

ORIGINAL ARTICLE

Discovering what works well: exploring quality dementia care in hospital wards using an appreciative inquiry approach

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Aims and objectives. To explore the quality dementia care in two geriatric hospital wards using appreciative inquiry with formal care workers and family members of inpatients with dementia.

Background. Care models such as person-centred and relationship-centred care have been developed to explain what 'quality' dementia care should be. However, their usefulness and relevance to clinicians has been questioned.

Design. Using an exploratory qualitative design within an appreciative inquiry framework, 33 care workers working in a geriatric hospital and 10 family members of patients with dementia were interviewed.

Methods. Open-ended questions were asked to encourage care workers to narrate positive care experiences when the care was perceived to be at its best and to identify what made these experiences possible. Interviews were audio-taped and transcribed whilst data were analysed thematically using a qualitative data analysis software to assist in data management.

Results. Positive care experiences can be understood within five care processes, namely building a relationship between the 'extended' dementia care triad, providing 'quality time' and 'care in time', going the 'extra mile', attending to the psychosocial needs and attending to the physical needs with a 'human touch'. Factors facilitating these positive care experiences included personal attributes of care workers, and organisational, environmental and contextual factors.

Conclusions. This study provides an alternative and pragmatic approach to understanding quality dementia care and complements the body of knowledge on factors influencing dementia care practices in hospitals.

Relevance to clinical practice. By understanding the components of quality dementia care and how these can be achieved from different stakeholders, it is possible to develop strategies aimed at improving the care offered to patients with dementia in hospitals.

Key words: appreciative inquiry, care workers, dementia, hospital, quality care

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What does this paper contribute to the wider global clinical community?

- Exploring positive care experiences using appreciative interviews can help in understanding the meaning of quality dementia care in hospitals from the perspective of the stakeholders involved.
- The study highlights a number of factors including personal attributes of care workers, and organisational, environmental and contextual factors that contribute to the provision of quality dementia care in clinical settings.

Introduction

As a result of population ageing, the prevalence of patients with dementia is expected to increase worldwide to an estimated 75.6 million in 2030, and 135.5 million in 2050 (Alzheimer's Disease International 2013). Due to different comorbid conditions, these individuals may require the need for referral and admission to a hospital setting. However, there is evidence that the quality of care of patients with dementia in hospital settings is far from optimal (Zekry *et al.* 2009) and can be very challenging for staff (Clissett *et al.* 2013a). Understanding what quality care is to patients with dementia in hospital environments can be the first step in identifying ways in developing strategies to achieve it.

Background

Person-centred care (PCC) is a recurring approach discussed in relation to the provision of quality dementia care (Brooker 2004, Edvardsson *et al.* 2008). PCC has been referred to as the 'new culture' of dementia care that has put the living experience of the person with dementia into perspective (Kitwood 1997). The application of the PCC principles has also been advocated in clinical guidelines on dementia care (e.g. National Collaborating Centre for Mental Health (UK) 2007) and in numerous national dementia strategies such as the 'Living Well with Dementia: A National Dementia Strategy' (Department of Health 2009), and in the National Dementia Strategy, Malta 2015-2023 (Scerri 2014).

Despite the frequent use of the term 'PCC' in policy documents, there is no consensus or agreement on its definition or what components need to be present in delivering quality dementia care (Edvardsson *et al.* 2008, Brooker 2004). Brooker (2006) argued that PCC can be perceived as a value base, a set of techniques for working with individuals with dementia (IWD), or as a synonym for individualised care and consists of four main elements, namely valuing patients with dementia and those who care for them (V), treating people as individuals (I), looking at the world from the perspective of the person with dementia (P) and providing a positive social environment in which IWD can experience relative well-being (S). Edvardsson *et al.* (2008, p. 363) defined person-centred care for people with severe AD as 'supporting the rights, values and beliefs of the patients with dementia, involving them and providing unconditional positive regard, entering their world and assuming that there is meaning in all

behaviour ... maximizing each person's potential and sharing decisions'.

Dewing (2008) suggested that PCC needs to be further understood and more evidence is needed to show its usefulness in clinical practice. Similarly, O'Connor *et al.* (2007) argued that further research is needed to understand the complex interactions between patients with dementia and formal and informal carers who seek to sustain personhood. This has encouraged researchers to look for a more inclusive vision of care that is more relationship-centred (Nolan *et al.* 2004).

The development of different definitions and frameworks on quality dementia care could have further confused clinicians who seem reluctant to adopt them in clinical practice as these are not perceived as useful (Dewing 2008). This has led to 'tension, if not conflict, between how the practice could be and how it seems to be' (Dewing 2008, p. 43). Nevertheless, McCormack (2004) argued that care workers, instead of trying to reach an ideal of person centeredness, need to strive for a constant state of becoming more person centred in their practice.

A different perspective in describing quality dementia care was put forward by Edvardsson *et al.* (2010), who explored the content of PCC as experienced by various stakeholders. According to the authors, IWD and family caregivers characterise PCC when care workers in residential care seek to promote a continuity of self and normality when they know the IWD, welcome the family, provide a personalised environment and promote flexibility and continuity.

Using Kitwood's five dimensions of personhood as an *a priori* framework, Clissett *et al.* (2013b) investigated whether hospital care for patients with dementia was really person-centred. By exploring the experiences of patients with dementia, family carers and co-patients (patients sharing the ward with people with mental health problems) during hospitalisation, the study reported that there were numerous missed opportunities by healthcare professionals to work within Kitwood's model of person-centred care. The authors concluded that this could be due to inability by care workers to understand this concept and the different interpretations given by different healthcare professionals.

Therefore, the aim of this study was to explore quality dementia care from the point of view of formal care workers and family members of inpatients with dementia by asking them to remember and narrate the most positive care experiences in relation to caring for patients with dementia in hospital. Factors that led to these positive experiences were also sought.

Methods

Design

This study is framed within an organisational development approach known as appreciative inquiry (AI). Cooperrider and Srivastva (1987) have defined AI as a form of action research that attempts to create new theories, ideas or images that aid in the developmental change of a system. Bushe (2011, p. 87) refers to AI as ‘one of the first post-Lewinian Organisation Development methods’, whilst Cooperrider and Srivastva (1987) present AI as an alternative approach to conventional action research. In fact, AI has been used in various contexts both as an approach to research (Reed 2007) and as an organisational development method for transformative change (Watkins *et al.* 2011).

Used as a change management tool, AI process uses a 4D cycle of *discovery*, *dreaming*, *designing* and *destiny* (Cooperrider & Srivastva 1987, Reed 2007). This exploratory study used an adaptation of the *discovery* phase as described by Michael (2005), during which care workers and family members of patients with dementia were interviewed using appreciative questions (Table 1) to discover the most vital and alive moments and stories in relation to caring for patients with dementia in a Maltese hospital for older persons. Exploring these positive care experiences could help in better understanding quality dementia care and what contributes to making these experiences possible.

Besides a single acute hospital, Malta boasts a number of ancillary hospital services specialised in oncological, mental health and geriatric rehabilitative care with the latter being the setting used in this study. Individuals admitted for acute care requiring further inpatient treatment are transferred to

the rehabilitation hospital with the aim of restoring function and reintegrate them back to society. Latest data show that less than half of the admitted individuals were discharged back to society with a remaining quarter admitted to residential or nursing homes (Annual Report 2012), denoting that the majority were frail older persons. Similar to previous data (Zekry *et al.* 2008), a significant number of admissions to rehabilitation services were made up of individuals with cognitive difficulties.

Specialised training and knowledge on dementia management and care among staff participating in the study was lacking with the only in-house training on patient-centred dementia care organised and provided by the consultant geriatrician in charge. Whilst a limited number of health-care professionals attended information workshops on dementia in preparation for the drafting of the National Dementia Strategy for Malta, the high staff turnover, shortage in nursing professionals and the use of care workers from private agencies makes it difficult to develop an effective trained workforce.

Data collection

A purposive sample of all full-time caring staff (including nurses, nursing aids, paramedics and their aids) working on day duty in the two geriatric rehabilitation wards was taken. The sample size was determined from data saturation at which point no new information of significance obtained for ongoing thematic analysis (Lincoln & Guba 1985). Interviews were carried out with 33 care workers and 10 family members. These were audio-taped and transcribed whilst field coding was used mainly to collect demographic data. Any verification and correction of the language-translated text (from Maltese to English) was carried out by a professional translator.

Table 1 Questions asked to care workers and family members of inpatients with dementia

Questions asked to care workers	Questions asked to family members of inpatients with dementia
Can you tell me an experience/s when you felt really satisfied with the care being given to a person or patients with dementia in the hospital?	Can you tell me of an experience when you felt satisfied with the care given to your relative who is being cared for in the hospital?
What helped in making this experience/s possible?	What qualities did you notice in the Care workers working in this hospital during this experience?
What personal qualities do you feel were required in this circumstance to provide this type of care?	Imagine the hospital Care workers treating patients with dementia in the best care possible. What would this care be?
What resources do you feel were required in this circumstance to provide this type of care?	How do you think, this can become a reality?
What did you notice the patient with dementia has that you were not aware of before this experience/s?	

Data analysis

Miles *et al.*'s (2014) three phases of data condensing, data display and drawing conclusions were followed. Data condensation was achieved following the reviewing of staff and relatives' experiences, coding sections of the narratives into initial themes and eventually generating categories to group these themes into nodes. Data display was used to analyse whether there was a difference between the themes as obtained from staff and those obtained from relatives. Following the selection of the final nodes, conclusions were drawn and verified with the narratives and relevant literature. A computer-assisted qualitative data analysis software program (NVIVO, version 10 QSR International, Victoria, Australia) was used to assist in coding, organising, clustering, identifying and comparing themes.

Ethical considerations

An information sheet was provided to potential participants to enable them to give informed consent prior to their agreement to participate in the study. On consenting, participants were asked to sign a declaration. Ethical approval was obtained from the University Research Ethics Committee (UREC) of the University of Malta. Permission was also given from the Research Committee of the participating hospital and from the consultant geriatricians responsible for the respective wards.

Results & discussion

Participants

Thirty-three care workers, just under half of the total population ($n = 68$) of those working full time in the two study wards, agreed to participate in the interviews. Staff interviews took an average of 15 minutes (range: 5–41 minutes). Interviews with relatives took slightly longer with a mean time of 25 minutes per interview. One-quarter of the care workers ($n = 8$) interviewed were males. Table 2 shows the distribution of participating care workers according to their occupation, categorised into three main groups.

Family members of inpatients residing in the two wards between January–February 2014 were recruited following contact by the nursing officer of the respective wards. All of the family members consisted of the main carer as identified in the patients' records. The relationship of the family members was as follows: seven were the son, one was the niece, one was the daughter, and one was the wife of the patient with dementia.

Table 2 Care workers interviewed according to their occupation

Occupation – categorised as	No. of care workers
Qualified nursing staff (charge nurses and nurses)	16
Nursing aides and clerks	9
Healthcare professionals and their aides (occupational therapists, pharmacists, physiotherapists, speech language pathologists, physiotherapy aides, occupational therapy aides)	8

Quality dementia care experiences

All healthcare professionals and family members participating in the study identified experiences where they felt satisfied with the level of care provided to patients with dementia. Most of the hospital workers mentioned experiences that focused on caring for the psychosocial needs, in particular to patients exhibiting behavioural and psychological symptoms. By exploring these experiences, care interactions were thematically categorised into five care processes, namely building a relationship between the 'extended' dementia care triad; providing 'quality time' and 'care in time'; going the 'extra mile'; attending to the psychosocial needs; and attending to the physical needs with a 'human touch'.

Building a relationship between the 'extended' dementia care triad

To better understand the patient's behaviour, care workers stressed the need to get to know the patient. In fact, at the centre of experienced quality dementia care practices was the relationship between the patient with dementia, care workers and family members; also referred to as the dementia care triad (Adams & Gardiner 2005). Interestingly, this relationship was experienced by nine care workers on noticing how patients, after a while, 'got used to them' and remembered their face or the carer's name:

Care worker (S18): Yes it makes a difference because he got used to us. He recognises us and his face shows that he recognises you.

Building a relationship was achieved when care workers used appropriate communication strategies such as distraction and validation. In line with the VIPS framework (Brooker 2006), care workers also mentioned experiences when they attempted to understand the meaning behind the patient's behaviour, especially in the presence of communication difficulties:

Care worker (S33) [talking about other care workers]: Mostly I appreciate when there are instances when clients with dementia

and the carers of patients with dementia, the staff here give notice to the expressive communication of patients with dementia. Sometimes, there is some of the staff who is actually able to turn communication which is not in context, into something meaningful, something which can actually change the behaviour of the patient [for example a patient] who is initially aggressive, verbally aggressive ...

Other communication skills adopted by hospital workers included using the patient's own language, genuine listening (listening skills rather than hearing), using a calm, low-tone, gentle voice, talking to them slowly and clearly, maintaining eye contact and sitting at eye level, using nonverbal communication skills (a smile, or touch when the patient enjoys it such as holding their hands) and probing when patients were difficult to understand verbally. This indicated that care workers were aware of communication strategies that maintain personhood (Savundranayagam *et al.* 2007).

Building a relationship between staff and family members was also perceived as important in attaining these positive experiences. Care workers acknowledged the role of family members as a source of information and assistance in regaining the patient's previous loss of function. This line of communication, however, needs to happen both ways. Thus, whilst care workers acknowledged the level of knowledge that family members have regarding their relatives with dementia, half of the family members appreciated when direct feedback about their loved ones during their stay in hospital was provided to them. Similar to other studies (Clissett *et al.* 2013b), this enabled relatives to feel in control of what is happening during hospitalisation:

Relative (R9): Even when you ask them anything they do not answer you just to get rid of you ... they answer what you have been asking for ... I think that one of the things that help is that they give you regular updates ... you do not need to ask yourself ... Because at times you ask the things that mostly concerns you ... you will be biased on one thing ... you are not seeing the situation as whole ... on the other hand they [care workers] can give a report of the whole situation ... if you do not know what to ask for you do not ask about them ... I think it helps

Both family members and care workers identified two other agents that can directly influence this care interaction, namely other inpatients (in particular those with no cognitive difficulties) and other colleagues. These can have either a positive or negative impact on the care experience.

The influence of other patients:

Relative (R6): Before she was in a 4-bedded [room] and there she was more able to socialise, do you understand ... and where she is

now, she is with another person but there is no contact with her as either she is hard of hearing ... so she is isolated and for my point of view it is worse.

Researcher: So maybe the fact that she is included with other patients?

Relative: Yes, that helps her a lot, a lot ...

The influence of other colleagues:

Care worker (S3): This lady was always asking for her gold. So, one of the nursing aids actually brought some old costume jewellery from home; which was great! Now this poor lady with dementia her eyes lit up, she was fine, she was dressed up, she was going around with her jewellery on. The only problem we had was the three ladies in the same room with her then got jealous because they wanted jewellery as well. But in fact that actually prompted all the care workers putting their thinking caps on to the point that I had five or six people coming in having cleared up all their costume jewellery boxes and we ended up giving each of these elderly ladies some costume jewellery. And we had actually four happy ladies then. One person's act of kindness had a synergistic effect.

In view of this, quality dementia care seems to be based on an 'extended' dementia care triad or triangle of care (Adams & Gardiner 2005) consisting of the continuous interactions between patients with dementia, hospital care workers, family carers and other patients/colleagues as indicated in Fig. 1.

Providing 'quality time' and care 'in time'

Results from the interviews with staff denoted that positive experiences could only be possible if staff engaged with

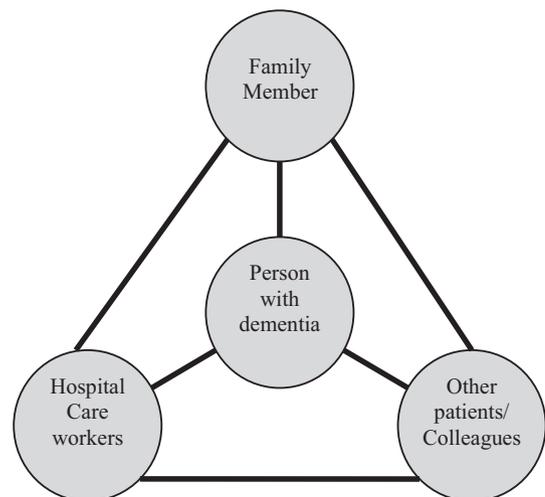


Figure 1 An 'extended' dementia care triad.

dementia patients by spending some time out of their busy schedule to get to know them better. According to a number of care workers, this does not mean solely spending time next to the patient, but engaging with the patient and showing genuine interest. This has been referred to by two members of staff as the provision of 'quality time' that sustains this relationship through the use of appropriate communication skills. This is congruent with other studies where quality dementia care was observed to be related to nursing staff giving sufficient time to residents in care homes (Van Beek & Gerritsen 2010) and is related to flexible time cultures (Egede-Nissen *et al.* 2013).

Five family members identified quality dementia care to be more associated with providing care 'in time' rather than being related to the quality of the time given. This 'immediacy', especially in the provision of physical needs, was greatly supported by family members who considered this approach as an important component of quality dementia care:

Relative (R2): ... He [the patient] stayed 11 or 12 days in the acute hospital ... He never emptied bowels during those days. When he came here, they tried everything. Twelve days not opening bowels!

Researcher: And they did something here?

Relative (R2): Yes ... immediately ... immediately ... until he is regular now.

Going the 'extra mile'

Although family members appreciated that care is provided in time and when required, hospital staff felt that positive experiences with dementia patients can be achieved if they went the 'extra mile'; when they adopted initiatives or carried out actions that were not part of the normal care routine or that fall within their job description. One particular episode, mentioned by a number of nurses, described how staff attempted to promote the well-being of one particular patient by bringing her clothes and costume jewellery from home. In another episode, a nurse described how she noticed a care worker who brought stewed apples from home out of her own accord to give it to one of the patients in her care.

The necessity to go beyond the routine work duties was also referred to by other healthcare professionals who felt that although some patients do not require their expertise, they still believed that they could make a difference in the patient's general well-being:

Care worker (S33): Not just as part of a chore or duties [but] as part of being really interested in the patients needs ... Going out of

your way, going out of your duty ... because sometimes I go to patients who do not need a speech therapist ... but if they ask for something I go out of my way.

Care worker (S32): I was thinking about this particular patient who did not need physiotherapy because he was here for respite care. He used to turn to all the staff to ask questions ... So every time I used to engage in a conversation with him and try to first calm him and reassure him because he was panicking and living in a situation as if it is real for him.

Meeting the psychological and physical needs of the patients with a 'human touch'

Care workers referred to numerous strategies used in an attempt to meet the patients' psychological needs. The one mostly adopted was that of engaging patients in a meaningful activity. Some of the activities described were spontaneous, whilst others were more organised.

Besides occupation, a number of staff members were able to identify the patients' need for inclusion. Interestingly, they referred to the fact that they enjoyed sitting next to dementia patients in the nursing station as this facilitated a working collaboration between the patient and the other members of the team:

Care worker (S2): When patients sit in the nursing station it also includes other people. Non-paramedics, for example like the ward clerk, become part of the team.

Providing a relaxed, safe and comfortable environment was highlighted by both care workers and family members. The latter particularly appreciated the focus given to maintaining physical comfort (for example through proper positioning), whereas care workers thought they are contributing positively when they provided psychological comfort by allaying the patient's fears and reassuring them especially when they are agitated or anxious. A relative referred to this attribute as having 'a human touch':

Relative (R4): The way not only how they lay him on the mattress, but the way they are taking care of him. The fact that they lay him down every day with a certain amount, how do you say it, human touch. I happened to also come over when they are feeding them [the patients]. . .not only as if they are doing only their job ... but there is certain dedication.

Similar to other studies (Edvardsson *et al.* 2010), staff mentioned approaches with which they managed to maintain 'normality' and the patient's identity. Care workers sought to celebrate these occasions through their positive comments resulting in an enhanced patient's self-esteem:

Care worker (S3) referring to the lady who was wearing jewellery brought by other care workers]: She used to remember about them...and the fact that at times the physiotherapist would come in her room and would tell her ... You look nice' and we used to match [the jewellery] with the clothes she wears and the fact that someone used to go and tell her 'You really look well!' or 'Look how nice those earrings look on you...they are not the same as yesterday's'. She used to enjoy [these comments] so much.

Factors contributing towards positive care experiences

Interviewees were asked to identify what made the observed positive care experiences possible. These factors were thematically categorised into four main subthemes: personal attributes of care workers, organisational factors, the physical environmental and contextual factors.

Personal attributes of care workers

Both participating staff and the family members identified a number of personal attributes that are required to successfully achieve a working relationship with patients with dementia and make the interaction a positive one. Patience was identified as an essential trait when caring for dementia patients especially in those exhibiting behavioural and psychological symptoms or frequent word repetition. Remaining calm was considered as important approach although both family and staff members acknowledged that it is not always easy:

Relative (R2): I cannot say that they should have more patience because if they are with one [patient] that is one thing, but if you have all these patients, it is difficult to stay with him only; but overall they take quality care of them.

Organisational factors

For both staff and family members, organisational factors play a major role in contributing towards making the hospital experience a positive one, such as the need of adequate staffing levels. Family members sympathised and sometimes excused nursing staff due to their heavy workload especially when caring for physically dependent patients. This is in line with a report published by the Royal College of Nursing highlighting the fact that health-care professionals with high workloads and low staffing levels contributed to the poor quality dementia care in hospital settings (Dean 2011).

Three family members indicated that avoiding staff rotation considerably helps patients and family members to get to know dementia patients well, thus helping in building a meaningful relationship. They were particularly concerned with the recruitment of 'bank' nurses/carers from contract-

ing agencies and relievers whom they felt they may not have received adequate training.

Staff development was perceived as an essential prerequisite in providing quality dementia care. The ongoing training, not only specific to dementia but also focusing on 'what the persons are experiencing', was essential according to one relative. Moreover, family members indicated that staff needs to be 'aware' that some of the patients have dementia even though they may have been admitted to the ward as a result of other medical conditions.

Physical environment

Interviewees referred to the need of a homely, safe, clean and relaxed environment that caters for the specific needs of patients with dementia. Both family and staff members acknowledged that much needs to be done for the hospital to take into consideration the needs of patients with dementia:

Care worker (S28): I think the first resource is the infrastructure of the place ... To be more dementia friendly ... there are things that are dementia friendly but it could be done better ... for example, better labelling, standardisation of all the wards...

Relative (R5): Maybe certain signs for example, near the bathroom ... If they are colour coded ... it is not dementia tailored ... Maybe certain pictures of villages of the past or parishes from different parts of Malta

Interestingly, some of the environmental changes described by the participants were not expensive to implement. These suggestions were categorised into 'no cost/minimal cost' and 'moderately/highly expensive' to implement (Table 3). A number of suggestions, especially those indicated by the staff, require more attitudinal/procedural changes as denoted by two members of staff who argued that there is no need of particular resources other than a positive disposition when requested to identify what resources were required to achieve a positive caring experience:

Care worker (S4): I think that it has to come from you. I don't think that you need any resources, to remain calm or to be caring.

Managing resources

Similar to other studies (Lintern *et al.* 2000, Jeon *et al.* 2011), effective management support was perceived by the interviewees as central in both developing human resources and enhancing the physical environment. This was facilitated by building collaborative interdisciplinary teams. Management support was particularly important especially when introducing new activities:

Table 3 Suggestions given by the respondents to enhance the physical environment of the hospital to make it more dementia friendly

No cost/minimal cost to implement	Moderately /highly expensive to implement
Adequate lightening	More colourful (e.g. wall painting)
Better paintings/pictures	A kitchen for the family/relatives
Avoiding transferring patients unnecessarily from one room to another	Television in each room
Better use of the dining room	
Encouraging a quieter and more relaxed environment	
Bringing the patients' personal belongings next to them	
Concentrating the patients with dementia in designated sections/wards	

Care worker (S15) [referring to the introduction of the breakfast group]: I discussed it with the management and we found an agreement that they will give us support between 8:00 am–9:30 am during the breakfast time.

In line with current evidence on leadership in dementia care (Loveday 2012), the two nursing officers mentioned that leadership skills were also important for quality dementia care in becoming an everyday reality. Particular reference was made to skills including those of not labelling staff, celebrating what goes well, giving feedback, measuring outcomes, being assertive and building an effective communication between management and staff. Moreover, certain organisational systems including hospital policies and procedures were considered by family members and care workers as important in promoting quality dementia care. These included flexible procedures (e.g. flexible visiting times for family members of patients with dementia), patient allocation practices and care workers handovers. Family members appreciated these practices whilst indicating that more of these are required. They suggested a number of changes that were necessary in making hospital procedures more flexible and person centred:

Relative (R6): For instance, tea is given on time ... Now she takes tea whenever she feels like it. And when I tell them, (they tell me), 'now at six we'll do tea' for instance.

Researcher: It's good it's available.

Relative (R6): Even if I prepare it myself, so as not to keep asking them to do it, as I used to do in the other hospital.

Researcher: You find it lacking.

Relative (R6): Of course, because she likes to peck with tea, tea is her life.

Other contextual factors

According to the interviewees, positive experiences were influenced by other contextual factors such as the heterogeneity and unpredictability of behaviour in patients with dementia. This means that 'every dementia is a different

experience, because all of them are different'. This variability can be due to a number of factors including different personalities, different coping strategies used by the patient and the level of disease progression. This was found to be particularly challenging for staff as in a number of occasions, they had to rebuild the relationship afresh. Moreover, considering that most of the time patients are not admitted in the hospital with dementia as the main diagnosis and having other comorbidities adds to the complexity of care, making it more challenging:

Care worker (S31): They would have been admitted with an orthopaedic condition but dementia is also there. So you still have to take care of that.

Limitations of the study

Due to the severity of dementia progression and the presence of other comorbid conditions, it was not possible to collect direct feedback from patients with dementia. Although this could have substantially contributed in enriching the presented findings, the heterogeneity in staff occupation and the inclusion of family members provided a very diverse platform of experiences. Moreover, the results may not be transferable to other settings although these were found to be similar to those reported elsewhere (Edvardsson *et al.* 2010, Clissett *et al.* 2013b). Furthermore, care workers could have referred to the most recent experiences shared with their patients rather than the most positive ones.

Conclusion

Studies (Zekry *et al.* 2009) show that dementia care in hospital settings is not optimal. However, this study reported that positive care experiences do happen and these can provide us with a means of understanding what quality dementia care is in clinical practice. The study also complements other findings highlighting the complexity of developing good quality dementia care and how this may be influenced by numerous factors including staff attri-

butes, and organisational, environmental and contextual considerations.

Brooker (2004) emphasised that an important component of person-centred care in dementia is valuing patients with dementia and those who care for them. A learning environment that cherishes and nurtures its nursing staff in geriatric and dementia care settings has also been associated with staff retention (Chenoweth *et al.* 2010). Moreover, Reed (2010) argued that the appreciation of gerontological care is important in laying the foundations for positive changes to occur.

This study sought to identify the components and the factors that enhance quality dementia care by exploring positive care experiences. The findings can help in understanding the changes required to enhance the quality dementia care in hospital settings when hospital staff include these care processes in their daily care practices. Moreover, hospital management needs to consider the factors influencing the care processes such as the personal attributes of staff, and organisational, environmental and contextual factors. In this way, the quality care of dementia patients in hospital wards can be transformed to become truly person centred.

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Relevance to clinical practice

By understanding the components of quality dementia care and how these can be achieved from different stakeholders, it is possible to develop strategies aimed at improving the care offered to patients with dementia in hospitals.

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