants own awareness was underpinned by their dementia education rather than the environment that they worked in. However, underpinning this awareness was the acknowledgement that relationships are considered significant and thereby it may be important to consider that not all caregivers have the capacity or sensitivity required to establish relationships with persons with dementia (Davies and Nolan 2008). Within this study the choice of care environment arose as a difficult decision to balance with participants acknowledging that staff working in different types of facilities portray different attitudes towards responsive behaviours (Nakahira *et al.* 2008) and that restrictive environments and interaction with other residents can influence the presentation of responsive behaviours (Rosen *et al.* 2008, Pulsford *et al.* 2011).

Within this study participants noted that decisions by nurse managers can affect care provision and influence where a person with responsive behaviours should be cared for these decisions can result in staff feeling under supported by management and with appropriate leadership, staffs views can influence staff views and care for patients (Skovdahl *et al.* 2003, Josefsson *et al.* 2007). While it is recognised that managers should not ignore the issue of responsive behaviours and aggression in the workplace and should facilitate open discussion without attaching blame (Bostrom *et al.* 2011). Participants in this study highlighted the importance of co-workers in supporting staff, and it is recognised that team members turn to one another for support (Zeller *et al.* 2011) and informal debriefing (Bostrom *et al.* 2011). Formal support systems such as employee assistance programmes were not mentioned by participants or in the literature as sources of support. Nonetheless, consideration needs also to be given to personal, supervisory and organisational supports (Hunter *et al.* 2016) and the fact where informal support is in operation reporting of incidences does not occur (Bostrom *et al.* 2011).

Implications for mental health nursing practice and education

Participants indicated that a collaborative approach to dementia training should be explored as described by Scott *et al.* (2011). Participants identified that all staff should have access to dementia education, and service providers must consider their responsibility in this regard. Participants acknowledge that staff also need to ensure that they seek out and receive dementia specific education (Lachs *et al.* 2012). The study highlighted that access to a multidisciplinary team was not

universal, with participants' opinions being that all people with dementia and responsive behaviours need access to all or any services that may support them to live well with dementia. This access should be timely and available in the person's place of residence and support (Zeller et al. 2011).

Access to multidisciplinary care for people with dementia needs to be prioritised. Strategies need to be established to support the nurse to report incidents of aggression and violence, without incurring blame; this research determines that managers need to know how to support their staff in relation to responsive behaviours and dementia and need to recognise the potential for staff frustration and stress in caring for people with responsive behaviours as highlighted in previous research (Josefsson et al. 2007, Rosen et al. 2008).

What the study adds to the international evidence

Little has been highlighted in research about the views of nursing staff on people with dementia and responsive behaviour (Pulsford et al. 2011, Duxbury et al. 2013). This study indicates that education strategies need to consider all staff working with people with dementia and responsive behaviours in order to develop and support management guidelines. This study highlights that nurses need to engage in self-reflective practice, examining their own actions, thoughts, attitudes and reactions; attributes that participants feel are more influenced by dementia education. In addition this study identifies that the choice of place of care is dependent upon a triad of responsive behaviour factors; the type, the duration and the impact of responsive behaviours on the person, other residents and staff. In order to plan a PCC approach to dementia care, the individual should be maintained as the pivotal point of service planning (Nolan *et al.* 2004). This study highlights that the decision regarding the place of care is difficult to come to and given the drive to a person-centered approach there is a need to consider the views of people with dementia as to where they would like to be cared for as a research priority.

Limitations

Time spent in interviews was limited as interviews were conducted during work hours with permission from the service provider to avoid disrupting family and leisure time. However, data saturation was achieved. The researcher was known to some participants on a professional basis and this may have affected their responses. To avoid this participants' were assurance that all comments and responses would be treated confidentiality. Within the study only one participant did not have dementia training and only one worked in a public long-stay facility and this may affect

transferability of the findings and further research may be warranted regarding the views of those without training and in public long-stay facilities.

Conclusion

The view carers have of people with dementia influences the care they provide (Jonas-Simpson *et al.* 2012). With negative views influencing quality of life and quality care for persons living with dementia (Graneheim & Jansson 2006). This study highlights the meaning of responsive behaviours as based on the person's inability to communicate a need and these behaviours are considered outside of the control of the person. Accepting this premise assists carers to be person-centered, see the person at the center of care and enable personhood. This draws similarly to other research which shows understanding of behaviours as responsive (Dupuis *et al.* 2004, Kontos 2005) and that when supported persons with dementia express their personhood (Kontos & Naglie 2007). In contrast quality of life is diminished when carers focus on; managing behaviour, assessing problems and labeling deficits (Kontos & Naglie 2006). Without understanding of a person's actions and opportunities to express their views/wishes, people with dementia are silenced and in reality dehumanised (Jonas-Simpson 2001).

Conflicts of Interest

No conflict of interest has been declared by the authors.

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References

Alzheimer's Society Ontario (2013) Shifting Focus: A Guide to Understanding dementia behaviour. Available: http://www.alzheimer.ca/on/~media/Files/on/Shifting-focus/Shifting_Focus_Full_Guide.pdf (Accessed 08 in Jan 2016).

Anderson, R.A., Toles, M.P., Corazzini, K., McDaniel, R.R. and Colon-Emeric, C. (2014) Local interaction strategies and capacity for better care in nursing homes: A multiple case study. *BMC Health Sciences Research*, 14(1), 244-260.

Cahill, C., O' Nolan, C., Caheny, D. and Bobersky, A. (2014) *An Irish National Survey of Dementia in Long-Term Residential Care*. Dublin: Dementia Services Information and Development Centre

Cubit, K., Farrell, G., Robinson, A. and Myhill, M. (2007) A Survey of the frequency and impact of concern in dementia on residential aged care staff, *Australasian Journal on Ageing*, 26(2), 64-70.

Boström, A.-M., Squires, J. E., Mitchell, A., Sales, A. E. and Estabrooks, C. A. (2011) Workplace aggression experienced by frontline staff in dementia care. *Journal of Clinical Nursing*, 21(9-10), 1453-1465.

Davies, S. and Nolan, M. (2008) *Attending to relationships in dementia care*. In: Downs, M. and Bowers, W. *Excellence in dementia care: Research into practice*. Open University Press, Maidenhead, pp. 438-454.

Department of Health (2014) *The Irish National Dementia Strategy*. Dublin: Hawkins House. Available at: <http://health.gov.ie/blog/publications/the-irish-national-dementia-strategy/> (Accessed 08 Dec 2015).

Doody, O. and Doody, C.M. (2015) Conducting a pilot study: case study of a novice researcher. *British Journal of Nursing*, 24(21), 1074 – 1078.

Doody, O. and Noonan, M. (2013) Preparing and conducting interviews to collect data. *Nurse Researcher*, 20(5), 28-32.

Dupuis S.L., Wiersma E. & Loiselle L. (2004) *The Nature of Responsive Behaviours in Long-Term Care Settings: Final Report Prepared for the Ministry of Health and Long-Term Care and the PRCS of South Central Ontario*. Murray Alzheimer Research and Education Program, Waterloo, ON, Canada.

Duxbury, J., Pulsford, D., Hadi, M. and Sykes, S. (2013) Staff and relatives' perspectives on the aggressive behaviour of older people with dementia in residential care: a qualitative study. *Journal of Psychiatric & Mental Health Nursing*, 20(9), 792-800.

Edvardsson, D., Winblad, B. and Sandman, P.O. (2008) Person-centered care of people with severe Alzheimer's disease: current status and ways forward. *The Lancet Neurology*, 7(4), 362-367.

Elo, S. and Kyngas, H. (2008) The qualitative content process. *Journal of Advanced Nursing*, 62(1), 107-115.

Enmarker, I., Olsen, R. and Hellzen, O. (2011) Management of person with aggression and violent behaviour: a systematic literature review. *International Journal of Older People Nursing*, 6(2), 153-162.

Fong, T.G., Tulebaev, S.R. and Inouye, S.K. (2009) Delirium in elderly adults: diagnosis, prevention and treatment. *Nature Reviews Neurology*, 5(4), 210–220.

Graneheim U. & Jansson L. (2006) The meaning of living with dementia and disturbing behaviour as narrated by three persons admitted to a residential home. *Journal of Clinical Nursing*, 15(11), 1397–1403.

Health Service Executive (2011) National Guidelines on Long Stay Charges (S.I. 382), July 2011, Available:

http://www.hse.ie/eng/services/list/4/olderpeople/residentialcare/Long_Stay_Charges/Long_Stay_Charges_Information_Leaflet_July_2011.pdf (Accessed 02 June 2016).

Health Information and Quality Authority (2016) Guidance on Dementia Care for Designated Centres for Older People. Dublin: Health Information and Quality Authority. Available: https://www.hiqa.ie/system/files/Dementia_Care-Guidance.pdf (Accessed 17 July 2016).

Hughes, J. and Common, J. (2015) Ethical issues in caring for patients with dementia. *Nursing Standard*, 29(49), 42-47.

Hunter, P.V., Hadjistavropoulos, T., Thorpe, L., Lix, L.N. & Malloy, D.C. (2016) The influence of individual and organizational factors on person-centred dementia care. *Aging and Mental Health*, 20(7), 700-708.

Isaksson, U., Astrom, S., Sandman, P.O. and Karlsson, S. (2008) Factors associated with the prevalence of violent behaviour among residents living in nursing homes. *Journal of Clinical Nursing*, 18(7), 972-980.

Jonas-Simpson C. (2001) From silence to voice: knowledge, values, and beliefs guiding healthcare practices with persons living with dementia. *Nursing Science Quarterly*, 14(4), 304–310.

Jonas-Simpson, C., Mitchell, G. J., Carson, J., Whyte, C., Dupuis, S., & Gillies, J. (2012). Phenomenological shifts for healthcare professionals after experiencing a research-based drama on living with dementia. *Journal of Advanced Nursing*, 68(9), 1944-1955.

Josefsson, K., Sonde, L. And Wahlin, T.B.R. (2007) Violence in municipal care of older people in Sweden as perceived by registered nurses. *Journal of Clinical Nursing*, 16(5), 900-910.

Kitwood, T., (1997) *Dementia reconsidered: The person comes first*. Buckingham, England: Open University Press.

Kontos P. (2005) Embodied selfhood in Alzheimer's disease: rethinking person-centered care. *Dementia: The International Journal of Social Research and Practice*, 4(4), 553-570.

Kontos P. & Naglie G. (2007) Bridging theory and practice: imagination, the body, and person-centered dementia care. *Dementia: The International Journal of Social Research and Practice*, 6(4), 549-569.

Kontos P.C. & Naglie G. (2006) Expressions of personhood in Alzheimer's: moving from ethnographic text to performing ethnography. *Qualitative Research*, 6(3), 301-317.

Lachs, M.S., Rosen, T., Teresi, J.A., Eimecke J.P., Ramirez, M., Silver, S. and Pillemer, K. (2012) 'Verbal and Physical Aggression Directed at Nursing Home Staff by Residents'. *Journal of General Internal Medicine*, 28(5), 660 - 667.

Livingston, G., Kelly, L., Lewis-Homes, E., Baio, G., Morris, S., Patel, N., Omar, R.Z., Katona, C. & Copper, C. (2014) Non-pharmacological interventions for agitation in dementia: Systematic review of randomized controlled trials. *The British Journal of Psychiatry*, 205(6); 436-442.

Macdonald, A. and Cooper, B. (2007) Long-term care and dementia services: an impending crisis. *Age and Ageing*, 36(1), 16-22.

Nakahira, M., Moyle, W., Creedy, D. and Hitomi, H. (2008) Attitudes toward dementia-related aggression among staff in Japanese aged care settings. *Journal of Clinical Nursing*, 18(6), 807-816.

Nolan, M.R., Davies, S., Brown, J., Keady, J. & Nolan, J. (2004) Beyond 'person-centered' care: a new vision for gerontological nursing. *Journal of Clinical Nursing*, 13(s1), 45-53.

Pulsford, D., Duxbury, J. A. & Hadi, M. (2011) A survey of staff attitudes and responses to people with dementia who are aggressive in residential care settings. *Journal of Psychiatric & Mental Health Nursing*, 18(2), 97-104.

Rosen, T., Lachs, M.S., Baharucha, J.A., Stevens, S.M., Teresi, J.A., Nebres, F. & Pillemer, K. (2008) Resident-to resident Aggression in Long-Term Care Facilities: Insight from Focus Groups of Nursing Home Residents and Staff. *Journal of American Geriatrics Society*, 56(8), 1398-1408.

Sandelowski M (2010) What's in a name? Qualitative description revisited. *Research in Nursing and Health*, 33(1):77-84.

Sandelowski M (2000) Whatever happened to qualitative descriptive? *Research in Nursing and Health*, 23(4), 234-340.

Sandelowski M (1995) Qualitative analysis: What it is and how to begin. *Research in Nursing and Health*, 18(4), 371-375.

Scott, A., Ryan, A., James, I. & Mitchell, E.A. (2011) Perceptions and implications of violence from care home residents with dementia: a review and commentary. *International Journal of Older People Nursing*, 1(2), 110-22.

Skovdahl, K., Kihlgren, A.L. & Kihlgren, M. (2003) Different attitudes when handling aggressive behaviour -narratives from two caregiver groups. *Ageing and Mental Health*, 7(4), 277-286.

Todd, S.J. & Watts, S.C. (2005) Staff responses to challenging behaviour shown by people with dementia: An application of an attributional-emotional model of helping behaviour. *Ageing and Mental Health*, 9(1), 71-81.

Tong, A., Sainsbury, P., & Craig, J. (2007) Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *International Journal for Quality in Health Care*, 19(6), 349-357.

Zeller, A., Dassen, T., Kok, G., Needham, I. & Halfens, R.J.G. (2011) Nursing home caregivers' explanations for and coping strategies with residents' aggression: a qualitative study. *Journal of Clinical Nursing*, 20(17), 2469-2478.

Zwijzen, S.A., Kabboord, A., Eefsting, J.A., Hertogh, C.M.P.M., Pot, A.M., Gerritsen, D.L. & Smalbrugge, M. (2014) Nurses in distress? An explorative study into the relation between distress and individual neuropsychiatric symptoms of people with dementia in nursing homes. *International Journal of Geriatric Medicine*, 29(4), 344-391.

Table 1 Interview Guide

Interview Guide			
Research Title: Exploring the views of Nursing Staff in Relation to supporting People with Dementia and Responsive Behaviours.			
All information collected will be held in the strict confidentiality and at the start of the interview, the researcher will confirm with the participant that they have given their verbal and written consent to participate in the interview and are aware that the interview will be audio recorded.			
Date of Interview	Location	Time Commenced	Time Completed
Participant Code: _____			
Interview commence with some general questions to enable participant to relax.			
1. How long have you been nursing?			
2. How long have you worked in care of the elderly?			
3. How long have you been worked in the area of Dementia care?			
4. What professional qualifications do you have?			
5. Do you have dementia specific qualifications?			
a. If yes.....what are they?			
b. Are you able to utilise the dementia specific training that you have acquired?			
Main interview - focus on the nurse's views of caring for people with dementia and probing of responses.			
6. What behaviours do you considered as responsive behaviours?			
7. Where should People with Dementia and Responsive Behaviours be care for?			
8. What factors facilitate you in delivering care to people with dementia who have responsive behaviours?			
9. What factors do you feel hinder your care delivery to people with dementia and responsive behaviour?			
10. What challenges to providing care to people with dementia and responsive behaviours do you experiences?			
11. What other services do you feel would support you to care for people with dementia and responsive behaviours?			
12. What education support do you feel would assist you in caring for people with dementia and responsive behaviours?			
End interview.			
13. Do we feel we covered all relevant areas?			
14. Is there anything you would like to add?			
15. Thank you for your participation and I will send you a copy of your transcript and a summary of my finding if you wish to comment on this your comments would be most welcome.			

Table 2 Participant details

	P1	P2	P3	P4	P5	P6	P7	P8	P9
Years Qualified	3	4	3.5	26	24	34	27	40	4
Primary Qualification	ID nursing	General Nursing	ID nursing	Psychiatric Nurse & General	Psychiatric Nursing	General Nurse & Midwifery	General Nurse	General Nurse & Midwifery	General Nursing
Years in Elderly care	3	4	3.5	7	12	14	20	10	1
Years in Dementia care	3 (mixed elderly care setting)	3 (mixed elderly care setting)	3.5 (mixed elderly care setting)	7 (mixed elderly care setting)	10 (mixed elderly care setting)	13 (mixed elderly care setting)	20 (mixed elderly care setting)	10 (mixed elderly care setting)	1 (mixed elderly care setting)
Dementia specific Training	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No
Type of Dementia training	Day courses x 2 National Dementia Programme	Post Grad in Dementia Care and Masters	Day course x 1 National	Study Days	National Programme & Dementia	National Programme	National Programmes	National Dementia Programmes (3 Days)	1 hour awareness talk
Current Role	A/DON*	Staff Nurse	Staff Nurse	A/DON	CNM2 ⁺	DON ⁻	DON	DON	Staff nurse

* Assistant Director of Nursing

+ Clinical Nurse Manager (grade 2)

- Director of Nursing