Essential Care for Older Patient Specialling in Acute Care Settings: A Concurrent Mixed Methods Study

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Certificate of Original Authorship

I, Jacquelene Jane Cook, declare that this thesis, is submitted in fulfilment of the requirements for the award of Masters of Nursing (Research), in the Faculty of Health at the University of Technology Sydney.

This thesis is wholly my own work unless otherwise referenced or acknowledged. In addition, I certify that all information sources and literature used are indicated in the thesis.

This document has not been submitted for qualifications at any other academic institution.

This research is supported by the Australian Government Research Training Program.

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Dedication

I dedicate this thesis to my parents, Jack and Dorothea Pendlebury.

Thank you for letting me be me.

You both gave me the foundation of unconditional love.

You were together over sixty years and when it was time for you both to pass on you did so together which broke my heart.

I miss your wise words, Mum.

I miss how proud you were of me, Dad.

You taught me how to be resilient and to fight for what I wanted. This journey has been that fight. Thank you for lighting this fire within me.

Although I may not have completed High School at the time, I've gone on to complete my undergrad, postgrad and 2 masters; all while raising three children in tow.

Thank you for the love to believe I can undertake the journey.

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Glossary of terms and abbreviations

Term/abbreviation	Definition
Acute care	Any promotion, preventative, curative, rehabilitative or palliative action, whose primary aim is to improve the health of individuals or populations and whose effectiveness depends on time-sensitive and, frequently, rapid intervention (Hirshon et al. 2013)
AIN	Assistant in Nursing
CNC	Clinical Nurse Consultant
CNE	Clinical Nurse Educator
CNS	Clinical Nurse Specialist
EN	Enrolled Nurse
ERIC	Emotional Responses in Care (Fleming 2005)
NUM	Nurse Unit Manager
Older person	Person aged over 65 years
PCC	Person Centred Care
QUIS	Quality Interactions Schedule (Dean et al. 1993)
RN	Registered Nurse
Specialling	Close monitoring and observation to prevent accidents and injuries, and to ensure timely recognition and response to clinical deterioration (Dewing 2013; Schoenfisch et al. 2015; Wilkes et al. 2010; Wood et al. 2018).
SPTPD	Socio-Psychological Theory of Personhood in Dementia (Kitwood 1993)
VIPS	Values, Individualised Care, Perspective of the Person, Social Inclusion (Brooker 2007)

Abstract

Background: During hospitalisation, older people can quickly become disoriented, confused and agitated. In these instances, 'specialling' is often provided and involves close monitoring and observation of the person to prevent accidents, injuries and clinical deterioration. Despite the widespread practice of older patient specialling, there is a lack of conceptual clarity around the scope, purpose and expected outcomes of specialling. There is no evidence of the best model, or any clear guidelines around the essential requirements for this practice in terms of who should be specialled, experience and qualifications of staff who special, the type of care that should be provided when specialling and the type of environment that is appropriate for specialling.

Aim: This study aimed to examine specialling of older people in acute care settings and to inform the development of a set of evidence-based care guidelines for specialling older people in these settings. Two research questions that guided the study were (a) what characterises older person specialling in the acute care setting? and (b) what essential care is required when specialling older people in acute care settings? The central premises are the concerns about the lack of guidelines and procedures for specialling the older person in hospital, the varying expectations of the specialling role and limited suggestions on what constitutes a positive, person-centred experience for older people who are specialled.

Method: Concurrent mixed methods were used to obtain data on older person specialling experiences. The inquiry was conducted in two phases in four acute aged care wards of a large metropolitan hospital in Sydney, Australia. Phase One comprised a focus group interview with nine registered nurses to obtain data on the characteristics of older person specialling. Phase Two used two validated tools to observe care interactions between staff and their care recipients, and the older person's care during specialling. A total of 58 observations of specialling were undertaken for 12 patients aged 65 years and older. These data were used to further inform the characteristics of older person specialling and identify the essential care required for specialling older people in acute care.

Results: Delirium was the most common reason for older person specialling, and most specialling was undertaken by assistants in nursing. Specialling was influenced by an ethos that did not always support person-centred care; rather adopting a task-focused custodial approach. Acute care administrative practices appeared to lack consideration of the impact of specialling on nurses' workload, and lacked clear policies or procedures around specialling, including staff most appropriate to special older people and how they should be prepared to undertake the role. However, 45 of the 58 care interactions and responses were recorded as positive. These observations were dependent upon the special's familiarity with the ward and their care recipients, the overall acuity of patients in the wards, the general ward busy-ness and the presence of personal possessions in the person's immediate surroundings.

Limitations: The diverse nature of the literature reviewed for the study precluded the use of a quality appraisal tool and therefore the extent to which findings are useful is difficult to determine. Limitations are also acknowledged in the methodology. One focus group of registered nurses held in one hospital potentially limits the findings in voice, time and location and may not fully represent the characteristics of older person specialling in acute care. The small sample size for the observations, small number of observations and short observation periods are also considered to be a limitation.

Conclusion: The use of formal guidelines for decision-making on initiation and cessation of specialling, requirements for workload allocation, staff qualifications, educational preparation for the specialling role and team-based care models are proposed for specialling the older person in the acute hospital setting, along with recommendations on what constitutes person-centred specialling practice. Research that focuses on outcomes for person-centred specialling of older people in acute care settings is suggested.

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1 Introduction

1.1. Chapter introduction

This introductory chapter to the thesis begins with an overview of older people in acute hospital settings, explains the term 'specialling' and describes how specialling has emerged as a means of protecting people from harm, injury or adverse events. The student researcher's motivation for the study is then provided, followed by an overview of each of the chapters comprising the thesis. The chapter concludes with the study's aims and research questions.

1.2. Health care needs and issues for older people in acute hospital settings

People over 65 years of age are now the major consumers of acute health services, being two to three times more likely to be admitted to hospital than their younger counterparts (AIHW 2017). The older population has an evolving pattern of disease, which is distinguished by multiple co-morbidities and associated poly-pharmacy (Portelli et al. 2016). This complexity makes them most vulnerable to complications and iatrogenic harms during a hospital stay. Nosocomial urinary tract infection, pressure injuries, pneumonia, falls and delirium have been identified as key complications for hospitalised older people (Bail et al. 2015; Dewing & Dijk 2016). These complications are even more prevalent in older people who present with an existing cognitive impairment such as dementia (Bail & Grealish 2016).

The Australian Institute of Health and Welfare (AIHW) (2017) estimate that one in five older people aged over 65 years admitted to hospital for any number of unrelated health issues will present with an underlying cognitive impairment, and many of them will develop delirium during admission. According to the Australian Commission on Safety and Quality in Health Care (ACSQHC 2018), there are over 22,700 hospital-acquired episodes of delirium occurring in Australian hospitals each year. The risk factors for delirium include patients over the age of 70 years with visual or hearing impairment,

polypharmacy and infection. Delirium rates are even higher when an older person has a pre-existing cognitive impairment (e.g., dementia), has been admitted to the intensive care unit, or is in the acute post-operative phase (ACSQHC 2014; Jackson et al. 2017). Older people with an undiagnosed cognitive impairment have an approximately 30% higher risk of developing a delirium during an admission to hospital (ACSQHC 2014). People living with dementia can be particularly sensitive to non-verbal cues and can mirror the behaviour of people around them, placing them at a higher risk of inpatient adverse events and delirium if other patients are agitated or distressed (Jackson et al. 2017).

Johansson et al. (2018) characterise the signs of delirium as an increase in confusion, delusions and paranoia as well as motor changes. Older people can become disorientated, anxious, have auditory or visual hallucinations, or can become quiet and withdrawn, when delirious. These signs and symptoms can be exacerbated by the unfamiliarity and busy-ness of the hospital environment (Dewing & Dijk 2016) and may also fluctuate over the course of the day (ACSQHC 2016). Although delirium is normally reversible, the condition can persist for days or months. Medical specialists acknowledge these symptoms as predictors of a medical emergency (Carr 2013).

Patient safety is of concern as the unfamiliar hospital environment poses a high risk of injury for older people. Issues include potential falls, leaving the ward unaccompanied by a family or staff member, wandering about the ward, or causing other patients to become verbally or physically aggressive toward them, skin tears and other trauma (Carr 2013; Dewing 2013; Donoghue et al 2005; Moyle et al. 2010; Portelli et al. 2016; Rape et al. 2015; Schroeder 2016; Shever et al. 2011; Tzeng et al. 2008; Wilkes et al 2010).

1.3. The acute hospital setting

Hospitals today are fast paced, largely focused on efficiency, throughput and care that follows the shortest possible trajectory for patients with a single condition (Bail & Grealish 2016). This is evidenced by Australian hospital key performance indicators of length of stay and waiting times (AIHW 2018), which are major funding determinants (Bail & Grealish 2016). Acute hospital beds have decreased, lengths of stay have

decreased, and bed occupancy is high (Kuntz et al. 2015). These hospital processes present a significant challenge in the care of older people. More people undergoing simple procedures in day units and private centres (AIHW 2013) means that the majority of hospital in-patients are older, have multiple co-morbidities and complex health issues, and need complex treatments. Current models of hospital care prioritise curative and acute care over non-technical (i.e. supportive) care to enhance patient throughput (Bail et al. 2015). Since older people have multiple and often complex healthcare needs, the current acute care model is incompatible with these care priorities. This situation needs urgent attention, given the high use of acute care in people over 65 years, in particular people over 80 years, who are vulnerable to iatrogenic harms associated with the fast-paced, task-driven acute care setting (Bail et al. 2015; Clissett et al. 2013; Dewing & Dijk 2016; Jackson et al. 2017).

Older people presenting to acute care settings with sensory deficits and/or underlying cognitive impairment can very quickly become disorientated confused and agitated by the busy-ness of the hospital environment. The hospital environment exposes vulnerable older people to increased stimulation from tactile sources including intravenous therapy, cardiac monitoring, dressings, casts or restraints including bed rails (Koch et al. 2009). Changes in environment and daily routine can elicit both physical and emotional responses in older patients. Admission to hospital can subject the patient to multiple bed moves (Duffield et al. 2009) which in itself can cause stress and disorientation (Koch et al. 2009). These changes can lead to, or exacerbate adverse behaviours such as agitation and confusion, and can result in the development of delirium in the older person.

Because of hospital system constraints, nurses working at the frontline in acute care settings struggle to meet the care needs of older people (Clissett et al. 2013; Gray-Siracusa et al. 2011). Nurses can also find it difficult to manage the unpredictable and challenging behaviours associated with delirium where specialist resources are absent or limited, and where they lack the time to supervise and comprehensively care for older people (ACSQHC 2016; Portelli et al. 2016; Wood et al. 2018). The care and stress burden for nursing staff is increased for patients with agitation and those who are inclined to wander (Bateman et al. 2016). Furthermore, these unpredictable behaviours may impact on other patients in the ward through unintentional harm caused by

confused patients. Other patients may receive less care because of the disproportionate amount of time spent caring for confused or delirious patients (Wilkes et al. 2010).

For these reasons, nurses are required to continually reprioritise their time and multitask to meet their patients' different care needs (Nobili et al. 2011). When the demand for nursing care exceeds the nurse's capacity, they will often resort to 'rationing' care according to acute medical need. In these circumstances, the nurse may only have time to undertake care tasks which they deem to be necessary to support the patient's health, e.g. administering medicines, taking vital signs, and omitting other care responsibilities such as mouth care, mobilisation, hydration and emotional support (Bail & Grealish 2016). A lack of resources including time, and inadequate staff ratios and nursing expertise, can also force nurses to ration the type of care provided, resulting in 'missed' care (Papastavrou et al. 2014). Jones et al. (2015) suggests that internationally, nurses omit at least one key care activity on a daily basis. Rationing of nursing care, or missed care, is likely to lead to further functional and cognitive decline in older patients, along with an increase in hospital-acquired complications (Bail & Grealish 2016). Thornlow et al. (2014, p. 66) coined the term 'cascade iatrogenesis' to describe the decline in older people in situations where vital health needs are unresolved. A failure to meet essential care needs can result in the older person acquiring health complications e.g. untreated pain leading to decreased mobility.

In an effort to improve patient safety and prevent these complications, specialling may be initiated. Specialling for delirium is considered an important non-pharmacological intervention, providing staff with the necessary time to ease symptoms and manage the associated risks before pharmacological treatment is considered (ACSQHS 2016). Dewing (2013) however, cautions that the goals of specialling should be therapeutic and not just aimed at surveillance. Specialling provides nurses with an opportunity to engage more intensively with the older person in lessening their distress and reducing their risk of complications. Activities such as helping to orient the person to the ward environment and paying attention to their basic activities of living such as mobilisation, toileting, hygiene, nutrition and hydration, are key aspects of specialling (Dewing 2013). As well, engaging with the patient's family when specialling the older person will assist in learning about the particular care requirements and communication approaches that will help the person to feel more settled.

1.4. Models of care for older people in Australian hospitals

Over the past few decades, there has been growing evidence about the importance of partnerships between health service organisations, health professionals, patients, families and carers as a means of improving patient safety, cost effectiveness and patient, family and staff satisfaction (ACSQHC 2017). In response, a number of different models have been developed that claim to focus on the individual.

For example, the Agency for Clinical Innovation (ACI) promotes a model of care for vulnerable older people in hospital called 'Care of the Confused Older Person in Hospital' (CHOPS) (Agency for Clinical Innovation 2019). This model outlines seven key principles to guide clinicians on delivering person-centred care (PCC), aiming to address the physical, medical, social and psychological needs of the older person in partnership with carers. This model promotes goals of care based on a person's values and experiences. ACSQHC include 'Standard Two: Partnering with Consumers' as one of the (formerly ten, now eight) standards for quality care against which Australian hospitals are regularly accredited (ACSQHC 2017). Standard Two stipulates that care should be respectful of, and responsive to the preferences, needs and values of patients. The clinical benefits claimed within Standard Two include decreased mortality, lower readmission rates, reduced length of hospitalisation, reduced rates of hospital-acquired infections, improved likelihood of adhering to prescribed treatments and improved functional status (ACSQHC 2017).

There is no universally accepted definition of PCC for hospitalised older people (Delaney 2018; Grealish et al. 2018). In their systematic review of the literature on PCC for older people, Kogan et al. (2016) established six domains: holistic care, respect and value, choice, dignity, self-determination and purposeful living. In acute care settings, it is possible for nurses to incorporate these domains into their clinical care through patient narratives and shared decision-making (McCormack et al. 2014). However, because of the aforementioned constraints in the acute hospital setting, including the focus on physical/medical issues and task-focused care, nurses need guidance on the provision of meaningful PCC for older people (McCormack et al. 2014). Nurses lacking the knowledge and skills required to care for older people with cognitive impairment

may find delivering PCC quite challenging, especially when agitation is present (Clissett et al. 2013; Grealish et al. 2018). Nurses may also not know how to communicate therapeutically with these patients, an essential skill in PCC (Moyle et al. 2010). On the whole, nurses may be uninformed, or have misperceptions, about the principles and approaches required to give PCC (Grealish et al. 2018). Since older patient specialling requires paying attention to the patient's individual needs in ways that avoid iatrogenic harms and distress, while engaging therapeutically in care delivery, PCC may be a suitable approach to specialling.

1.5. Models of older person specialling

Specialling in acute care settings involves close monitoring and direct observation to prevent accidents and injuries, and to ensure timely recognition and response to clinical deterioration (Dewing 2013; Schoenfisch et al. 2015; Wilkes et al. 2010; Wood et al. 2018). With the disproportionate number of older people being admitted to acute care settings, along with increasing numbers of older people with a cognitive impairment, the incidence of specialling the older person has increased (Portelli et al. 2016). However, there is a lack of clarity and formal policy on what constitutes therapeutic specialling (Carr 2013; Dewing 2013; Kerr et al. 2013).

In acute care settings, specialling often occurs as an unplanned event in response to a person's additional care requirements, giving rise to an ad-hoc approach to the practice. How specialling is initiated and ceased is problematic. Several specialling request forms, flow charts and algorithms are available to guide the use of specialling (Feil & Wallace 2014; Spiva et al. 2012), but for the most part the decision-making process in commencing and ceasing specialling varies according to context (Wood et al. 2018). The challenges associated with this ad-hoc approach to specialling are compounded by specialling being undertaken by personnel with non-professional healthcare qualifications (Wood et al. 2018). Non-professional staff are often assigned the specialling role in an effort to reduce high staffing costs associated with providing special care and to ensure that professional staff-patient ratios are not negatively impacted. Yet, the staff often allocated to the specialling role are usually ill prepared to care for older people with complex health issues and care needs (Dewing 2013; Kerr et

al. 2013; Portelli et al. 2016; Rape et al. 2015; Schoenfisch et al. 2015; Schroeder 2016; Wood et al. 2018).

Despite the anecdotal widespread practice of older person specialling in acute hospital settings, there is no clear evidence of the best model or any evidence-based guidelines on the essential care practices required in the specialling role (Cook et al. 2018; Dewing 2013; Schroeder 2016; Wood et al. 2018). From both a human resource and a patient outcome perspective, the important questions that need answering include what specialling entails for older people, what essential care is required and what benefits accrue to the older person from being specialled in an acute hospital setting. This study aimed to answer some of these questions by identifying the characteristics, requirements and provision of specialling to older persons in this setting.

1.6. My interest in older person specialling

I am a Registered Nurse who has worked across acute aged care wards in several general hospitals for over 30 years. During this time, I have observed many older people, usually with cognitive impairment, becoming delirious in the hospital setting. My observations suggest that staff-to-patient ratios in acute aged care wards are inadequate, and nursing staff do not have the resources such as time, knowledge and skills to adequately care for their older patients.

In my clinical practice I have noticed nurses (including myself) becoming increasingly stressed when caring for older people who have additional and challenging health issues such as delirium. Stress levels rise for nurses with the increased risk of adverse events such as falls in confused older patients, and when patients constantly attempt to leave the confines of the ward. Specialling is considered to be an appropriate intervention to help settle confused older patients (Dewing 2013; Schoenfisch et al. 2015; Wilkes et al. 2010; Wood et al. 2018). However, rather than feeling relief that the person is being adequately cared for when specialling is initiated, I have observed that the inexperienced, unlicensed staff are often assigned as specials. Allocating inexperienced, non-professional staff to the role causes nurses (and the specials themselves) to become even more stressed, as they try to deal with challenging behaviours, all while being poorly prepared for the role. What's more, I have been concerned about the approach of

many specials to the care of older people, and I worry that it focuses on restraining, or otherwise confining, the person so that they do not fall, rather than providing them with opportunities to mobilise with support, or paying attention to the reasons for agitation.

When I searched the literature and guidelines to inform best practice specialling in acute aged care wards, what concerned me greatly was that despite specialling being such a common occurrence, there was a lack of evidence on best-practice specialling of the older person. Initially, much of the literature I located was aimed at reducing the need for nurse specialling with alternatives such as alarms and other technology.

Consequently, my personal motivation in commencing this study is to add to the body of knowledge in identifying what essential care is required when specialling the older person in the acute hospital setting, especially in the context of PCC. I am hoping that the results from this study will inform guidelines and development of tools on exactly how specialling should be supported and conducted. First, I will use this evidence to develop a set of care guidelines for older person specialling in the acute aged care wards where I work. These guidelines could then be adapted for use throughout the entire hospital and eventually endorsed and used across the entire local health district. Ultimately, I aim to improve outcomes for older people who require specialling during a hospital stay.

1.7. Thesis structure and chapter overview

This thesis has six chapters. It has commenced with an abstract and this introductory chapter that considers the health care requirements and issues for older people in the acute care setting. A review of the literature on specialling follows in Chapter Two, which includes a definition of specialling and its historical context and indications for older patient specialling in acute hospital settings. Chapter Three outlines the study's conceptual framework and the study methods. Chapter Four presents the results of the research. Chapter Five critically analyses the integrated study results with reference to the study's conceptual framework and the literature. The last chapter (Chapter Six) presents the conclusions drawn from this work, culminating in a set of recommendations arising from the research and suggestions for future research. There are three articles arising from this study. One is a review/research article now published in an industry journal and therefore, has been referenced in this thesis. The other two

have been submitted to peer reviewed scholarly journals and at the time of preparing this thesis are currently under review. Material from these submissions is contained within this thesis, although not explicitly referred to in the work.

1.7.1. Chapter one: introduction

As foreshadowed, this chapter provides some of the background to the research, including the increasing number of older people (i.e., over 65 years) now presenting to Australian hospitals. The current hospital setting, associated resource constraints and the impact this has for older people are discussed. Models of care for older people in Australian hospitals are reviewed, along with a rationale for older person specialling in acute care settings. The researcher's motivation for the study is outlined, which includes, among other things, frustration at the lack of guidelines for older person specialling and concerns about the type of care provided. After an overview of the chapters, this chapter concludes with the study's aims.

1.7.2. Chapter two: literature review

Chapter Two reviews local and international literature that focuses on specialling. An explanation of the search strategy for the review is provided, along with the search outcomes. Characteristics of the located literature are noted, and the literature is reviewed in a number of sections and sub-sections that include a definition of specialling and its historical context and indications for older person specialling in acute hospital settings. Various models of care provision when specialling are then discussed. The type of staff who are typically allocated to the specialling role are outlined, and specialling alternatives and costs are also considered. The literature is also reviewed in relation to patient outcomes from specialling. The chapter concludes with a restating of the study's aims and identifies the research questions.

1.7.3. Chapter three: methodology

Chapter Three outlines the conceptual framework for the study. The study is underpinned by the Socio-psychological Theory of Personhood in Dementia (SPTPD) (Kitwood 1993), from which Person-Centred Care (PCC) was derived. As a means of

evaluating the extent to which older patient specialling was person-centred in this study, Brooker's (2007) VIPS framework is used. After an explanation of both PCC and VIPS, an outline and justification of the research design, study setting and participants, study measures and data collection procedures, and data analyses is provided. The study's ethical considerations are also reported in this chapter.

1.7.4. Chapter four: results

Chapter Four presents the results of the two phases of this mixed method research study, including the study participant characteristics. The results from each of these two phases are outlined in two main sections. Results from the focus group that comprise Phase One are presented first (4.2) followed by the observations of specialling that comprise Phase Two (4.3), with a number of subsections as appropriate.

1.7.5. Chapter five: discussion and recommendations

Chapter Five interrogates the main results and key themes arising from the integrated data obtained in the two study phases, with respect to the study's aims and research questions, the study's conceptual framework and the literature on specialling of the older person. Recommendations from the study are outlined and justified. Limitations of the study are also presented in this chapter.

1.7.6. Chapter six: conclusion

This final chapter briefly re-states the study's aims and research questions, provides a summary of the study results and makes recommendations for practice that are intended to improve the journey of the older person who is specialled in hospital. Details are provided of work currently in progress regarding an initial draft set of care guidelines for older person specialling in the acute care setting. These care guidelines include the recommendations arising from the study. Suggestions are made for future research and the thesis is drawn to a close.

1.8. Study aims and research questions

This study aimed to examine specialling of older people in acute care settings and to inform the development of a set of evidence-based care guidelines for specialling older people in these settings. Two important questions that need answering are:

1. What characterises older person specialling in the acute care setting?
2. What essential care is required when specialling older people in acute care settings?

The central premise is that currently there is a lack of guidelines and procedures for specialling the older person in hospital and there are considerably varying expectations of the role, including what constitutes person-centred specialling for hospitalised older people. A review of current literature in relation to specialling follows in the next chapter.

2 A review of the literature on specialling

2.1. Chapter introduction

This literature review focuses on specialling older people in an acute care setting. Specialling terminology is discussed along with the historical context of specialling. The review identifies the particular issues and needs of older people who require care that is additional to routine nursing care. The process of specialling is discussed, including the type of care that might be provided when specialling and the outcomes that might be expected from specialling. Qualifications of staff who undertake specialling are outlined, along with specialling costs and alternative forms of care for vulnerable patients.

2.2. Aim of the review

The aim of this literature review was to identify and summarise literature on specialling. As foreshadowed in Chapter One, the central premise is that there are considerably varying expectations of the specialling role (Carr 2013; Dewing 2013; Kerr et al. 2013; Moyle et al. 2010; Portelli et al. 2016; Schoenfisch et al. 2015; Wilkes et al. 2010), and a dearth of guidelines, procedures and other evidence for specialling the older person in the general hospital setting. The lack of strong evidence for the benefits of specialling practices as they pertain to the older person is a significant barrier to the adoption of specialling for this patient group within acute care settings (Feil & Wallace 2014).

2.3. Review method

Whittemore and Knafl's (2005) methodology informed this literature review. This methodology was chosen because it assisted in identifying assorted sources of information, thereby enabling a review of a rich and comprehensive understanding of specialling in general hospital settings. Whittemore and Knafl's (2005) five-phased process entails a rigorous search strategy and audit trail, critical analysis, aggregation and synthesis prior to interpretation and dissemination of findings.

2.4. Search strategy and outcome

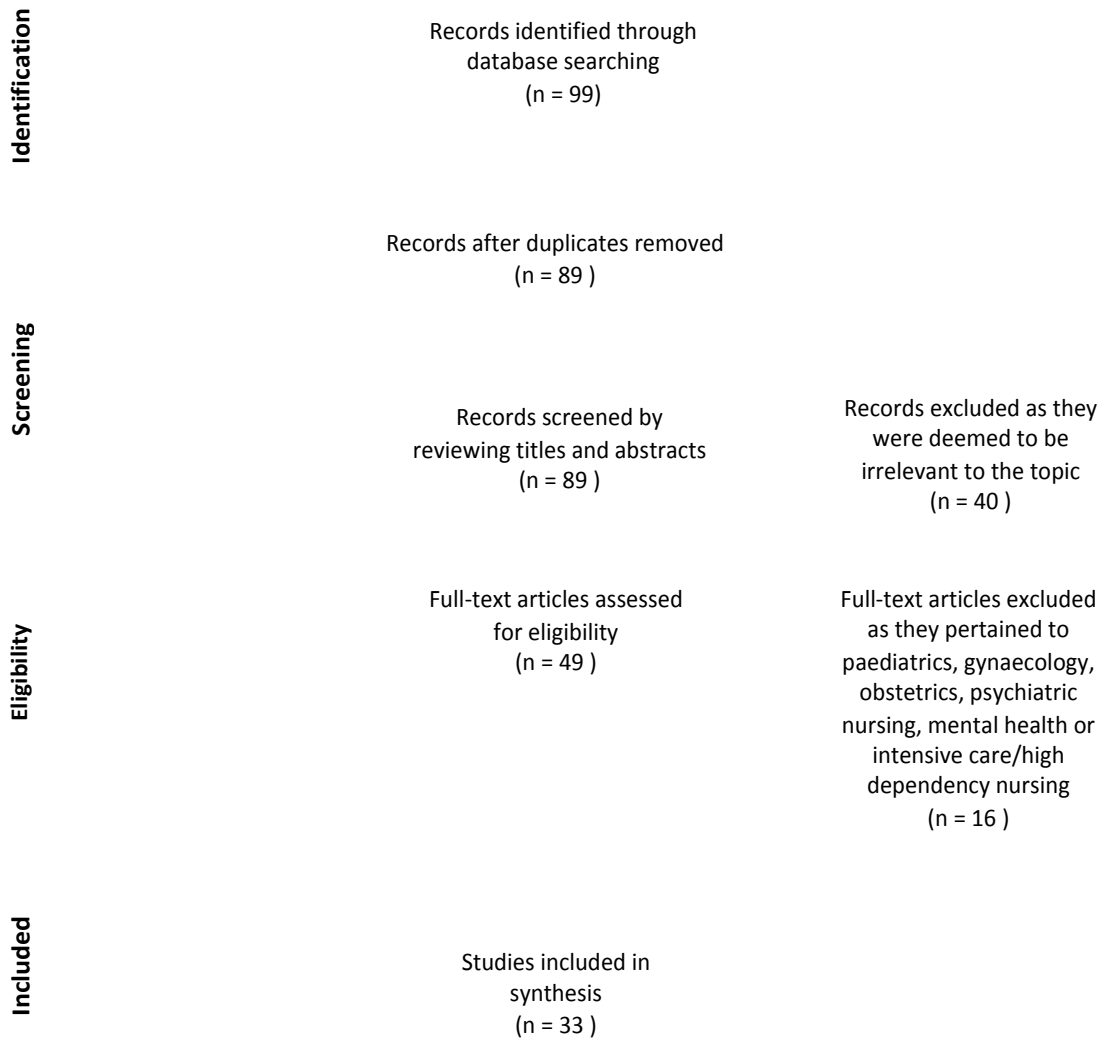
The literature search initially considered any articles that related to specialling older people in hospitals. The major electronic databases of PubMed, MEDLINE (OVID), and CINAHL (EBSCO) were initially searched using a Boolean/Phrase mode with various combinations of the following terms*: specialling, special, general hospitals, acute care, older patients, older people care, PCC, individualised care.* The search was limited to the following selection criteria: peer reviewed research articles, English language patients aged 65+ years and publications between January 1990 (to incorporate the historical aspect of specialling) and April 2018 (a cut-off date to commence writing the thesis). It was also anticipated that a 28-year time span for the literature search would accurately reflect the development of specialling older people over time. This initial search resulted in only three articles: Dick et al. (2009), Wilkes et al. (2010) and Wood et al. (2018) all of which were retained for further analysis.

Terminology played a pivotal role in the progress of the search strategy. In the initial stage of the literature search it became apparent that the lack of consensus concerning the terminology would make the search cumbersome in locating articles. However, with the establishment of key terms, the search findings progressed. To expand the search process, Scopus and Web of Science databases were accessed and the following terms were added: *delirium, dementia, 1:1 observation, close observation* and *sitters*. The expanded search was informed by regular hand searching of relevant journal articles and their accompanying reference lists. These additional searches were supplemented by a hand search of any policies for healthcare staff within the time period of January1990 - April 2018. By applying the same inclusion criteria, 88 additional articles were retrieved, and these were further reduced to 47 potentially relevant articles that met the inclusion criteria upon reading the article abstracts.

The focus of this study is older people who require specialling for additional care in general wards during an admission to an acute care hospital. Exclusion criteria comprised studies that concentrated solely on acute psychiatric intensive care units, as in these settings constant observation includes younger patients experiencing a psychiatric crisis such as suicide attempt, psychosis, or violence to self or others

(Manna 2009). Studies pertaining to paediatric units, obstetrics and gynaecology were omitted, as were all the papers on 1:1 intensive care or high dependency nursing. Literature published outside the established time frames and for which English translations were unavailable were also excluded. With these criteria in mind, 16 of the 47 papers located on constant observation were excluded.

Figure 2.1 Flowchart of search and screening process adapted from Moher et al. (2009)



2.5. Characteristics of the included literature

Papers for review in this chapter include empirical studies (19), literature reviews (4), service improvement papers (8), one report and one commentary piece. These papers originate from the USA (20), Australia (7), Canada (2), UK (2), Taiwan (1) and New Zealand (1). Figure 2.1 contains a summary of papers that are the focus of this review. The review was supplemented by a hand search for any policy/practice guidelines or any other publications available within the same timeframes as the literature search needed to support or refute the discussion in this chapter. Due to the inclusive and diverse nature of this review and the literature, it was decided not to use a specific quality appraisal tool. A table of included literature for this review can be found at Appendix 1.

2.6. Analysis of the included literature

Systematic methods are required when analysing literature to provide unbiased and comprehensive interpretation of included papers (Whittemore & Knafl 2005). The student researcher independently extracted data from the research articles and entered it onto a shared worksheet. This process generated a table ready for initial analysis and synthesis by the student and an additional researcher (i.e., the student's primary research supervisor). In keeping with thematic analysis, the literature review findings were read and reread carefully to identify emerging themes (Liamputtong & Serry 2017). Analyses of the reported findings were undertaken in consultation with the entire research team (i.e., student researcher and research supervisors) to maintain a rigorous and transparent process and to resolve any perceived discrepancies in the findings. Through this course of interpretation, at times the research team members considered other relevant information pertaining to older person specialling as reported in all accessed literature.

The key findings of the selected literature were organised into the following themes: definitions and descriptions of specialling, indications for specialling, care provision during specialling, specialling staff, patient outcomes, specialling costs and alternatives. Chapter One disclosed a personal motivation in undertaking this study as seeking to

identify essential care requirements for specialling older people in hospital, especially in the context of PCC described by Kitwood (1993, 1997). For this reason, each of the research articles was also scrutinised for evidence relating to the Kitwood's (1997) guiding principles of PCC. Papers were explored for references to, or emphasis on, the need to create and strengthen positive relationships, communicate respectfully, value and treat the person as a unique and sentient person, view the person's world from their individual perspective, and help them to maintain meaningful social and emotional attachments to others (Kitwood 1997).

2.7. Specialling defined

2.7.1. Terminology

Evidence from the reviewed literature reflects the lack of consensus concerning the terminology on patient specialling. The terms 'specialling' and 'special nurse' are colloquial descriptors of the role (Carter 2016; Wood et al. 2018); in the literature the terms used include: 'close', 'maximum', 'continuous', 'constant observation', 'special observation', 'constant observer', 'constant companion', 'therapeutic companion' and 'sitters' (Carr 2013; Goldberg 1990; Feil & Wallace 2014; Harding 2010; Lang 2014; Nadler-Moodie et al. 2009; Weeks 2011).

2.7.2. Description

The literature review established the ambiguity as to what is actually involved in the process of specialling. Differences in terminology have also contributed to misunderstanding and misinterpretation of the patient specialling process (Dewing 2013). A lack of consensus on the defining features of the specialling role is reflected in both Australian (Wilkes et al. 2010) and international literature (Carr 2013; Schoenfisch et al. 2015; Wood et al. 2018). Differences in conceptualisation of the role means that managers and nurses working on the same ward can have different understandings of the context, purpose and expected processes involved in patient specialling. There is no clear guidance on the required knowledge, skills and experiences of nurses expected to undertake this role, giving rise to different interpretations of the specialling process (Dewing 2013). In most cases the Nurse Unit Manager (NUM), or nurse in charge decides the role of the special at the time it is required (Wilkes et al. 2010). In these

circumstances, patient specialling is used indiscriminately and inconsistently, resulting in variable models of care approaches and associated patient and system outcomes (Dewing 2013; Rochefort et al. 2012; Schoenfisch et al. 2015; Wilkes et al. 2010; Wood et al. 2018).

However, there are ongoing efforts to improve current specialling practices, including the Carter (2016) review in the United Kingdom (UK) that suggested replacing the term specialling with 'enhanced care'. The authors argue that the range of terminologies in use reflect the differences in the type of care that specialling staff provide (addressed later in this chapter), i.e., either active, therapeutic and person-centred, or passive and custodial (Dewing 2013). In any case, there appears to be consensus in the literature around what specialling generally entails, that is, close monitoring and observation to prevent accidents and injuries, and to ensure timely recognition and response to clinical deterioration (Dewing 2013; Schoenfisch et al. 2015; Wilkes et al. 2010; Wood et al. 2018).

2.7.3. Historical context

Historically, 'special observation' and 'constant observation' are terms most commonly associated with mental health nurse specialling, a widely accepted protective intervention to reduce the incidence of adverse patient outcomes such as suicide, self-harm, absconding and aggression (Manna 2009). In relation to general hospitals, however, several explanations for the introduction of specialling over the last two decades have emerged. An early study by Goldberg (1990) identified the usual management of the older person with agitated behaviour as use of physical restraints, while at the same time the use of constant observation was emerging as a strategy for patients with delirium in the general hospital, to prevent them from "engaging in harmful behaviours" (Goldberg 1990, p.193). Later, Torkelson et al. (1999) and Boswell et al. (2001) maintained that specialling in the general hospital setting originated as an alternative to the use of physical restraints, which were becoming increasingly associated with a high risk of physical injury.

Patient specialling was promoted following the compulsory reporting of sentinel hospital events to the Joint Commission on Accreditation of the Healthcare Organisation (JCACHO) in the United States of America (USA), which challenged the routine use of physical restraints for the older confused person (Boswell et al. 2001). The other influences on specialling as a preferred alternative to physical restraint were the incidences of suicide occurring in general hospitals. However, it was the adverse outcomes for acutely confused older people with delirium, which were reported to be as high as 70% post-surgery (Torkelson et al. 1999), that saw specialling widely adopted for at-risk older people (Boswell et al. 2001; Worley et al. 2000).

The deleterious outcomes for older people from the use of physical restraint in USA hospital settings caused hospital administrators to consider less restrictive methods of caring for people experiencing confusion (Boswell et al. 2001). The increased focus on patient safety and restraint minimisation saw specialling emerge as a response to these initiatives (Boswell et al. 2001). Restraint-free patient specialling is now widely considered to be a reliable indicator of quality of nursing care in healthcare settings (Worley et al. 2000) and is a common intervention in general hospitals around the world (Wood et al. 2018). Specialling the older person in hospital has increased over recent years for those at risk, to prevent them from sustaining injury from falls, wandering around and away from the ward and/or causing unintentional harm to others (Carr 2013; Dewing 2013; Rape et al. 2015; Portelli et al. 2016; Schroeder 2016).

2.8. Indications for older person specialling

2.8.1. Older peoples' needs and issues

The need for constant surveillance of particular groups of patients in general hospitals has been well documented (Dick et al. 2009; Moyle et al. 2010; Rochefort et al. 2012). Earlier studies identified people with mental health and other challenging behaviours such as those exhibiting suicidal tendencies, substance withdrawal, or psychotic episodes and/or delirium being allocated for special observation (Blumenfield et al. 2000; Duffy 1995; Goldberg 1990; Torkelson et al. 1999). However, as foreshadowed in Chapter One, people over 65 years of age are now the major consumers of acute health services and account for 48% of hospitalisations (AIHW 2017). Hospital care

over the last 30 years has shifted from younger people with single diseases to an older population with multiple diseases (Bail et al. 2016). This shift, combined with an increasing number of surgical procedures being provided in private hospitals and day surgery units, have further contributed to the changing profile of the general hospital inpatient (AIHW 2017). Acute hospital patients are older, have more complex healthcare needs and often present with multiple co-morbidities and associated polypharmacy, disabilities and frailty (Wilkes et al. 2010, Portelli et al. 2016). Their complex health issues and treatments are most often the reason for their admission to an acute hospital, and they are also likely to be the rationale for requiring specialling.

On admission to hospital older people have far higher risks of further illness and/or injury than younger adults (Feil & Wallace 2014; Kerr et al. 2013; Moyle et al. 2010; Wilkes et al. 2010). This can be due in part to the older person's cognitive responses to hospitalisation, thereby increasing the older person's vulnerability to iatrogenic harms and complications. These complications include urinary tract infections, pressure injuries, pneumonia and delirium (ACSQHS 2018; Bail & Grealish 2016). As a consequence of these complications, falls are the most commonly reported adverse event of older persons in hospital (Donoghue et al. 2005; Shever et al. 2011). These complications are even more prevalent in older people who present with an existing cognitive impairment such as dementia (Bail & Grealish 2016).

For the most part, the literature reviewed couched patient needs during specialling in terms of managing such risks as falls, and harm to themselves or others (Harding 2010; Lang 2014; Schoenfisch et al. 2015; Wood et al. 2018). Another of the more commonly described set of needs for people being specialled are therapeutic care and engagement. These include patient-special interactions, reality orientation, therapeutic touch and diversional activity such as playing cards and other games (Adams & Kaplow 2013; Carr 2013; Dewing 2013; Donoghue et al. 2005; Kerr et al. 2013). Assisting with personal hygiene and mobilisation were also described as part of the specialling role (Schoenfisch et al. 2015; Schroeder 2016), along with meal assistance and pressing the nurse call bell (Donoghue et al. 2005). There is a lack of clarity, however, around whether these activities and interventions are part of general nursing care, or whether they comprise 'special' care (Wilkes et al. 2010; Wood et al. 2018).

2.8.2. Initiating and discontinuing specialling

Knowing when a special is required is problematic for hospital staff, especially when the older person's health can change quite quickly and for reasons unknown. The decision-making process around initiating, maintaining and terminating specialling varies considerably (Wood et al. 2018) and there is a lack of clarity and formal policies on how the need for specialling is determined (Carr 2013; Wood et al. 2018).

This lack of clarity has resulted in the development of tools and criteria to assist with the initiating, monitoring and discontinuation of specialling. For example, Tzeng et al. (2008) evaluated a tool designed to guide staff when requesting a special. Harding (2010) evaluated a specialling request form, which listed alternative care management strategies to try, ahead of seeking management approval for a special. Additional specialling request forms, flow charts and algorithms to initiate specialling are in use (Spiva et al. 2012), however, there remains a paucity of clear guidelines for initiating, documenting and discontinuing specialling (Feil & Wallace 2014).

Portelli et al. (2016) reported on the increase of older patients presenting with multiple comorbidities to an emergency department, which require increased observation to prevent and manage identified safety risks. These patients were described as 'highly resource intensive' (Portelli et al. 2016, p. 2), which justified the initiation of specialling in this particular healthcare setting. In relation to discontinuing specialling, the lack of criteria for starting and stopping specialling often makes it easier to simply continue. This is especially so in settings where opportunities to seek alternatives are limited, or there is family pressure for continued one-to-one patient care (Rausch et al. 2010). Consequently, Weeks (2011) suggests a specified period for specialling based on a nursing assessment of the patient. Currently, as specialling is an unplanned event in response to a change in a patient's behaviour, there is an ad-hoc approach to the initiation and discontinuation of specialling.

2.9. Care provision

2.9.1. Custodial or PCC

All 33 articles which focused on specialling of the older person were explored for references to Kitwood's (1997) guiding principles of person-centred care (PCC). Only 11 of the articles included some or all of the principles: creating and strengthening positive relationships, respectful communication, valuing and treating the person as a unique and sentient person, viewing the person's world from their individual perspective, and helping the person to maintain meaningful social and emotional attachments to others (Kitwood 1997). Most of the literature reviewed described specialling as a common intervention for patients deemed at risk of harm to themselves, other patients or staff (Portelli et al. 2016). In particular, specialling for the prevention of patient falls featured strongly (Donoghue et al. 2005; Feil & Wallace 2014; Giles et al. 2006; Lang 2014; Rausch et al. 2010). However, the lack of conceptual clarity on the scope, purpose and expected outcomes of specialling have led to different views on the type of care that should be provided when specialling, i.e. whether it should be custodial or therapeutic (Dewing 2013). In some cases, e.g., the mental health model, and/or where a person is at risk of causing harm to themselves or to others, and/or where a person's physical health status is stable, the special is required to take an observational approach, remain within touching distance, or at arm's length of the patient at all times (Goldberg 1990; Moyle et al. 2010; Wilkes et al. 2010). In relation to older people in acute care settings, however, there are many instances where the risks are not caused by the person themselves, but by the resource constraints of the acute care setting. For example, the patient could be dehydrated, or develop an infection, delirium or pressure injury as a result of 'missed' or 'rationed' care (Bail & Grealish 2016). In these cases where physical care is required to support the person's health needs, the rules of maintaining a distance need to be forfeited (Carr 2013).

Dewing's (2013) review of special observation of the older person concluded that clinicians should be cautious when adapting the mental health special observation model in the general hospital setting. She argues that there is a lack of empirical research to support a custodial approach, especially with regard to the older person with

dementia and/or experiencing a delirium. By adopting a more active, therapeutic approach to specialling there is an opportunity for person-centred interventions to be integrated into care goals. For example, specialling may afford an opportunity for staff to engage more positively with the patient with delirium to connect them with their environment and provide other PCC such as psychosocial support, mobilising, toileting, hydration and orientation strategies aimed at reducing agitation or anxiety (Dewing 2013).

Kerr et al. (2013) also support a therapeutic, person-centred approach to care, as stated in their working definition of specialling the older patient in hospital with dementia and/or delirium:

> *"special observation is delivered following an individual assessment undertaken by nurses with advanced assessment and care planning skills using a nurse-patient ratio of 1:1 to (i) enable person-centred therapeutic practice interventions and (ii) promote safety. Best practice special observation is promoted through the delivery of evidence-based education and monitoring of adherence to a single policy". (p. 10).*

Beyond the suggested PCC and therapeutic interventions, however, there is a paucity of literature on what these interventions might be, how they should be enacted, and the kinds of patient outcomes that might result. These evidence gaps and implications for older person specialling suggest an area ripe for nursing research, so as to inform nursing practice policy development, and evidence-based education and training interventions.

2.9.2. One-to-one or cohorted care

Most of the literature reviewed describes specialling as one-to-one supervision and care, although group specialling or 'cohorting' (i.e. one nurse allocated to special two or more patients) with similar symptoms or risks is also practiced (Blumenfield et al. 2000; Lang 2014). Cohorting is considered to be a more cost-effective approach when a small group of 'at risk' patients is located in close proximity with common needs being addressed, such as mobilisation, hydration, assistance to ring the nurse call bell and emotional support (Donoghue et al. 2005; Nadler-Moodie et al. 2009; Tzeng et al. 2008).

In a review of this practice, Lang (2014) found that there are conflicting results for cohort specialling, but a common finding was no increase in falls for at-risk patients. To date, there is no strong evidence comparing outcomes between single versus cohort specialling for older people, or data around which method is most commonly practiced.

2.10. Staff who special

Personnel with varying qualifications and nursing experience currently undertake specialling in the general hospital setting. Registered Nurses (RNs) and Enrolled Nurses (ENs) occasionally assume the specialling role (Feil & Wallace 2014). How these staff members are assigned to the role is contentious, as nurse specials may be recruited from existing nurse complements and replacement staff is not always provided (Portelli et al. 2016). In these circumstances patient-to-nurse ratios can be adversely impacted, as the remaining nursing staff are left responsible for large numbers of patients (Portelli et al. 2016). Feil and Wallace (2014) also support the findings that general hospitals use various approaches when allocating staff for specialling roles, assigning both licensed (e.g., RNs, ENs) and non-licensed nurses to the role, including Assistants-in-Nursing (AINs). There is also some suggestion that hospital security guards, ward clerks, kitchen workers, volunteers and housekeeping staff have functioned as patient specials when nurse specials are unavailable (Feil & Wallace 2014; Wood et al. 2018). Family members, too, have also been incorporated and empowered to contribute to the caring for their relatives during hospitalisation as substitute patient specials (Blumenfield et al. 2000; Tzeng & Yin 2007). While including relatives in patient care can be beneficial, especially in helping to settle the patient and provide them with assistance in activities of living, there are no clear guidelines to ensure that relatives are adequately informed about the patient's condition and appropriately educated to undertake specialling responsibilities.

Due to staff workload issues and the high costs involved in specialling individual patients in general hospitals, it is commonplace for an unlicensed (non-professional) member of staff, such as an AIN to be given this role (Dewing 2013; Moyle et al. 2010; Rape et al. 2015; Schoenfisch et al. 2015; Schroeder 2016). This practice raises issues about the education and training of staff to take on the specialling role, and the kind of

care they are able to provide. Wilkes et al. (2010) noted AINs' anxieties concerning on being educationally unprepared to care for patients who they are required to special, which may cause them to undertake this role in a detached manner. In some cases, unlicensed staff draw upon their own life experiences to special older people (Schroeder 2016). However, nursing care delegated to unlicensed staff has been associated with missed nursing care (Wilkes et al. 2010; Schroeder 2016). Untrained specials may also be subjected to physical and verbal abuse from their specialled patients if they have not harnessed the skills required to care for people with a cognitive impairment. Experiencing patient abuse and resistance to the care they provide may leave untrained staff feeling vulnerable and undervalued in the specialling role (Schoenfisch et al. 2015; Wilkes et al. 2010). These issues highlight the potential risks for both patients and staff when special staff are not adequately trained for the role.

While the literature confirms that mostly AINs are assigned to special in general hospitals, their training and preparation for the role is often lacking or ad-hoc (Dick 2009; Carr 2013). This poses a risk for the special and the patient, e.g. with managing confusion, agitation and other challenging behaviour, and using unnecessarily restrictive care practices. There is also an absence of research focused on the health and wellbeing of specialling staff (Schoenfisch et al. 2015). These concerns are compounded by the lack of guidelines, procedures or regulations for staff undertaking the specialling role (Schoenfisch et al. 2015) and the varying expectations of this role (Carr 2013; Dewing 2013; Rochefort et al. 2012; Schoenfisch et al. 2015; Wilkes et al. 2010; Wood et al. 2018).

2.11. Specialling costs and alternatives

The increased nursing care needs of older people can have an impact on staff workload. The business model of hospital care provides minimal opportunity for staff education, training and supervision in care of the older person, especially in care of the person with a cognitive impairment (Dewing 2013; Moyle et al. 2010). This has led to nursing staff expressing their concerns about the lack of appropriate training opportunities in caring for such patients. Nurses have long advised that patients who are specialled require allocation of additional staffing resources, as a proactive measure to prevent and better manage unpredictable events, e.g. impulsive behaviours (Moyle et al. 2010; Wilkes et

al. 2010). Current nurse to patient ratios in the acute care setting do not accommodate time for extra monitoring or specialling of 'at risk' older people (Rochefort et al. 2012). Inadequate care places the older person with cognitive impairment, e.g., at increased risk of significant health deterioration (Bail & Grealish 2016). Specialling has, therefore, been identified as a common staffing model to address this concern for people with dementia (Moyle et al. 2010; Wilkes et al. 2010; Carr 2013; Dewing 2013; Kerr et al. 2013).

Specialling of vulnerable older people may also have an impact on other patients. It may deny other patients extra attention, or even sufficient attention to their own care needs. Boswell et al. (2001) and Weeks (2011) claim that when observing a patient being specialled, other non-specialled patients view this as preferential treatment, perceiving their own care needs to be not as important to nursing staff. If such concerns are anticipated, this may inhibit staff requests to have a particular patient specialled (Weeks 2011).

Some researchers have also found that specialling is not a particularly effective or economical strategy for maintaining patient safety (Harding 2010). Rausch et al. (2010) and Adams & Kaplow (2013) suggest that nursing staff often initiate specialling without exploring the use of alternative strategies to maintain patient safety. Less costly and perhaps more effective alternative nursing strategies include instituting behaviour management plans, monitoring and adjusting medications and limiting the number of times a patient is moved during a hospital stay. In an effort to reduce costs, a number of other alternatives to staff specialling are suggested (Wood et al. 2018). These include technological measures such as video cameras and audio monitoring e.g., alarm cushions on chairs, or sensor mats beside the bed, designed to react to changes in pressure when a high-falls-risk patient attempts to stand or get out of bed (Skowronsky et al. 2015). Environmental modifications include beds that lower close to the floor, sensor mats either side of the bed, and special non-slip socks that patients can wear (Lang 2014). Extended visiting hours and family care rosters, too, have been introduced in an effort to reduce the need for staff specials (Feil & Wallace 2014; Tzeng & Yin 2007). However, research around the effectiveness of such interventions has mainly

focused on their efficiency and cost benefit analysis, with little consideration of patient outcomes (Lang 2014; Schoenfisch et al. 2015; Wood et al. 2018).

The majority of the studies reviewed on alternative strategies to specialling found that these other approaches reduced workforce costs (Harding 2010; Lang 2014; Nadler-Moodie et al. 2009; Rausch et al. 2010; Spiva et al. 2012; Tzeng et al. 2008; Weeks 2011). A New Zealand study introduced an education program aimed at getting RNs to use alternative approaches to specialling as a way of preventing older patient falls (Dick et al. 2009). While staff costs were reduced with this model, there was no reported reduction in patient falls or any other patient outcomes. Other studies have used patient specials in different ways and some were very cost-effective. For example, Donoghue et al. (2005), Giles et al. (2006) and Tzeng & Yin (2007) were able to considerably reduce the fall rate in older people by training volunteers to undertake a limited specialling role. Wright (2006) and Nadler-Moodie et al (2009) reduced the cost associated with specialling by introducing a high fall risk room in the ward and specialled the patients as a group in this room. Rausch et al. (2010) reduced specialling by 50% over a 12-month period, by introducing a specialist liaison nurse to review patients who were specialled. Rochefort et al. (2012) and Shever et al. (2011) investigated whether the skill mix of nurses affected the request for specialling. Rochefort et al. (2012) identified the more experienced registered nurses considered alternatives for high-risk patients before requesting specialling, whereas Shever et al. (2011) failed to identify any correlation.

As a consequence of a lack of empirical research on the requirements and benefits of specialling for older people, general hospital nurses should be cautious about specialling older people using models that have been adapted for other patients e.g., people with severe mental health issues, or implementing technological or equipment measures. To progress a specialling model suitable for older people with complex health issues, the essential nursing requirements first need to be established.

2.12. Patient outcomes from specialling

While the incidence of older person specialling has increased in recent times (Portelli et al. 2016), there remains a lack of evidence in regard to patient outcomes and its

effectiveness (Dewing 2013). Feil & Wallace (2014) claim that whilst expert opinion has driven the promotion of specialling, especially as a strategy to reduce falls, it has been difficult to prove the clinical effectiveness for patients. This challenge is intensified by the aforementioned lack of formal guidelines on patient specialling, which make it difficult to assess its benefits for patients, and whether specialling facilitates safe and effective patient care (Carr 2013).

Presently, older people with complex issues are care requirements represent almost half of all public hospital admissions (AIHW 2017). As previously identified, in busy and changeable acute hospital settings, nurses continually prioritise their care according to medical acuity. The prioritisation of clinical management can influence attention to essential care provision such as supporting mobility, hydration, nutrition, skin care and oral care, and to communication needs (Bail & Grealish 2016). Missed nursing care will negatively affect the vulnerable older person and make them susceptible to higher rates of hospital-acquired complications e.g., delirium, dehydration and pressure injuries, which will lead to longer lengths of stay, increased costs to hospitals and poorer patient outcomes (Bail & Grealish 2016). These outcomes feature in the reviewed literature on patient specialling, because they relate to hospital outcomes (Wood et al. 2018). Less is known about the patient experience and satisfaction with their specialling experience, and the quality of specialling for vulnerable older people.

2.13. Conclusion

Older people are increasingly becoming the core business of general hospitals. Their complex conditions, co-morbidities and associated polypharmacy often require them to be specialled to prevent them from sustaining unintentional injury such as a fall (Carr 2013; Dewing 2013; Rape et al. 2015; Portelli et al. 2016; Schroeder 2016). The reviewed literature suggests a lack of clarity on the scope, purpose and practice of older patient specialling. There is a dearth of guidelines, procedures or regulations for staff undertaking the specialling role in relation to initiating and discontinuing the process (e.g., Carr 2013; Feil & Wallace 2014; Wood et al. 2018), specialling care models(e.g., Carr 2013; Dewing 2013; Lang 2014; Moyle et al. 2010; Wilkes et al. 2010), staff qualifications (e.g., Feil & Wallace 2014; Portelli et al. 2016; Wood et al. 2018), or staff

training and preparation (Schoenfisch et al. 2015; Schroeder 2016). Further, there is a lack of evidence that reports on patient outcomes from specialling (Dewing 2013) and little is known about whether specialling has a positive impact on older person care.

This study aimed to contribute to addressing this knowledge gap by investigating how older people are specialled in general hospital settings. A concurrent mixed methods approach has been adopted to answer two main questions:

1. What characterises older person specialling in the acute care setting?
2. What essential care is required when specialling older people in acute care settings?

Findings from this study are intended to contribute to the emergent body of literature on the specialling of older people in the acute hospital setting, with the intention of developing a set of evidence-based care guidelines on what is required to ensure a positive, person-centred experience for older patients in general hospitals. A presentation of the study methodology used to answer the research questions is the focus of Chapter Three.

3. Methodology

3.1. Chapter introduction

The literature review in Chapter Two identified a relatively small number of research articles pertaining to specialling the older patient in the general hospital setting over the past 30 years and identified many gaps for further research. This chapter outlines the methodology that was used in this study to answer the research questions:

1. What characterises older person specialling in the acute care setting?
2. What essential care is required when specialling older people in acute care settings?

The chapter comprises five sections: the conceptual framework of the study (3.2), the description, rationale and visual representation of the overall research design (3.4); a description of the study setting and study participants (3.5); Phase One study methods and procedures (3.6); Phase Two study methods and procedures (3.7); ethical considerations for the study and how they were addressed (3.8); and approaches that were used to enhance the credibility and validity of the findings (3.9).

3.2. Conceptual framework

In view of the increasing number of ’people presenting to acute care settings with an existing cognitive impairment (e.g., living with dementia) and/or experiencing cognitive impairment during their admission (e.g., delirium), the conceptual framework for this study is the 'Socio-Psychological Theory of Personhood in Dementia (SPTPD) (Kitwood 1993), which provides a theoretical basis for Person-Centred Care (PCC). Although PCC is not a new concept (Mitchell & Agnelli 2015), social psychologist Tom Kitwood (1993, 1997) pioneered work on PCC specifically for people with dementia. His SPTPD (Kitwood 1993) proposes that people exist in a social, relational context, and that positive and enriching interpersonal relationships can prevent the disabling effects of dementia and promote a sense of well-being (Brooker 2004; Dewing 2008). Kitwood (1997) characterises personhood as ‘…a standing or status that is

bestowed upon one human being, by others, in the context of relationship and social being' (p. 8).

Informed by social construction theory, SPTPD (Kitwood 1993) explains how life experiences for the person with dementia are socially constructed and can have a more significant effect on personhood than the nature of the illness. Using negative terminology to describe the person and their responses to the social milieu, focusing on the person's deficits rather than their abilities, and blaming the person's altered or challenging behaviour on their cognitive impairment, will both shape social perceptions about the person and harm the person's sense of personhood, or self-identity (de Medeiros & Doyle 2013). As a result, people with dementia are regularly subjected to what Kitwood terms 'malignant social psychology' (1997, p3). Such actions by others include:

1. Treachery: using deception to distract, manipulate or force people into compliance
2. Disempowerment: not allowing a person to use their remaining abilities
3. Infantilisation: treating a person as they would a very young child
4. Intimidation: inducing fear in people
5. Labelling: using the category of dementia as the frame for all interactions with the person and explanations of behaviour
6. Stigmatisation: treating a person like a diseased object or an outcast
7. Outpacing: providing information at a rate too fast for the patient to understand, or rushing them through tasks
8. Objectification: treating a person as an object to which a series of tasks are carried out
9. Ignoring: conversing or performing tasks/actions without acknowledgement of the person's presence (Kitwood 1997).

Such social constructions are likely to influence the relationships that direct caregivers, including family members and health professionals have with the person (Bauer & Nay 2011), giving rise to custodial, functional, task-driven care practices (Coyle & Williams 2001). This detached approach to caring diminishes the person's sense of identity, self-esteem and well-being, distance the person from the caregiver and leads to negative health outcomes for them (Kitwood 1997).

In contrast to the disease-focused, technical and detached approach to care, Kitwood (1997) advocates for care that is person-centred (PCC) and pays attention to the person's fundamental human needs. Kitwood presented the following guiding principles for PCC:

1. Creating and strengthening a positive relationship with the person through warm and accepting human contact;
2. Respectful communication, valuing and honouring the person and treating each person as a unique human being;
3. Treating the person as a sentient and unique human being, by valuing their innate nature and assisting them to retain their remaining strengths;
4. , Viewing the person's world from their perspective in all interactions with them;
5. Helping the person to feel socially confident and to maintain emotional attachment to others.

Therapeutic relationships underpinned by negotiation of care, offering choice and empowering a person and their family to participate in care and lifestyle decisions, also acknowledges and respect the inherent value and uniqueness of individuals, assists them to focus on their strengths and abilities and supports their freedom (Bauer & Nay 2011; Morgan & Yoder 2012). Therefore, PCC is customised to each person's unique needs, rather than simply meeting the demands of the health care service (McCormack & McCance 2006). In this way, even when the person's clinical needs are a priority, a person-centred approach to meeting these needs will ensure that they feel a sense of self-worth and value. Positive health outcomes are also more likely when people are treated with respect and dignity, are included in care and treatment decisions and are encouraged to maintain their function and autonomy in issues that matter to them (Brooker 2007).

While PCC has become a benchmark for quality and safety in health care (Grealish et al. 2018), especially for people with a cognitive impairment, acute care service staff struggle to provide care that values personhood and the principles of PCC. In these settings nurses can face barriers to PCC provision when priorities are given to rapid diagnosis and therapeutic interventions with shorter lengths of stay (Edvardsson et al.

2008) in the hospital's bid to meet its financial and productivity targets (Bail & Grealish 2016; Bail et al. 2015). Kitwood (1997) acknowledges that providing PCC can be difficult to give when nurses' workloads are heavy and distracting. Nurses and other care staff do not necessarily set out to harm their older patients, however when they overly focus on the biomedical aspects of care and neglect to focus on what matters to the older person, i.e. comfort, patience, understanding, communication and empathy, they can undermine the patient's personhood. Lack of attention to the person's communication needs, in particular, can have deleterious outcomes such as delirium. As well, a detached clinical approach to care can make older patients to feel isolated, afraid, disempowered and confused (Chenoweth et al. 2009).

PCC aims to provide for all aspects of care, but in a way that meets the older person's psychosocial needs, aiming to optimise wellbeing as well as better health. To effect a person-centred approach to care of older people while being specialled, more research is needed on what characterises and constitutes older person specialling and what constitutes positive care in these situations.

3.3. Evaluative framework

Brooker's (2007) VIPS framework is used in this study as a means of evaluating whether older person specialling is person-centred and if so, to what extent. This framework was originally designed as a practical guideline for operationalising and evaluating PCC at a service/systems level, and as part of quality improvement and monitoring in care services (Røsvik et al. 2013). In the VIPS framework, Brooker (2007) summarises Kitwood's (1993) philosophy of PCC for people with dementia and reorganises it into four major pillars:

1. Valuing: a person and their humanity
2. Individual: appreciating the life story of a person and their uniqueness
3. Perspective: accepting the experience of the person and respecting the validity or therapeutic potential of their perspective.
4. Social environment: recognising the relationships of the person and that the person can compensate for their impairment and enhance their wellbeing

Each of Brooker's (2007) four VIPS pillars are underpinned by more specific criteria, used to assess how and in which ways care services are person-centred. These are outlined in Table 3.1 below.

Table 3.1 VIPS framework indicators

V	**Valuing**
VI	Vision – *are staff aware of the vision of the organisation?*
V2	Human resources – *are systems in place to ensure staff know they are valued?*
V3	Management ethos – *are management practices empowering staff to deliver PCC?*
V4	Training and practice development – *are there systems in place to support workforce skills development in PCC? Do staff understand that supporting people living with cognitive impairment is skilled and important work?*
V5	Service environments- *are there supportive and inclusive physical and social environments for people living with cognitive impairment? the workplace physical and socially supportive*
V6	Quality Assurance- *are there processes that strive to understand and act upon the needs and concerns of people with cognitive impairment, in an effort for continuous improvement?*
I	**Individual lives**
I1	Individual support and care – *do care plans promote individuality and show that everyone is unique, with hopes, fears, strengths and needs?*
I2	Regular reviews – *does the service recognise and respond to change?*
I3	Personal possessions – *do people have their favourite and important things around them? Do the staff understand why these are meaningful?*
I4	Individual preferences – *are the person's likes, dislikes, preferences and choices listened to, understood and acted upon?*
I5	Life stories – *are the person's important relationships, life stories and key events known about and referred to in everyday activities?*
I6	Activity and occupation – *is the person's day full of purpose and engagement with the world regardless of their needs and abilities?*
P	**Personal perspective**
P1	Communication – *is the service alert to the ways that people with cognitive impairment communicate and are the staff skilled at responding appropriately?*
P2	Empathy and acceptable risk – *do the staff appreciate the person's world view?*
P3	Physical environment – *does the service help someone with a cognitive impairment feel comfortable, safe and at ease?*
P4	Physical health needs – *is the service alert to, responsive to and working to optimise peoples' well-being?*
P5	Challenging behaviour as communication – *do the staff always consider and act upon what a person is trying to communicate through their behaviour? Do the staff look for underlying reasons rather than seek to 'manage' it?*
S	**Social support**
S1	Inclusion – *are people helped to feel part of what is going on and supported to participate?*
S2	Respect – *are people respected as individuals with unique identities, strengths and needs?*
S3	Warmth –*is the atmosphere creating a warm, welcoming and accepting?*
S4	Validation- *are peoples' emotions and feelings taken seriously, acknowledged and responded to?*
S5	Enabling – *are people supported to be actively involved as partners in their care?*
S6	Part of the community – *does the service work to connect people with the local community?*
S7	Relationships – *does the service welcome the people who are important to the person?*

From Brooker and Latham (2016, p. 177-178)

PCC, as described in Brooker's (2007) VIPS framework, involves all levels of the organisation e.g., senior management, policies/procedures committees and direct care staff (Røsvik et al. 2013). The VIPS framework has been used in residential aged care facilities and hospitals, including in Australia (Oppert et al. 2018) as a tool to evaluate care and raise awareness of delivering PCC (Brooker & Latham 2016). It is used in this study, firstly because of its very specific criteria for evaluating Kitwood's (1993; 1997) extensive work on PCC (Røsvik et al. 2013). Secondly, the VIPS model is used because of its practical applications in translating the concepts of PCC into the everyday, essential care for specialling older people (the second research question of this study) and its potential for building up a shared knowledge base around PCC for staff who special older people in acute care settings (McCarthy 2012; Røsvik et al. 2013). In using VIPS as an evaluative framework there is a focus both on facilitating positive change and quality improvement with regards to PCC at an individual staff and organisation level (McCarthy 2012).

3.4. Description, rationale and visual representation of the overall research design

3.4.1. Overall research design

A concurrent mixed methods design, sometimes called the convergent design, (Creswell & Creswell 2017) was adopted for this study, where both the quantitative and qualitative phases were predetermined and planned at the outset of the research process. The concurrent design represents equal status of qualitative and quantitative elements in that data collection will occur simultaneously. Within this design, quantitative and qualitative data are collected concurrently but remain separate – the findings of one phase are not dependent on the results of another (Creswell & Plano Clark 2011).

3.4.2. Study methods and rationale

The study employed mixed methods, comprising a face-to-face focus group discussion

with a convenience sample of nurses working in the acute aged care wards of a large principal referral and teaching hospital, and direct observation of older patents being specialled in acute aged care wards. These complementary study methods were selected once the research questions were determined, as it was considered that using quantitative or qualitative methods alone would be insufficient for enabling a multi-faceted understanding of specialling older people in hospital settings. Doyle et al. (2016) argue that although quantitative and qualitative research methods are the traditional research paradigms, approaches that combine both quantitative and qualitative techniques are becoming widely accepted as an emerging research approach. Therefore, it was decided that an integrated mixed methods approach that purposefully combines both quantitative and qualitative techniques in the same research project was needed to gather comprehensive data for analysis. This allows the researcher to use both qualitative and quantitative methods in complimentary ways for a single purpose, without being constrained to one methodology (Creswell & Plano Clark 2011). This differs from traditional triangulation which is used to determine the degree of corroboration between quantitative and qualitative findings (Bryman 2006). Johnson et al. (2007) define this approach:

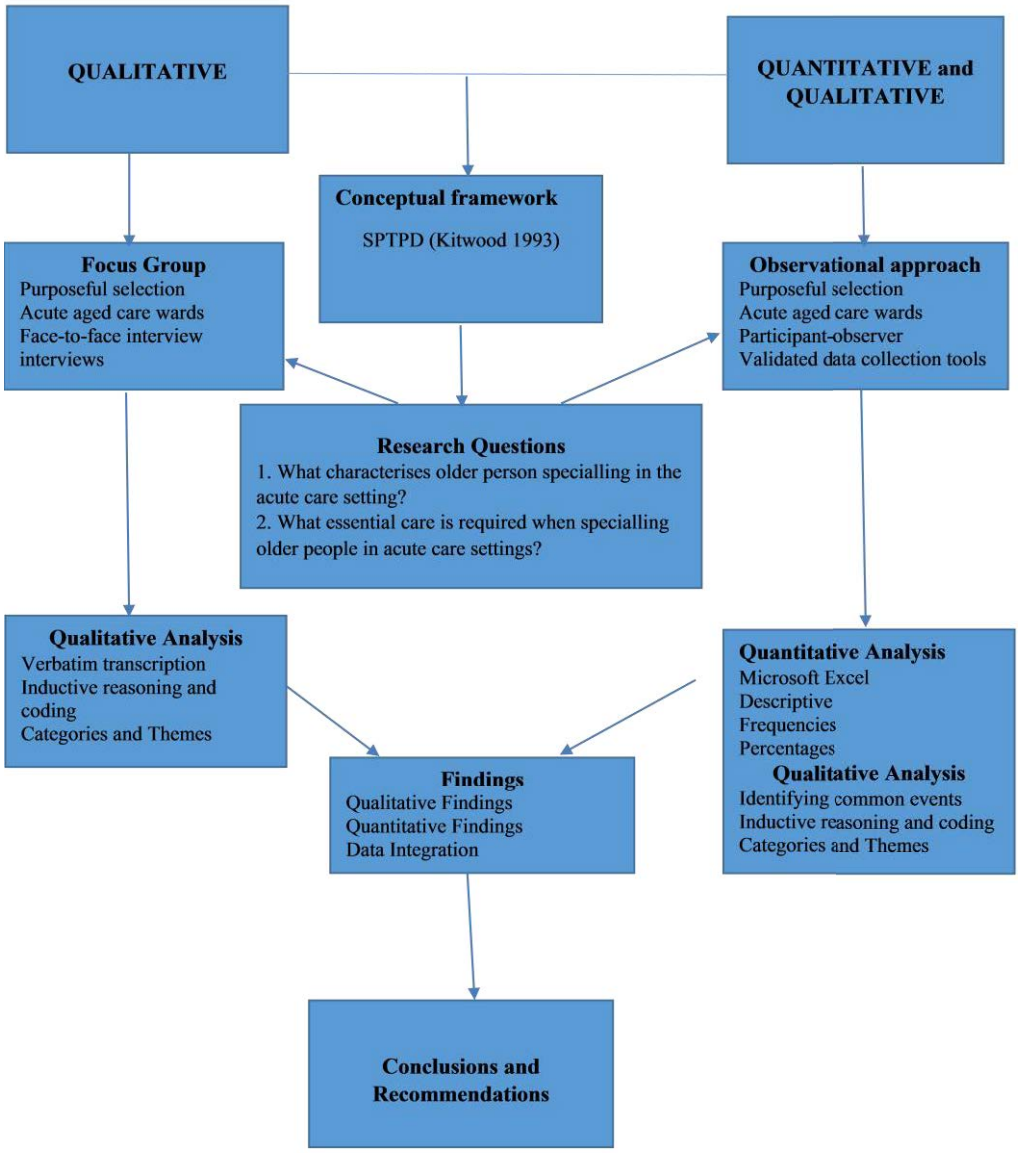
> *Mixed methods research is the type of research in which a researcher or team of researchers combines elements of qualitative and quantitative research approaches for the broad purposes of breadth and depth of understanding and collaboration* (p. 123).

While findings from studies employing one-method design provide important insights, evidence from the literature review presented in Chapter Two identified the need for further research studies that seek to provide a more holistic understanding older patient specialling in acute care settings. The mixed methods approach has become increasingly popular in health-related research over the past decade (Creswell & Creswell 2017), however exemplars of the use of mixed methods design in studies focusing on specialling practices are limited (Riddell 2012). A mixed methods approach was used by Schoenfisch et al. (2015) to characterise the prevalence of and circumstance surrounding incidents of violence experience by staff involved in patient specialling across six hospitals in the United States. The quantitative phase collected data using

surveys and qualitative phase consisted of focus groups and individual interviews. Similarly, Riddell (2012) utilised a mixed method design to explore the models of care used in specialling. The quantitative phase involved secondary analysis from a database while the qualitative phase involved interviews. In both studies, results from the qualitative and quantitative phases were analysed separately and integrated during the discussion phase.

Considering the use of mixed methods in these studies and in placing the focus on the research aims, a mixed methods design helped to establish the characteristics of the interactions between staff and patients during specialling, while also giving nursing staff the opportunity to reflect on this widely used practice. Therefore, this study employed a concurrent mixed methods design in which both qualitative and quantitative and were collected simultaneously to offer a more complete and balanced view of older person specialling in acute hospital settings. A visual representation of the research design is provided in Figure 3.1.

Figure 3.1: Visual representation of the Concurrent Mixed Methods Design



3.5. Study setting and participants

3.5.1. Setting

The setting for both phases of the study was the four acute aged care wards of a large principal referral and teaching hospital in Sydney, Australia. This site was selected because it is known to the student researcher, being her place of full-time employment. Three of the wards have the capacity for 26 patients, the remaining ward 14 patients. Two of the wards cater specifically for acutely ill patients over the age of 65 years. These wards focus on caring for people with multiple or complex medical problems and care needs. The other two wards have a rehabilitation focus, with particular attention to the needs of people over the age of 65 who have had a stroke, have chronic disease or brain injury.

At this particular hospital, the policy on determining the need for specialling is identified by a senior nurse e.g., Clinical Nurse Consultant (CNC), Nurse Unit Manager (NUM), and/or initiated by a medical officer. The policy identifies that patient specialling will be carried out by RNs, ENs or AINs, recruited from the existing ward staff, the hospital's casual staff pool, or from a nursing agency, and is undertaken as either one-to-one or cohorting a small group of patients.

Approval to conduct the study at this site was obtained from the hospital executive, the hospital's Human Research Ethics Committee (HREC) and the University's HREC.

3.5.2. Study participants

3.5.2.1. Nursing staff participants in Phases One and Two

Nine RNs who all worked in any or across all of the four acute aged care wards in the hospital participated in the focus group that comprised Phase One. Nurses from these wards were chosen because they are routinely required to special older patients, so they were expected to have more clear-cut views than those working in other ward settings. The focus group participants comprised two males and seven females varying in age and previous types/duration of nursing experience. However, all RNs had at least five years' experience of working in acute aged care settings, and all had worked in this

particular hospital's wards for a minimum of one year. Seven RNs in the focus group were employed as general ward nurses, one worked as a CNS and one was a CNE.

In Phase One, support for the focus group discussion and approval to recruit the nurses was obtained from the hospital executive. Information about the overall study, including information about informed consent were distributed to all nursing staff by way of flyers and posters on ward notice boards and in tea rooms. Interested participants were invited to contact the student researcher directly to express their willingness to take part in the focus group and/or seek clarification of any aspects of the study. Written consent was obtained prior to conducting the focus group discussion.

A total of 28 staff involved in specialling were observed in Phase Two. These staff members comprised 18 AINs, 6 ENs and 4 RNs, and were employed as regular, casual or agency staff in the hospital. As with Phase One, support to recruit staff for the second, observation phase of the study was also obtained from the hospital executive. Four weeks prior to study commencement, general information about the study was disseminated on the aged care wards by way of posters on ward notice boards and flyers and the contact details of the student researcher were provided for any queries related to the study. Since the need for specialling is predominately an unplanned event, and participants may have felt coerced into the research if approached 'on-the-spot', a third-party approach was used to approach potential participants. Because the observations occurred on a variety of shifts (including nights) and a completely detached third party such as a ward clerk was not always available, the third party was another nurse who, although not directly involved in the study, was familiar with the project (see Study Limitations 5.5.2). After being approached, staff were given time (without the third-party presence) to consider their involvement before verbally consenting to or declining participation in the study. Time provided to staff to consider their participation ranged from four weeks to several hours prior to the observations.

3.5.2.2. Patient participants in Phase Two

A total of 12 older people being specialled, comprising seven males and five females, were observed in the second phase of the study. For three months leading up to and

during the observation phase, flyers and posters with information about the study were placed around the wards in positions where patients and their relatives/visitors were likely to access information e.g., entry to ward, waiting areas. Interested participants or those seeking more information were invited to contact the student researcher. Potential study participants were identified by the hospital's Aged Care CNC through an online specials report which identifies all patients requiring specialling. To be eligible for inclusion, participants were required to be aged 65 years or over, identified as requiring specialling and able to provide informed consent. This consent was provided either personally, or if lacking capacity, provided on the patient's behalf by their 'person responsible', (i.e., guardian, relative or carer) as stipulated by the New South Wales Guardianship Act (1987).

As the older people in this study were being observed at a time when they were vulnerable and potentially receiving very personal aspects of their care, it was important to ensure that these people and/or their relatives were protected and did not feel coerced into participation. As with recruitment of the special staff during this observation phase, the same third-party approach was used to approach potential participants i.e., another nurse who, although not directly involved in the study, was familiar with the project. After being approached, patients and/or their relatives/guardians were given time (without the third-party presence) to consider their involvement and have any concerns or queries about the study addressed before consenting (or declining) either verbally or in writing to participation in the study. Some study participants consented within a short time frame, others considered their involvement overnight and responded the next day. Two people who were approached did not respond, and no further action or follow up was taken.

3.6. Phase One (focus group) study methods and procedures

3.6.1. Aim

The aim of this first study phase was to answer the first of the two research questions that underpinned the study i.e., to determine what characterises older person specialling in the acute care setting. To answer this question, Phase One aimed to explore nurses' perceptions of specialling the older person in their acute aged care wards, including

indicators for specialling, how specialling is undertaken, and the skills and knowledge required to special the older person. In keeping with the study's theoretical framework, literature review, research aims and questions, the central premise of this phase was a lack of guidelines for person-centred specialling for older people in the acute care setting, particularly in relation to the characteristics of specialling in these settings and the essential care requirements. Focus group discussion questions were formulated with this central premise in mind.

3.6.2. Method

This phase utilised a qualitative, descriptive approach, aiming to obtain, analyse and present authentic responses from ward nurses regarding their views on older patient specialling in acute hospital settings (Colorafi & Evans 2016; Sandelowski 2000, 2010). Qualitative description was considered appropriate for this phase because it accommodates a broad range of theoretical approaches and data collection techniques, making it suitable for novice health researchers, which was the case in this study (Colorafi & Evans 2016; Sandelowski 2000, 2010). A focus group was selected as the means of data collection for this study, for three reasons. First, focus groups are considered effective in exploratory phases of research designed to inform larger studies (Hesse-Biber & Leavy 2010). This particular focus group was intended to inform the second phase of the study that further articulates the requirements for older patient specialling in acute hospital settings. Second, as focus groups provide the opportunity for participants to consider, clarify and more fully articulate their views in the context of others (Broyles et al. 2011; Fusch & Ness 2015), it was considered that this focus group would yield rich data from the nurses in relation to specialling older people. Finally, in view of time constraints and staffing issues on hospital wards, data can be collected more quickly in focus groups than when conducting individual interviews (Broyles et al. 2011; Stewart & Shamdasani 2014). There are limitations in focus group research, however, such as the reluctance of participants to speak up in front of others, especially those senior to themselves, reluctance to speak up about sensitive issues, or dominant participants (Fusch & Ness 2015). These limitations are discussed in section 5.5.1.

3.6.3. Approach

Data on specialling older people were obtained through one focus group discussion with ward nurses. Prior to undertaking this first phase of the study, there was considerable deliberation over how many focus groups would be held, and whether they would comprise nurses with varying qualifications (e.g., RNs, ENs, non-licensed AINs). In the end, it was decided that because of ward time and staff constraints and the scale of the study, only one focus group would be held with RNs who were part of the ward roster, rather than nurses with other qualifications who were part of the casual pool/agency staff.

3.6.4. Data collection

The focus group discussion was held in a private meeting room adjacent to one of the hospital's aged care wards in May 2017. The group was moderated by the student researcher, an experienced aged care nurse who, as a longstanding staff member, had an established rapport with the participants. Before the focus group discussion commenced, the moderator reiterated the reason for the study, informed the nurses that participation was voluntary, and that the discussion would be audiotaped and transcribed. Participants were also informed that their identities would be protected on all transcripts, reports and publications that resulted from the discussion. Signed informed consent was obtained from each participant. The student researcher's primary supervisor, with a background in nursing, education and with experience in qualitative research, also sat in on the focus group, took field notes and wrote summary notes immediately after the focus group discussion.

To give each participant the opportunity to practice speaking and listening within the group, and to establish some commonalities among the group, the discussion began with brief introductions and background from each participant. Refreshments were also provided. The focus group discussion was then guided by seven open-ended questions that aimed to explore ward nurses' experiences of specialling older patients in the acute aged care wards. The following questions were asked:

1. In your experience when is specialling used with older people in general hospital wards?

2. What are the reasons for specialling an older person in general wards in this hospital?
3. Which members of staff are usually asked to special older people in general hospital wards?
4. When and why is individual, or group, specialling undertaken in general wards in this hospital?
5. In your experience when is individual and group specialling of older people in general wards appropriate?
6. What knowledge and skills are needed to special an older person in general hospital wards?
7. Do the staff that are usually allocated to special older people in general wards have the knowledge and skills to undertake this role?

Two main objectives shaped the questions asked of the focus group: (a) to obtain the RNs' truthful perceptions of specialling older people in their wards; and (b) to avoid leading the participants in a discussion on what they thought they ought to be doing in relation to specialling older people. For these reasons, it was decided that no explicit references would be made to PCC in the focus group questions. Given that all participants in the focus group were RNs with a minimum of five years' experience, it was anticipated that PCC would be embedded into their clinical practice (ACSQHC 2017) and would therefore emerge from the data. In hindsight, however, the lack of explicit reference to PCC in the focus group questions is considered as a limitation of this phase of the study (see Study Limitations section 5.5.1).

Focus group discussion was very lively and all participants appeared to contribute equally. The discussion continued until it was clear all nine participants had sufficient opportunity to contribute and discussion had abated. At the end of the discussion, the moderator gave a brief summary of the group's responses and checked that the field notes had captured the main points. Each participant was then asked if they had anything to add. The focus group concluded after approximately 60 minutes.

3.6.5. Data reduction and analysis

Inductive reasoning and coding processes were used to analyse the data. According to Thomas (2006), inductive reasoning should follow five steps: (a) reading of the text data, (b) identifying specific segments of information related to the research aims, (c)

summarising these segments and arranging them in general categories, (d) editing the categories to reduce overlap and redundancy, and (e) creating a model or framework incorporating these categories. These steps were used to assist analysing data gathered in the focus group discussion. Analysis of the data began soon after the discussion. All transcribed texts were read multiple times by the student researcher, and segments of information were identified in relation to the research questions (i.e. characteristics of older person specialling in acute care settings, essential care practices) and arranged into themes. Themes with no close connections to the research aims were put aside. Established themes were then aligned with the four pillars of Brooker's VIPS framework (2007), the organising framework for this study (see Table 3.1). From these four pillars, information was then organised under each of the indicators (e.g., V1 – Vision, V2 – Human Resources, V3 Management Ethos etc.). To enhance the credibility of the findings, a second researcher (the student's primary supervisor) independently analysed the data against the research aims and VIPS framework. Further analysis and discussion between the student researcher and the primary supervisor occurred to establish the extent of overlap, reduce redundancy and develop a more robust set of themes from the data. These results were then discussed until consensus was reached.

3.7. Phase Two (observation) study methods and procedures

3.7.1. Aim

The main aim of this second study phase was to examine specialling practices for older people in the acute hospital setting against Brooker's (2007) VIPS framework i.e., to determine if PCC was being provided. In doing so, this phase aimed to answer both research questions that underpinned the study i.e., to determine what characterises older person specialling, and to understand some of the essential care requirements for specialling older people in acute care settings. As with Phase One, the central premise of this phase was a lack of guidelines for person-centred specialling for older people in the acute care setting, particularly in relation to the characteristics of specialling in these settings and the essential care requirements.

3.7.2. Method

An in-depth examination of specialling practices for older patients was undertaken using an observational approach in the four acute aged care wards of the same hospital as Phase One. This involved the collection and analysis of both quantitative and qualitative data in a single phase, with the aim of bringing different perspectives and methodological expertise into the data analyses (Creswell & Creswell 2017).

The nature and type of interactions observed between the older person and specialling staff were recorded simultaneously on two validated observation tools: the Quality of Interactions Schedule (QUIS) (Dean et al. 1993) and the Emotional Responses in Care Assessment (ERIC) (Fleming 2005). The QUIS and ERIC tools allowed for the concurrent collection of both quantitative (interactions and responses) and qualitative data (supporting field notes). A copy of the QUIS and ERIC tools, merged onto one document for ease of data collection, can be found at Appendix 2. Patient demographics and reason for commencing specialling were also documented along with the qualifications and experience of the staff undertaking the specialling role.

3.7.3. Measurement

The observational data were obtained over a three-month period (July – October 2017). To obtain first-hand data on specialling practices, direct observation of the interactions between specials and patients, and the patient's responses to these interactions were obtained using validated observation tools. The Quality Interactions Schedule (QUIS) (Dean et al. 1993) was used to collect data on staff interactions and care provision, while the Emotional Responses in Care (ERIC) (Fleming 2005) was simultaneously used to obtain data on the patient's reactions to staff interactions and care delivery (Appendix 2).

3.7.3.1. Quality of Interactions Schedule (QUIS)

The QUIS (Dean et al. 1993) was initially developed as a research instrument for evaluating the quality and quantity of staff-patient interactions in residential care, however a recent study by McLean et al. (2017) established the validity and reliability

of the QUIS (Dean et al. 1993) as a measure of the quality of staff-patient interactions in the acute care setting. This tool has six descriptors for measuring and rating the quality of staff-patient interactions, each are assigned a number. These descriptors are: positive social (1), positive care (2), neutral (3), negative protective (4), or negative restrictive (5) and interactions with others (6) (Dean et al. 1993). Whenever any of these descriptors are observed, the corresponding number is recorded on the QUIS data collection form.

'Positive social' (i.e., allocated a '1' on the data collection form) comprises staff-patient interactions where productive conversations and companionship take place in the care process. This can be observed when an explanation of care goals and encouragement are given. 'Positive care' (i.e., '2') involves verbal interactions between staff and patient when giving personal care such as toileting, bathing, administration of medication and treatment. 'Neutral care' (i.e., '3') comprises brief indifferent interactions or care provision with no/minimal engagement with the patient, e.g. placing a meal in front of the person, or changing a wound dressing, without any salutation or explanation to the patient. 'Negative protective' interactions (i.e., '4) are those initiated by staff in a resistive manner without explanation e.g. continuing to administer oxygen therapy to a patient who is agitated by the presence of an oxygen mask/nasal prongs without an explanation and reassurance to the person. 'Negative restrictive' (i.e., 5) interactions may be seen when staff respond or react by restricting a person's freedom of movement and expression e.g. focusing the care primarily on fall-prevention by forcing the patient to remain in bed without a clear explanation for this requirement and not providing reassurance or comfort to the person whose movement and/or verbal expression is being restricted either by verbal commands, or physical restraint. 'Interactions with others' (i.e., '6') are recorded in relation to a person's interactions with other patients/residents on the ward and visitors. These interactions could be observed as positive, such as meaningful and inclusive communication with the older person, or negative e.g., being ignored or excluded by others (Dean et al. 1993).

Hand-written notes are recorded on the QUIS (Dean et al. 1993) data collection form to describe the context and events occurring against each code allocated in defined observation periods. By way of examples, the student researcher recorded examples of positive care as occurring when a special staff member picked up the patient's hairbrush

out of her locker and asked her if she would like her hair brushed. Positive social care was recorded when the same staff member engaged in conversation with the older person whilst brushing her hair. A negative protective code was recorded when a special persisted in reapplying an oxygen mask to the person despite their agitation and resistance to the task.

The QUIS (Dean et al. 1993) was chosen as a data collection tool for this phase because its codes align with Kitwood's (1993) SPTPD. The positive social and positive care interactions in the QUIS are considered as those that recognise, respect and trust the individual (i.e., they support personhood), whereas the negative restrictive, negative protective and neutral care interactions are considered to constitute Kitwood's (1997) 'malignant social psychology' (p. 3), care that dehumanises a person and neglects their psychosocial needs (i.e., they undermine personhood). The quality of care interactions is an important influence on care recipients' quality of life, which is central to PCC (Fazio et al. 2018).

3.7.3.2. Emotional Responses in Care Assessment (ERIC)

The ERIC (Fleming 2005) is an observation tool that quantifies the person's emotional responses to care provision, categorising and coding these as three positive and/or three negative emotional responses: 'pleasure' (i.e., '1'), 'affection' (i.e., '2), 'helpfulness'(i.e., '3), 'anger' (i.e., '4'), 'anxiety' (i.e., '5') and 'discomfort' (i.e., '6', along with a 'neutral' response (i.e., '7'). Each of these responses is also categorised and recorded on the data collection form according to their strength i.e., mild is recorded as '1', moderate is recorded as '2' and strong is recorded as '3'.

As examples, positive emotional responses could be 'pleasure' (i.e., code 1) when a person smiles or displays other positive body language such as relaxed posture. If a person displays a number of positive expressions, this response could be coded as 'strong – 3'. 'Helpfulness' (i.e., code 3) could be when a person assists their staff member with helping to stand, mobilise or reposition themselves in bed, and depending on their willingness to participate might code from 1 – 3 in strength. Negative responses such as 'discomfort' (i.e., code 6) could be recorded when a person grimaces as if in

pain, and depending on other cues such as vocalisation, closed body language etc., could be coded from 1 – 3 in strength. Neutral – 7 codes reflect a patient sleeping/dozing, or a patient sitting/standing without showing any emotion.

Hand-written notes are recorded on the ERIC to describe the context and the events occurring against each code allocated in defined observation periods. In this study, for example, a 'pleasure – 1' code was recorded as strong when one particular patient responded by smiling, using receptive body language and conversing with the special while her hair was being brushed. Anxiety – 5 was recorded as moderate when a patient was intermittently attempting to remove her IV therapy yet responded to the commands of the staff member not to do this.

The ERIC (Fleming 2005) was also chosen as a data collection tool because its items align with the study's conceptual framework (Kitwood 1997). This approach has been successfully used by Chenoweth et al. (2014) to measure the effectiveness of person-centred interventions for older people with dementia in residential care, by observing the resident's emotional responses to care given by staff. The appropriateness of both of these instruments and methods (i.e., the QUIS and the ERIC) for this phase of the study was assessed through pretesting and feedback from experienced nurses and researchers.

3.7.4. Data collection

The study was conducted over a three-month period (July – October 2017) in four aged care wards at the same hospital as Phase One (i.e., a large principal referral and teaching hospital in Sydney, Australia). These wards were selected because they routinely have a high proportion of older patients requiring specialling.

Observational data were collected by the student researcher, an experienced aged care nurse whose clinical role extends to reviewing patients who are specialled in aged care wards. In this way, the student researcher could act as a participant-observer. Consented patients and staff did not know exact times of observation, and observations were not announced – data collection was incorporated into the student researcher's usual patient review duties. The QUIS (Dean et al. 1993) and ERIC (Fleming 2005) tools to obtained data on the way in which specialling was conducted by the different

staff, the staff/patient interactions occurred during specialling and the responses of patients being specialled. Observation periods were planned to occur during different shifts (morning, night and afternoon and shift cross over) to capture a wide variety of conditions in which specialling occurred. Start and stop times of the observations were also recorded. Consistent with observation studies conducted in clinical settings, a 'serious error' protocol was implemented, that allowed the student researcher/observer to intervene if they witnessed any incident that was potentially dangerous to a patient, visitor or staff member.

To further explain and gain a comprehensive understanding of specialling practices, qualitative data related to contextual information were collected by way of extensive research field notes. These data included the type and location of specialling, qualifications and experience of the staff member, the duties and care provided, and the busy-ness of the ward. Artefacts in the older person's immediate environment, such as diversional activities (e.g., newspapers, activity – 'fiddle' mats) and personal possessions (e.g., photos, other objects from home) were also noted. Data were also obtained from the patients' electronic medical records on the demographics and characteristics of each older person being specialled.

3.7.5. Data reduction and analysis

3.7.5.1. Quantitative data

Data clean-up and crosscheck were carried out prior to data analysis. Microsoft Excel spreadsheets were used for data entry and analysis. Descriptive statistics (frequency, percent, mean, standard deviation, and tables) were employed for summarising demographics and other characteristics of staff and patients. Observation data were classified according to the descriptors established on the QUIS (Dean et al. 1993) and ERIC (Fleming 2005). The number of codes under each descriptor were counted and expressed as frequencies and percentages. When multiple codes were generated from the same participant, only one was counted so that one participant's experience was not over-represented in the findings.

3.7.5.2. Qualitative data

Qualitative data included those data recorded alongside the QUIS (Dean et al. 1993) and ERIC (Fleming 2005) codes to provide the context to the codes allocated, and as research field notes. These data were analysed using the general inductive approach described in Phase One (Thomas 2006). Data were read multiple times by the student researcher, segments of information were then identified and allocated to emergent themes in relation to the research questions (i.e., characteristics of older person specialling in acute care settings, essential care practices).This was facilitated by an initial counting of common events occurring when the different QUIS and ERIC codes were allocated. Established themes were aligned with the four pillars and specific indicators of Brooker's VIPS framework (2007). Consensus was then sought with two additional researchers (i.e., the principal and secondary supervisor) in interpreting and reporting these events/themes.

3.8. Ethical considerations

The study followed the principles outlined in the Declaration of Helsinki. Ethics approval was obtained from the University and the participating hospital's HREC.

3.8.1. Phase One ethical considerations

In Phase One, consideration was given to how participation or non-participation in the focus group would impact on the RNs, and the dynamics in their wards. Information provided to potential participants assured confidentiality and clearly outlined the potential risks and benefits in participation in the focus group. While there was no expected direct benefit to the RNs by taking part, it was suggested that they would, however, be making a contribution to knowledge in the area of specialling older people in general hospitals. The potential risks in taking part in the focus group were considered to be minimal, although the stress and psychological impact of speaking about specialling, particularly if they had negative experiences associated with the practice, was considered as a potential risk. To minimise this risk, the student researcher's contact details and details for the hospital's HREC in the event of any problems or issues concerning the research were provided.

3.8.2. Phase Two ethical considerations

In Phase Two, consideration was given to the potential impact of the study on the older people and their relatives, being observed at a time when they were vulnerable and potentially receiving very personal aspects of their care. To minimise this impact, information provided to potential participants and/or their relatives/guardians outlined the reason for the study, the risks and benefits, assured privacy and confidentiality, and included contact numbers of both the student researcher and the hospital's HREC in the event of any concerns. Participants were also given time to consider their participation in the study. Moreover, the observation data were collected by the student researcher who as an experienced aged care RN was fully conversant with care provision in a safe environment, the importance of maintaining privacy and confidentiality and the 'serious error' protocol (mentioned in 3.7.4).

3.9. Trustworthiness of the data and findings

The concurrent mixed methods design aims to enhance the strengths and minimise the weaknesses of standalone qualitative and quantitative methodologies. However, there are a number of limitations that are associated with this pragmatic approach. A number of approaches were therefore used to account for the possibility of researcher bias and limitations associated with mixed methods. Guba & Lincoln's (1985) four types of trustworthiness in qualitative research: credibility; transferability; dependability and confirmability were carefully considered when undertaking Phase One of this research. Credibility was achieved by using a purposive sampling technique to recruit ward nurses who had experience in specialling older people in the hospital. Participants were assured that their identities would be protected on all transcripts, reports and publications that resulted from the focus group discussion. Open-ended inquiry was utilised throughout the discussion to encourage participants to share their experiences. The moderator and an additional investigator used field notes to enhance the reliability, validity and authenticity of the qualitative data collected (Sutton & Austin 2015). Confirmation and discussions amongst the student researcher and her supervisor(s) were also used to enhance the trustworthiness of the data analysis. For these reasons it is considered that the focus group findings represent a microcosm of nurses' views about

specialling older people in acute care settings, and they could be transferred to similar contexts.

While it is hoped that the observation findings are generalisable to other situations, because each older person's care experiences have many unique aspects, a limitation of this study may be non-generalisability of older person specialling in the acute care setting. However, a clear outline of the setting (section 3.3.3), use of validated data collection tools (i.e., the QUIS [Dean et al. 1993] and the ERIC [Fleming 2005]), and rigorous data analysis may increase the trustworthiness of the data and findings (Wiersma 2009). In addition, the degree of convergence between quantitative and qualitative findings increase the contribution of the study findings to the field of older people specialling.

3.10. Conclusion

This chapter has outlined the methodology for examining specialling practices of older people in acute care settings and addressing two research questions:

1. What characterises older person specialling in the acute care setting?
2. What essential care is required when specialling older people in acute care settings?

A concurrent mixed methods approach was adopted for this study, which was conducted in two phases: (a) a focus group discussion with acute aged care ward RNs; and (b) observation of specialling practices in these wards. A justification for the methodological approach adopted for the study has been provided, and both phases outlined and discussed. A rationale for the selection of the site and participants for the study has been presented, including procedures for recruiting and accessing both the site and the participants. Data forms (i.e., focus group discussion and direct observations) and procedures for data reduction and analysis have been discussed. Ethical considerations for both phases of the study have also been taken into account. Results from the study are now presented in Chapter Four. Recommendations for specialling older people in acute hospital settings will arise from a synthesis of the literature and results.

4. Results

4.1. Chapter introduction

Chapter Three outlined the methodology adopted for this study. A pragmatic (mixed methods) research design was used to gather data on specialling practices for older patients in four acute aged care wards of a large metropolitan hospital in Sydney, Australia. Qualitative and quantitative data were collected in two concurrent phases, from May to October 2017. Phase One comprised a focus group discussion with nine RNs working in the hospital's four acute aged care wards, convened to gain their insights into the experiences with and the requirements of older people specialling. Phase Two used two validated tools (i.e., the QUIS and the ERIC), to observe 12 older people being specialled in the same four hospital wards, specifically the care interactions between the specialling staff and older people, and older persons' responses to nursing care during specialling. Alongside the quantitative data obtained on these tools, qualitative data were also recorded in the form of field notes. The results of each of these two study phases are outlined in the two main sections: Phase One (4.2) and Phase Two (4.3), with a number of subsections as appropriate.

4.2. Phase one: focus group

Chapter Three outlined the questions asked in the focus group discussion, which were designed to explore RNs' perceptions of specialling practices and requirements for the older person in acute aged care wards**.** Following this discussion, segments of information were organised into themes. These themes were then analysed against the four pillars of Brooker's VIPS framework (2007), the auditing/organising framework for PCC in this study. More specifically each piece of information was analysed against Brooker's (2007) indicators for each of the four pillars (e.g., V1 – Vision, V2 – Human Resources, V3 Management Ethos etc.). Themes emerging from each of these four pillars (categories) and where appropriate, their indicators are summarised in Table 4.1. Please note, while the focus group data were analysed against the four pillars, emerging themes were only able to be matched to the first three (i.e., V, I and P). No themes could

be identified in relation to Brooker's (2007) 'S' – social/psychological pillar and therefore themes against this category are intentionally left blank.

Table 4.1: Focus group pillars, indicators and themes

Category	Indicator	Theme
Valuing	V3 Management ethos	Workload impact
		Initiating specialling
	V4 Training and practice development	Staff qualifications and experience
		Staff familiarity with the ward and specialling procedures
Individual	I1 Individual support and care	One-to-one vs. cohort specialling
Perspective	P1 Communication	Communicating appropriately with specialled older people
	P3 Physical environment	Risks to patient safety
	P4 Physical health needs	Recognising and responding to delirium
Social/ psychological		

4.2.1. Valuing the specialled older person

Four major themes emerged from the focus group discussion that could be aligned with this pillar of Brooker's (2007) VIPS Framework: *the impact of specialling on nurses' workload, initiating specialling, staff qualifications and experience, and staff familiarity with the acute care ward and specialling procedures.*

4.2.1.1. Workload impact

Differing views were voiced by participants about the impact of specialling on nurses' workload, which appeared to be related to the management ethos of specialling older people in hospital. First, the introduction of specialling to the hospital's acute aged care wards was identified as a supportive move by one RN:

> *"Six years [ago] we rarely had specials…I came back and I thought WOW this is fantastic we have people being specialled. And I wondered how many less people are absconding how many less falls we are having?"*

The suggestion from this participant was that the increased use of AINs had resulted in more specialling, which had also positively impacted on staff workload:

> *"What difference has having the specials made…somehow there is this gate opened but I think it is the AINs being more available."*

However, of concern for most focus group participants was the increased workload for the ward when older people required specialling. First, allocation was flagged as an issue, and participants suggested that when specialling was initiated, they were effectively short one staff member:

> *"When we have to…special that means we are going to use [staff] out of our numbers. That means we are looking at more patients. We are giving one nurse focusing on one patient… the other two nurses will be dividing the whole ward".*

Second, concerns were (again) expressed around the increased workload placed on ward RNs when junior or unlicensed staff were allocated to special, or if indeed they themselves were allocated the role:

> *"…really that junior person really is really not equipped to special, then you have to supervise that person who is specialling. But if you are more senior who is the most ideal person or someone with a lot of experience, if you are the person specialling how do you then ensure the rest are getting the care or supervision or whatever is required?"*

These quotes may suggest that RNs felt disempowered by management's approach to specialling. While they appeared to consider the impact of the practice on their own workload, some of the comments suggest that specialling could have a positive impact on the quality of care and outcomes for older people in these situations.

4.2.1.2. Initiating specialling

Participants identified doctors, the Nursing Unit Manager (NUM) and Clinical Nurse Consultants (CNC) as the major staff involved in the commencement of specialling once the need had been identified by a ward nurse. They considered that initiating specialling was largely based on the ward nurses' intuition, and expressed concerns at the lack of tools or criteria to support this process:

> *"You flag them, you say I think this person's trying to pull out his IDC and I think this patient needs specialling".*

Participants also vocalised their reluctance to flag a person for specialling because of the common practice of recruiting specials from the existing ward staff, resulting in an increased workload and staff/patient ratios for the remainder of the ward:

> *"[if specials are recruited] out of your numbers, you can only imagine you do not want to flag them"*

The dilemma of whether or not to identify a person for specialling and risk losing a staff member was reported as being very difficult. In summary, RNs in the focus group acknowledged two issues in relation to initiating specialling. First, that it was largely up to the ward nurse to identify the need and then convey this to a senior staff member, and second, that this process was not always carried out as frequently as it may have been indicated, due to concerns about the negative impact on the workload of the remainder of the ward.

4.2.1.3. Staff qualifications and experience

Participants voiced frustrations at being allocated specials who were not necessarily the most appropriate for the specialling role. In most cases, specials were unlicensed and lacked experience in acute nursing care of older people:

> *"...usually an AIN who maybe has never worked in the hospital before or maybe never worked in aged care before and they are*

coming specifically for management of a patient who is very high risk of aggression or delirium".

Unlicensed nursing staff (usually AINs) who were assigned as specials also raised concerns for existing RNs on the ward. Rather than feeling reassured that the person in need of specialling was now in the care of an experienced nurse, RNs worried about the special in addition to their own workload:

"…the poor AIN who turns up on our ward…the look on their face of absolute sheer terror and then I think now I not only have 12 patients…but I got another AIN now I am really concerned for their safety."

The issue of gender in assigning specials was also discussed. One male participant suggested that males were only allocated to special because of their gender, not necessarily their qualifications or experience:

"[The administration] do request a male…because they are stronger, and that patient only responds to a male and it is better."

Another participant remarked:

"I know some male staff have big issues with that….I only get called [to special] because I am a male".

The topic of the allocation of specialling staff based on gender was a discussion that emerged during the focus group. The remarks by participants echoed the concerns for specialling staff assigned based on gender. In summary, the RNs considered that staff allocated to special were not always the 'best fit' for the role.

4.2.1.4. Staff familiarity with the ward and specialling procedures

It was not necessarily the qualifications of the special per se that appeared to be of concern to the RNs, but their familiarity with the ward and ward procedures for specialling. While some participants agreed that:

> *"In [an ideal world] we would have an RN. Or very qualified experienced EN",*

they conceded that successful specialling really depended on the individual's experience in undertaking the role. For example, they compared two types of specials: one who was new to the ward, with comments such as:

> *"for someone who is a high fall risk all you hear is sit down, sit down because they are so scared that the person is going to fall"; and "sometimes the AIN will keep buzzing because they do not know what is going on….they are moving look they are doing this…";*

to a special who was familiar with the ward, permanent staff and routine:

> *"We often get the same AINs, but there are not enough to fill those gaps"*; and *"They know the approach."*

A discussion by the participants followed regarding recruitment of a pool of AINs that could be trained up for the specialling role and would be familiar with the ward routine and nursing staff.

> *"I remember saying to our Nursing Unit Manager can we have a pool of AINs that we could train up and we ended up with a girl for the short time on our permanent roster, but unfortunately that fell off".*

This familiarity with the ward and staff also extended to situations of compromised staff safety, for example, in the case of aggressive patients:

"You spend a lot of time together, you need rapport with your colleagues and with your patients as well. If something goes wrong…all of us need to know what level we are at so that you know someone has got your back… if you are not confronted with that regularly..."

Further to these comments, RNs suggested that when there was continuity with the AINs allocated to the specialling role, including agency/casual staff, and when these staff had aged care experience and an affinity with older people, outcomes for specialled patients were likely to be improved.

In summary, focus group discussion data suggest that specialling was potentially undervalued as a practice in the acute aged care wards, particularly in terms of management practices, training and practice development. RNs viewed older person specialling in their acute care wards as a favourable practice in terms of providing safer, quality care. However, they conveyed a number of stressors in relation to the practice, including negative workload impact, an ad-hoc approach to initiating specialling, and junior or unlicensed staff, or staff who were unfamiliar with the ward being allocated to special.

4.2.2. Recognising the specialled older person in hospital as an individual

One theme was identified and aligned with the 'Individual' pillar of Brooker's (2007) VIPS Framework: *one-to-one vs cohort specialling.*

4.2.2.1. One-to-one vs. cohort specialling

Participants reported that the practice of specialling can vary across the four aged care wards in which they worked. It was generally assumed by these RNs that specialling should be undertaken as one-on-one supervision and care, and they were troubled by what they described as the increasing practice of 'cohorting' older people when specialling (i.e., one special for two or more patients with similar symptoms). The main concern expressed with cohorting was compromised patient safety and quality care:

"...basically you are compromising every time...you can't special both of them normally they need constant attention for either pulling at lines, or falls, like agitation, interfering or absconding. You need to be intervening consistently and constantly and they want the staff member to care for both of them..."

Privacy, too, was concerning for RNs when older people were specialled as a cohort:

"You are supposed to uphold privacy between patients so if you are changing one then you have the other one you are specialling then you are going to have to expose the both of them".

Cohort specialling was understood to be a stressful practice for nurses. Mentions of preventing falls and dislodging medical equipment suggest some concern for patient outcomes, however most of the discussion was framed in terms of impact on the actual staff member, who at times felt as though they needed to be in two places at once:

"...you need eyes in the back of your head!...You are here and the other one is there...You are the one standing there and the other one is standing there! How do you manage for the patient not to fall...? Are we waiting for that to happen before we can special [one-to-one]?"

The overwhelming view of the focus group was that specialling was best undertaken one a one-to-one basis. In summary, the practice of cohort specialling, reported by focus group RNs as being increasingly undertaken in their aged care wards, seemed only to heighten staff stress levels and make it even more challenging to provide individualised care.

4.2.3. Understanding the personal perspective of the specialled older person

Three major emerging themes were aligned with this pillar of Brooker's (2007) VIPS Framework: *communicating appropriately with older people, risks to patient safety, and recognising and responding to delirium.*

4.2.3.1. Communicating appropriately with older people during specialling

While focus group discussion was largely based around human resource, management, staffing, workload etc., the participants did acknowledge the importance of communication skills when specialling an older person. Firstly, the RNs emphasised that compassion for older people when specialling was absolutely essential. More specifically, their list of required skills extended to both verbal and non-verbal communication, including the ability to communicate and act in a calm manner, creating a 'safe space' for specialled patients:

> *"If you [or another staff member] start raising your voice or [the special] gets excited or agitated themselves because [the patient] is hitting out, you have to be calm and manage them, yes. That is my experience recently."*

The implication here is that staff who are untrained in effective communication techniques for specialling older people are likely to react in unhelpful ways, causing stress for both the staff member and the older person. However, the word 'manage' was again used in the context of communication, suggesting that no attempts were made to understand how older people might communicate in situations of distress, and the kinds of responses from the special that might be appropriate.

4.2.3.2. Risks to patient safety

"Managing" patient safety and preventing adverse events emerged from the focus group data as priority indicators for the commencement of specialling the older person in hospital. All nurses reported that the symptoms of delirium were the most common cause for specialling in their aged care wards, increasing the patient's acuity and requiring closer observation and monitoring. Fears for the safety of their patients was reported:

> *"they need constant attention for…falls…agitation or interfering or absconding."*

Further comments included:

> *"with delirium they can abscond, we are on the ground floor we can see them wandering past and we say that is our patient…you cannot like…lock the door and so they literally leave"*

and concerns such as:

> *"…they are bleary-eyed, they really do not know where they are. They are trying to climb out of bed".*

Participants reported stress and frustrations in prioritising time to manage the accompanying behaviours with delirium such as pulling out indwelling catheters, peripheral intravenous central catheter (PICC) lines and nasogastric tubes, impulsive behaviour and attempts to leave the confines of the ward or "abscond" in their words.

4.2.3.3. Recognising and responding to delirium

Participants considered that knowledge and skills in managing challenging behaviours would improve specialling outcomes for both staff and their specialled older patients. Besides worry about the lack of skills being "terrifying" for inexperienced specials, the RNs vented their frustration about the inability of specialling staff to recognise triggers before older peoples' behaviour escalates, especially in the case of delirium. Multiple comments were made in relation to early recognition and response to delirium, including:

> *"Noticing and observing what is going on in the person before they start to escalate not only the triggers but watching those early signs before that behaviour escalates"*; and *"Pre-empting what are they going to do. And trying to figure out what part of the delirium they are in".*

The RNs also identified a deficit in specials' skills and knowledge in managing the behaviours associated with delirium and communicated that it was upsetting to see an older person inappropriately managed while in a delirious state.

"[Specials] have got to [be]…non-confrontational. That is a skill. A lot want to argue with the patient 'I told you sit down sit down'. It is terrible, it is heart breaking you know".

The suggestion here was that specials be trained not only in understanding the underlying pathophysiology of delirium, but also in the kinds of care that would elicit positive responses from older people:

"We need someone who understands the mechanism of what is relating to the falls, not…to keep someone sitting down."

Finally, there was some discussion about the practicalities of managing challenging behaviours, such as the need for specials to understand how to break the holds of aggressive older people, and how to raise the duress alarm and call for help in these situations.

In summary, an understanding of the personal perspective of the older person being specialled in acute care settings appeared to be lacking in the focus group data. Communication skills, keeping patients safe, and early recognition and response to delirium were all flagged as important, however they were couched from the staff perspective and not necessarily in terms of understanding challenging behaviours and their underlying causes from the older person's perspective.

4.2.4. Focus group summary

A total of eight themes emerged from the focus group of nine RNs who worked across the hospital's acute aged care wards. The focus group discussion flagged specialling as a favourable practice, however some stressors, especially for ward staff, were identified. Delirium was considered as the most common reason for specialling. Patient safety in these cases was an issue, along with concerns around how RNs could flag the need for specialling and initiated it in their aged care wards. RNs also worried about workload support when specialling was required. One-to-one specialling was preferred over cohort specialling. The focus group also suggested that staff allocated to special were not always the most appropriate for the role. They called for specials who are

experienced and familiar with the ward environment, have an affinity with older people, and are able to recognise and respond to the challenging behaviours associated with delirium, including the use of effective communication techniques.

4.3. Phase Two: Observation of older person specialling

4.3.1. Patient demographics

A total of 58 observations of specialling practices involving 12 patients were completed during the study period. The age range of patients who were specialled was 65-98 years (Mean: 84.33, SD = 10.24), with the majority being male (n= 7, 58.3%). Delirium (n =10, 83.3%) and falls (n =2, 16.7%) were the reasons documented as the main reason for commencing specialling.

4.3.2. Observed specialling practices

The observation session varied in length from 10 to 15 minutes (Mean = 12.81, SD= 5.75) with the majority (n = 26, 44.8%) occurring during the morning shift. Staff qualified as Assistants-in-Nursing (AIN) (n= 45, 77.6%), predominantly from nursing agencies, undertook most of the specialling, followed by Enrolled Nurses (ENs) (n = 9, 15.5%). The Registered Nurses (RNs) who undertook specialling roles were either regular staff or staff redeployed from another ward within the hospital. The most commonly used specialling approach was one staff to one patient (n= 52, 89.7%). One-on-one specialling, as well as undertaking additional duties, such as caring for the other patients in the room, occurred in 13 (22.4%) of the observations (see Table 4.2).

Table 4.2: Observed Specialling Practices

Observed specialling practices	Frequency	Percent (%)
Staff providing specialling		
Assistants-in-Nursing (AIN)	45	77.6
Enrolled Nurse	9	15.5
Registered Nurse	4	6.9
Reason for specialling		
Delirium	10	83.3
Falls risk	2	16.7
Type of specialling		
1 to 1	52	98.7
Cohort	6	3.1
Nature of specialling		
Specialling only	45	77.6
Specialling plus additional duties	13	22.4
Time of observation		
Morning Shift	26	44.8
Afternoon Shift	22	37.9
Cross over - morning and afternoon shifts	7	12.1
Night Shift	3	5.2

4.3.3. Quality of Interactions Schedule (QUIS)

Positive care practice (n = 25, 43.9%) was the most frequent descriptor observed. This involved positive verbal interactions and the delivery of appropriate care between staff and patient. Care provided included toileting, bathing, administration of medication and treatment. Positive social (n = 20, 35.1%) was the second most common descriptor observed, comprising positive interactions where productive staff-patient conversations and companionship took place in the care process. This was observed when an explanation of care goals was given to the patient and encouragement. One observation included a special staff brushing a patient's hair engaging with her about her past occupation. Prior to this engagement that patient was pacing, seeking a way to exit the ward. Neutral care (n= 5, 8.8%) occurred when special staff were observed to have brief interactions with minimal emotional engagement with the patient. This occurred when special staff were attending to other patients in a bay or when a patient was sleeping.

Negative Protective practice (n =3, 5.3%) constituted care that was given without explanation, for example staff continuing to give oxygen therapy to a patient who was agitated by wearing the oxygen mask/nasal prongs, or with having intravenous therapy, without any attempt to provide reassurance or comfort to the patient. Negative restrictive practice (n =1, 1.8%) involved interactions where staff did not give adequate explanations for care, or restricted the movements of patients**.** This was observed when an agitated patient flagged as having a risk of falling continued to stand up unaided. The special reacted by telling the patient to sit down continually without giving an explanation to the patient for the restrictions placed on their movements and made no attempt to identify why the patients was agitated, e.g. discomfort/pain, needing to toilet, or feeling cold or thirsty. These results are presented in Table 4.3.

Type of Interactions	**Frequency**	**Percent**
Positive Social: interaction principally involving "good, constructive, beneficial" conversation and companionship, e.g. greeting directed to individual take out explanation	20	35.1
Positive Care: interactions during the appropriate delivery of physical care, e.g. general explanation of procedure, but no general conversation	25	43.9
Neutral: brief, indifferent interactions not meeting the definitions of the other categories e.g. putting plates down without verbal or non-verbal contact	5	8.8
Negative Protective: providing care, keeping safe or removing from danger, but in a restrictive manner, without explanation or reassurance	3	5.3
Negative Restrictive: interactions that oppose or resist residents' freedom of action without good reason, or which ignore resident as a person	1	1.8
Interactions with Others (not staff)	4	6.9
Total	58	100.0

Table 4.3: QUIS Quantitative Results

4.3.4. Emotional responses in care (ERIC)

'Helpfulness' (n = 25, 43.1 %) was observed when a patient responded to the care provided to them such as a bed sponge or when being mobilised to the toilet by the special. 'Pleasure' (n =7, 12.3%) and 'Affection' (n = 7, 12.3%) were benchmarked when a patient responded emotionally to care being given by special staff such as by smiling at the special and showing pleasure through their positive body language. One example of this was when the special staff brushed a patient's hair. The 'Neutral' response (n = 9, 15.5%) was observed when a patient was lying or sitting quietly or when special staff was assisting other patients in the room. This category was observed during periods when the ward was very busy. The strength of the responses overall was 'Strong' (54.4%). These results are presented in Table 4.4.

Table 4.4: ERIC Quantitative Results

Type of Emotional Responses	Frequency	Percent
Pleasure: the person smiles, laughs, makes happy noises or expresses pleasure in words	7	12.1
Affection: the person shows or verbally expresses a liking or affection to someone or responds with liking or affection when approached	7	12.1
Helpfulness: the person attempts to assist someone with a task or to assist someone trying to help him/her.	25	43.1
Anger: the person glares, clenches teeth, shouts, curses, insults, pushes, threatens to be, or is aggressive.	2	3.5
Anxiety: the person has a furrowed brow, is restless, makes repeated or agitated movements, sights, withdraws from a person or situation, trembles, has tight facial muscles, calls repetitively, wrings hands, jiggle legs, has wide open eyes.	5	8.6
Discomfort: the person grimaces, yells, moans, or groans, has noisy laboured breathing, a rigid body, fists clenched or knees pulled up.	3	5.1
Neutral: the person shows no emotional response to the situation, may be withdrawn or simply looking on with no apparent feeling about what is going on.	9	15.5
Total	58	100.0

4.3.5. QUIS and ERIC qualitative data

In addition to the general patterns revealed by the quantitative analysis, the qualitative observation data provided the context for the QUIS and ERIC codes allocated, and the scores derived. These data helped with developing insights about the provision of specialling to older people in the acute hospital setting. For both the QUIS and the ERIC, the emerging themes, coinciding with the most common occurring events recorded alongside the codes and scores allocated were: (a) the performance of additional duties during specialling; (b) where the specialling was conducted; (c) the type of specialling being conducted (i.e., one-to-one or cohorting); and (d) the special's qualifications and ward experience. These data are presented in Tables 4.5 and 4.6. In addition to these common events, qualitative data were also collected around the type of care being provided during specialling to evoke positive, neutral or negative responses from older people, along with any artefacts (e.g., personal possessions, activities) that may have supported these responses. These data are presented in Tables 4.7 and 4.8.

Table 4.5: QUIS Qualitative data: Commonly Occurring Events

	Total no. of observations	Additional duties (no. of observations)	Type of specialling one-on-one vs. cohort (no. of observations)	Location of specialling	Qualifications/ experience of staff	Comments
Positive social	20	5	18:2	Four-bedded room	14 AINs; 6 ENs; all familiar with ward	Additional duties undertaken for other patients *within* the four-bedded ward (i.e., not external); ward noted to be busy and patient acuity was high when additional duties were undertaken
Positive care	25	8	21:4	Four-bedded room	18 AINs; 4 RNs; 3 ENs; all familiar with ward	Additional duties undertaken for other patients *within* the four-bedded ward; all RNs and ENs + 1 AIN undertook additional duties
Neutral	5	0	5:0	Four-bedded room	5 AINs; 4 of these not familiar with ward	Ward busy/high patient acuity on all observations
Negative protective	3	0	3:0	Four-bedded room	3 AINs; none of these familiar with ward	Ward busy/high patient acuity on all observations
Negative restrictive	1	0	1:0	Four-bedded room	1 AIN; not familiar with ward	Ward busy/high patient acuity on observation
Interactions with others (not staff)	4	0	4:0	Four-bedded room	4 AINs; 3 not familiar with ward	Ward busy/high patient acuity on all observations

Table 4.6: ERIC Qualitative Data: Commonly Occurring Events

	Total no. of observations	Additional duties (no. of observations)	Type of specialling one-on-one vs. cohort (no. of observations)	Location of specialling	Qualifications/ experience of staff	Comments
Pleasure	7	3	7:0	Four-bedded room	5 AINs; 2 ENs; all familiar with ward	Ward not busy – adequately staffed; patient acuity high
Affection	7	2	7:0	Four-bedded room	4 ENs; 3 AINs; all familiar with ward	Ward not busy – adequately staffed; patient acuity high
Helpfulness	25	10	21:4	Four-bedded room	16 AINs; 5 ENs; 4 RNs; all familiar with ward	All RNs and ENs observed to undertake additional duties for other patients *within* the four-bedded ward; ward very busy/high patient acuity on all observations
Anger	2	0	2:0	Four-bedded room	2 AINs; neither familiar with ward	Ward very busy/high patient acuity on both observations
Anxiety	5	1	5:0	Four-bedded room	5 AINs; all familiar with ward	Ward very busy/high patient acuity on both observations
Discomfort	3	0	3:0	Four-bedded room	3 AINs; 2 of which not familiar with ward	Ward very busy/high patient acuity on both observations
Neutral	9	1	7:2	One patient barrier nursed in single room; 7 observations occurred in four-bedded rooms; 1 patient sitting on verandah adjoining room	9 AINs – 8 of which not familiar with ward	Special sitting with patient on verandah was asked by other patients in the adjoining room for assistance – undertook these additional duties and did not interact with their specialled patient; ward busy/high patient acuity on 6 of the 9 observations.

Table 4.7: QUIS Qualitative data: Care Provided

	Total no. of observations	Type of care (n= observations of type of care)	Artefact/Environment (n= observations of type of care)	Staff
Positive social	20	Reorientation to prevent patients from leaving confines of ward (n = 17); reassurance, engagement and companionship (n = 17);); reading newspaper to patient (n = 5); brushing patient's hair (n = 1 assisting patient to set up a table for a meeting (n = 1)	Newspapers and other reading material (n = 10); photos of family and/or pet on locker (n = 5); photo album in top drawer (n = 4); patient's surroundings set up to resemble a board meeting (n = 1); family in attendance (n = 1); 'My Story' in all bedside notes but not referred to	14 AINs; 6 ENs; all familiar with ward
Positive care	25	Personal hygiene/grooming (n=13); assisting with mobilise in hospital grounds (n = 10); reorientation to prevent patients from leaving confines of ward (n=8); presence of family members (n = 4); redressing patient after removal of clothing (n = 1)	Cups of tea made to decrease agitation (n – 10); patients wearing favourite items from home e.g., bed jackets (n = 2); quilt from home on patient's bed (n = 1); 'My Story' in all bedside notes but not referred to	18 AINs; 4 RNs; 3 ENs; all familiar with ward
Neutral	5	Special sitting at bedside while patient sleeping/drowsy/lying quietly in bed (n = 5)	Hospital-like environment, personal items absent; 'My Story' in all bedside notes but not referred to	5 AINs; 4 of these not familiar with ward
Negative protective	3	Special trying to prevent patient from removing medical devices (e.g., IV, oxygen masks) (n=3)	Photo of family members on locker (n = 1); 'My Story' in all bedside notes but not referred to	3 AINs; none of these familiar with ward
Negative restrictive	1	Special telling patient to sit down while patient agitated, pulling off oxygen mask (n=1)	Hospital-like environment, personal items absent; 'My Story' in all bedside notes but not referred to	1 AIN; not familiar with ward
Interactions with others (not staff)	4	Special standing around bedside while patient interacts with family members (n=3); or other patient (n=1)	Hospital-like environment, personal items absent; 'My Story' in all bedside notes but not referred to	4 AINs; 3 not familiar with ward

Table 4.8: ERIC

	Total no. of observations	Type of care (n= observations of type of care)	Artefact/Environment (n= observations of type of care)	Staff
Pleasure	7	Special engaging with patients in conversation, patients laughing (n = 4); special diverting patient with conversation about their previous occupation (n = 2);	Personal grooming items e.g., hair brush, shaving equipment (n = 3); family in attendance (n = 1); newspapers and car magazines (n = 4); fiddle mat (n = 1); 'My Story' in all bedside notes but not referred to	5 AINs; 2 ENs; all familiar with ward
Affection	7	Patients smiling, interacting, positive body language, holding special's hand (n = 7)	Reading newspaper (n = 7); fiddle mat (n = 1); 'My Story' in all bedside notes but not referred to	4 ENs; 3 AINs; all familiar with ward
Helpfulness	25	Special reorientating and reassuring patient to prevent them from leaving (n = 2); assisting patient to mobilise (n = 5); applying medical devices e.g., oxygen mask, IV therapy (n = 3); personal hygiene (n = 11); taking observations e.g., BP, blood sugar level (n = 2)	Personal grooming items e.g., hair brush, shaving equipment (n = 9); fiddle mats (n = 2); 'My Story' in all bedside notes but not referred to	16 AINs; 5 ENs; 4 RNs; all familiar with ward
Anger	2	Special debating with and redirecting delirious patient who wanted to leave hospital for a meeting (n = 1); persistently attempting to apply heating blanket for patient's low temperature (n = 1)	Medical devices e.g., IV cannula/therapy, oxygen masks, TED stockings, urinary catheters (n = 2); 'My Story' in all bedside notes but not referred to	2 AINs; neither familiar with ward
Anxiety	5	Special reorientating patient who was anxious about being in hospital, wanting to go home and care for family (n = 1); family present, patient wanting to be discharged into their care (n = 1); patient anxious about presence of medical devices e.g., IV line, urinary catheter, TED stockings and wanting to remove same (n = 5); patient anxious and removing clothing (n = 1)	Medical devices e.g., IV cannula/therapy, oxygen masks, TED stockings, urinary catheters (n = 5); 'My Story' in all bedside notes but not referred to	5 AINs; all familiar with ward
Discomfort	3	Patients grimacing, very agitated, delirious (n = 2); patient experiencing pain and clinically deteriorating (n = 1)	'My Story' in all bedside notes but not referred to	3 AINs; 2 of which not familiar with ward
Neutral	9	Patients drowsy or sleeping (n = 5); patient sitting on verandah staring at the sky (n = 1)	Family present but conversing amongst themselves and not interacting with patient (n = 2); special in protective mask and gown, patient showing no response to care (n = 1); 'My Story' in all bedside notes but not referred to	9 AINs – 8 of which not familiar with ward

4.3.6. Observations summary

In summary, 58 observations of 12 specialled older people were undertaken. The mean age of patients who were specialled was 84.33 years, and just over half of these patient were male. Most older people were specialled because of delirium, and most specialling was conducted one-to-one. AINs were more likely to special older people than RNs or ENs. In the staff-patient interactions, positive care practice was the most frequent descriptor observed. Qualitative data collected to support the QUIS and ERIC codes list some of these cares as being reorientation, engagement and companionship. When observing patients' emotional responses to their special care, helpfulness was most the frequent descriptor observed, including when staff were assisting their specialled patient to mobilise or attending to their personal hygiene and grooming needs. Wards were noted to be busy and with high patient acuity in a majority of the observations, and on multiple occasions staff were noted to be undertaking additional duties for other patients whilst specialling their allocated patient. Artefact and environmental factors observed in relation to positive care and interactions included newspapers and other reading material, photos of family and pets, and personal grooming items. The presence of medical devices such as Intravenous (IV) therapy and oxygen masks were associated with negative care and interactions, as were hospital-like surroundings devoid of peoples' personal items. 'My story', providing a personal background, likes, dislikes and preferences for each older person in the ward was noted in each person's bedside chart, but not referred to during any of the observations.

4.3.6.1 Positive care: 'Don's story'

Don's story provides a good example of positive social care practices observed when patients were specialled in the study. Don (a pseudonym) was being specialled in the acute aged care ward for dementia and associated wandering. Prior to specialling being initiated Don was often observed to be wandering around the ward, and in the afternoons routinely became agitated, verbalising that he "need[ed] to arrange a meeting immediately". At one point during his hospital stay Don had even been found in the car park. Nursing staff expressed concerns about his safety and were frustrated at not being

able to keep Don within the confines of the ward. On one shift, however, an AIN special who was familiar with the ward and its patients having worked there on numerous occasions, and having seen a photo of Don dressed in a business suit beside his bed, engaged Don's wife in a conversation about Don and their life together. The special learned that prior to his retirement, Don had been the Chief Executive Officer (CEO) of a large corporation for many years, and therefore convening and chairing large meetings was a regular part of his role. After hearing this, on the afternoon that the AIN was specialling Don she assisted him to set up his 'meeting', including helping him to arrange tables and chairs in his four-bedded ward, and invited other patients to attend. Almost immediately, Don appeared less agitated. As soon as the meeting was concluded, he returned to his chair and sat quietly for the remainder of the shift.

The interactions described in Don's story are person-centred, including recognition, negotiation, collaboration, play, validation, facilitation and creation (Kitwood 1997). This creative approach to identify the cause of Don's agitation was resolved quickly and with very little resource implications for the ward and staff time. As Kitwood (1997) urged, PCC does not take more time and often does not require additional resources; it requires rather creativity and a mindset that is proactive and solutions-focused. Moreover, Don's story captures a number of Brooker's (2007) VIPS elements in responding to the unmet needs of older people. P1 - communication, P2 – empathy and acceptable risk, and P3 – creating a physical environment which puts the person at ease, are all evident. Older peoples' responsive behaviour is very likely to be a sign of distress when they are not able to communicate their needs, or when those needs are unmet by staff (Brooker 2007). Special staff who are able to identify and respond to the underlying cause of these responsive behaviours by attending to the person's needs, whether these be physical, emotional or social, or a need for explanation and reassurance, are more likely to be engaged in positive, compassionate care and positive social interactions with older people. Fazio (2018) encapsulates Kitwood's (1997) principles of PCC by suggesting that the focus for staff should "…be less on *what* is done and more on *how* it is done" (p. S11).

4.3.6.2 Negative care: 'Enzo's story'

The story of Enzo is illustrative of the negative restrictive and negative protective care that was observed during the study. Enzo (a pseudonym) was being specialled in the acute aged care ward for an acute postoperative delirium. He was agitated and aggressive at times, and wandered around the wards, especially at night. From around 10pm until 6am Enzo would attempt to get out of bed and not sleep at all until the morning, when he would then sleep all day. At night, the entire ward was 'heavy', with overall busy-ness and high patient acuity. Staff were extremely frustrated at Enzo's repeated attempts to get out of bed and his lack of compliance with keeping his postoperative oxygen mask on. During the observation of Enzo's specialling practices, the AIN, who was new and unfamiliar with the acute aged care ward, was constantly telling Enzo to "sit down, sit down", or "go back to bed". She was almost fighting with Enzo, telling him "you must keep that [oxygen mask] on". However, on subsequent shifts, special staff learned that Enzo was previously employed as a railway worker/mechanic, and for the past forty years had worked the night shift. This, the special thought, explained his lack of sleep overnight, which was confirmed by Enzo's wife: "you can't change his body clock now". Upon hearing this information specials then accepted Enzo's night time wakefulness. They went one step further in providing Enzo with an old hospital bed and some (safe) tools that he could 'tinker' with overnight. After these PCC interventions, Enzo was reported during handover as being much more settled.

The interactions described in Enzo's story are person-centred and representative of Kitwood's positive person work, particularly recognition, negotiation, collaboration, play, creation and facilitation (1997). Moreover, Enzo's story captures a number of Brooker's (2007) VIPS elements in responding to the unmet needs of older people, namely V5 – creating a supportive and inclusive service environment, I1 – individual support and care, I5 – life stories, I6 – activity and occupation, P5 – considering and acting on what a person is trying to communicate through their behaviour, and S4 – validation, recognising and meaningfully responding to a person's emotions. In Enzo's case, these actions all served to preserve his personhood and maintain a relative state of

wellbeing when staff embraced the opportunity to learn from past mistakes in placing judgement on Enzo, rather than getting to the root cause of his agitation (Kitwood 1997)

Table 4.9 provides an overall analysis of the data collected against each of Brooker's (2007) indicators in the VIPS Framework for a person-centred service. Brief examples of evidence in relation to each indicator is provided. In some cases, evidence supports both positive and negative indication of Brooker's VIPS elements for PCC. Data not collected in relation to a specific indicator is noted as 'missing from data'.

4.9 Overall results analysed against VIPS Framework (Brooker 2007)

Indicators	Positive	Negative	Missing from data	Examples of evidence
Valuing				
V1 Vision		✓		Negative care and interactions (QUIS and ERIC)
V2 Human resources		✓		Busy wards, additional duties performed for other non-specialled patients; specialling undertaken by new, unlicensed or inexperienced staff; staff not always appropriate for role; negative care and interactions (QUIS and ERIC)
V3 Management ethos		✓		Ad-hoc process for initiating and discontinuing specialling; specialling undertaken by new, unlicensed or inexperienced staff specials; staff not always appropriate for role; negative care and interactions (QUIS and ERIC)
V4 Training and practice development		✓		Specialling undertaken by new, unlicensed or inexperienced staff specials; negative care and interactions (QUIS and ERIC)
V5 Service environment	✓			"Enzo's story"
V6 Quality assurance			✓	
Individual lives				
I1 Individual support and care	✓	✓		Positive care and positive social care noted on QUIS; although cohorted specialling did not necessarily support individual care
I2 Regular reviews	✓	✓		Delirium recognised and responded to, although regular reviews not part of initiating and discontinuing specialling
I3 Personal possessions	✓	✓		Present in all instances of positive care and interactions, missing in some instances of negative care and interactions
I4 Individual preferences			✓	
I5 Life stories	✓			Positive care and interactions (QUIS and ERIC)
I6 Activity and occupation	✓			Positive care and interactions (QUIS and ERIC)
Personal perspective				
P1 Communication	✓	✓		Positively noted in care and interactions (QUIS and ERIC). Negative in staff response to behaviours associated with delirium; lack of training and preparation around appropriate communication; new, unlicensed or inexperienced staff allocated to special
P2 Empathy and	✓			Positive care and interactions (QUIS and ERIC)

Indicators	Positive	Negative	Missing from data	Examples of evidence
acceptable risk				
P3 Physical environment	✓			"Don's story"
P4 Physical health needs	✓			Recognising and responding to delirium
P5 Challenging behaviour as communication		✓		Staff seeking to 'manage' challenging behaviour; lack of training and preparation for person-centred specialling
P6 Advocacy			✓	
Social/psychological support				
S1 Inclusion	✓	✓		Positive care and interactions. Negatively noted in terms of lack of training and preparation for person-centred specialling.
S2 Respect		✓		Lack of training and preparation for person-centred specialling
S3 Warmth	✓			Positive care and interactions
S4 Validation		✓		Lack of training and preparation for person-centred specialling
S5 Enabling			✓	
S6 Part of the community			✓	
S7 Relations	✓			Positive care and interactions

4.4. Conclusion

This chapter has presented the findings of the two phases of the study, designed to gather comprehensive data on the practice of older person specialling in the acute care setting. Ward RNs approved of specialling, but they considered it a stressful practice in terms of staff and workload impact. They were mainly anxious about patient safety, particularly the prevention of falls and preventing people from leaving the confines of the ward. Delirium was identified as the most common reason for specialling, but RNs were concerned about the lack of guidelines for commencing specialling, workload support and the qualifications, experience and preparation of the staff allocated to the role.

Observations of specialling practices further examined specialling. Data in this second phase confirmed RNs' views that most older people were specialled because of delirium. AINs were more likely to be assigned the role of special than RNs or ENs. Yet, while RNs were worried about the type of staff allocated to specialling role in their wards, some positive care provision was observed, along with older persons' positive responses to that care. That said, there were some variables that influenced the type of care provided, such as the busy-ness of the ward, the overall acuity of patients on the wards, the familiarity of the special with the ward, and whether or not additional duties were undertaken for other patients while at the same time being required to 'special' an older person. Artefacts such as newspapers, magazines, photos personal grooming items were associated with positive care. Hospital-like surroundings devoid of peoples' personal items, and the presence of medical equipment such as IV therapy and oxygen masks, were observed in association with negative care and interactions.

Positive indicators in Brooker's (2007) VIPS Framework were those that supported the individual lives of the older people being specialled, some personal perspective indicators, and some social support indicators. Negative indicators of a person-centred approach to specialling were valuing indicators, some individual lives indicators, personal perspective and social support indicators (Brooker 2007). In some cases, indicators were recorded as both positive and negative. A discussion and synthesis of the data from both phases follows in Chapter Five.

5. Discussion

5.1. Chapter introduction

This study aimed to examine specialling of older people in acute care settings and inform the development of a set of evidence-based care guidelines for specialling older people in these settings. Consideration of both the nurses' perspectives and observation of specialling practices were central in understanding what characterises older person specialling, and the essential care required when specialling older people in acute care settings.

The investigation revealed that specialling was influenced by an ethos which did not always support PCC. Frequent use of terms such as "manage" and "absconding" by the nurses suggest a largely functional, custodial approach to specialling. These attitudes appeared to stem from hospital administrative practices that were reported as lacking consideration of the impact of specialling on nurses' workload, lacking clear policies or procedures for initiating or discontinuing specialling, and reported as not considering the type of staff most appropriate to special older people, or how best to prepare them to care for older people in a person-centred way.

Yet, despite concerns about a task-focused and custodial approach to older person specialling, data collected on the QUIS and the ERIC indicate some positive care interactions and responses. Good quality specialling, evidenced by positive care interactions and responses were seen when staff engaged with older people conversationally, providing reassurance, reorientation and companionship, when specials read aloud to patients, walked around the hospital grounds with them, or provided assistance with personal hygiene and grooming. Photos, newspapers, personal grooming items e.g., hair brushes, shaving equipment, and engaged family members were also observed in association with good quality specialling. Poor quality specialling, evidenced by neutral or negative interactions, was seen when staff tried to prevent older people from removing medical devices, restrict them to bed, or ignored/did not engage with the patients at all. These responses were influenced by the busy-ness of the ward, the overall acuity of patients on the wards, the familiarity of the special with the ward and the need for the special to undertake additional duties for

other patients whilst specialling. In a number of cases, the absence of personal items, presence of medical equipment, and non-engaged family members were also observed in association with poor quality specialling.

The integration of quantitative and qualitative data collected in both phases of this study provides evidence of the benefits of using a mixed method approach in studies of specialling practices, as it allows for more comprehensive and wider understanding of the processes through which older person specialling occurs in acute care settings. As foreshadowed in Chapter One, the following discussion interrogates the study results and key themes in light of the two research questions used to guide study, the conceptual framework of SPTPD (Kitwood 1993), the VIPS model (Brooker 2007) and the literature on specialling of the older person. Recommendations arising from the discussion around what facilitates person-centred specialling of older people in acute care settings are proposed. Limitations of the study are also presented in this chapter.

5.2. What characterises older person specialling in acute care settings?

Study results suggest a lack of a person-centred approach when specialling older people in acute care settings. Specialling was largely reported by nurses in terms of impact on staff, workload and their attempts to safely "manage" older people. For these reasons, initiating and discontinuing specialling in acute care was noted to be an ad-hoc process, as was the practice of either cohort or one-to-one specialling. Busy wards and high overall patient acuity resulted in the performance of additional nursing duties for others while specialling an older person. The role was mostly performed by unlicensed staff (e.g., AINs) and specials were sometimes inexperienced, new to the ward and/or unprepared to special older people. In essence, the study findings suggest specialling practices which do not value the older person or support individualised care in the acute care setting, nor do they value the staff who perform the specialling role or empower them to provide direct PCC.

5.2.1. An ad-hoc approach: initiating and discontinuing specialling in acute care

Ten of the 12 older people in this study were specialled due to delirium. Delirium is recognised as a predictor of a medical emergency (ACSQHC 2016; 2018) and yet the decision-making process for commencing and ceasing specialling was considered by RNs in this study to be ad-hoc, because it was largely left to ward RNs to flag their concerns with more senior staff. These findings are supported by Dewing (2013) whose literature review also found a paucity of guidelines for initiating and commencing specialling, even more so in relation to the older person. Moreover, RNs in this study admitted that they often remained silent about a person's need for specialling because of the detrimental impact on ward staffing, i.e., the special would be recruited from the existing staff allocation. This is supported by Dewing (2013), who affirms that hospital administrators are often reluctant to support specialling as the high costs of one-to-one staff are absorbed by, and adversely impact on ward budgets.

In relation to Brooker's (2007) VIPS Framework, a management ethos that empowers direct care staff to deliver PCC (V3), and services with the capacity to recognise and respond to change (I2 – Regular reviews) are indicative of PCC provision, yet these indicators were negatively noted in the data. Adopting a PCC approach requires that specials need to feel empowered to act on behalf of the people they support, are able to be flexible and responsive to patient changes, and be able to seek advice and/or consult with senior colleagues as appropriate regarding their patient concerns (Brooker & Latham 2016). In this study, staff could consult with more experienced others about initiating specialling, but in some cases were disempowered and unable to provide PCC because of the risk of their workload and staff allocation being adversely impacted. The process for initiating specialling did not consider the psychological needs of the person, such as their need to feel safe and supported, connected to their social world, nor did it consider whether these needs had been met during or prior to discontinuation of specialling (Kaufman & Engel 2016; Kitwood 1997). Moreover, the older people being specialled appeared to have no control over the process for commencing or ceasing specialling, an important reference point for PCC (Moyle et al. 2010).

Torkelson & Dobal (1999) suggest that as nurses have firsthand knowledge of patients and their families, they are well placed to observe behavioural changes in their patients

and therefore should be supported in decisions regarding the commencement of specialling. However, Rausch et al. (2010) consider that often specialling is often commenced and continued unnecessarily by staff without exploring alternative, person-centred interventions such as medications, room changes, family visits, volunteer support, technology and frequent, brief staff contact.

Feil & Wallace (2014) propose that as specialling is often commenced on the opinions of various 'experts' (e.g., nurses, managers), more formal tools or guidelines are needed to support the process. Some facilities have successfully implemented algorithms, flowcharts and request forms that justify the need for specials (Feil & Wallace 2014). These tools and documents have resulted in better collaboration between staff, patients and their families (Wood et al. 2018), reduced organisational costs and improved patient outcomes such as falls reduction (Feil & Wallace 2014). For example, Spiva et al. (2012) use a decision tree represented as an algorithm to guide nurses with the process for commencing specialling. The guide outlines an approach for assessing the physiological, psychosocial and pharmacological state of the patient. Their study concluded that formal tools may assist with the commencement and discontinuation of specialling, however the focus of the research is on supporting inexperienced nurses with the process, without mention of the need to place the patient at the centre of care. Harding (2010), too, trialled an online request for the commencement of specialling which incorporated patient assessments from ward nurses, managers, medical practitioners and nurse supervisors. The request form suggests a number of alternatives for consideration prior to the request for specialling. Again, the person-centred approach, which may well be implicit, is not articulated.

In overview, guidelines for initiating and discontinuing specialling are needed. Collaboration between older people and/or their relatives, nurses and other members of the multidisciplinary health care team around the process of recognising and responding to change and optimising older people's physical wellbeing needs to be made clearer (Dewing 2013; Rausch et al. 2010; Tolkelson & Dobal 1999). This is consistent with the VIPS model of PCC (Brooker 2007), in that staff are supported to treat older people in acute care settings as individuals, and the process for initiating and discontinuing specialling is not a 'one-size-fits-all' approach.

5.2.2. A supervisory approach: one-to-one vs cohort specialling

Both one-to-one and cohort specialling were practiced in the aged care wards during this study, however the deployment of one method over the other was observed or reported to be ad-hoc and not necessarily person-centred. Nurses reported that the decisions to special patients as one-to-one or a cohort were usually made by a senior nurse – the Assistant Director of Nursing or an after-hours CNC, and were a "systems thing", suggesting that decisions to special older people as a cohort may be made primarily as a cost cutting measure. This is consistent with literature that also discusses cohorting as a cost-effective way of addressing 'common' (i.e., not necessarily individual) needs such as getting people drinks, assisting them to press their nurse call bell etc. (Donoghue et al. 2005; Nadler-Moodie et al. 2009; Tzeng et al. 2008).

One-to-one specialling was preferred by nurses in the acute aged care wards rather than cohorting of people with similar symptoms. To some extent this preference was because of concerns around patient safety and quality care, but mostly because of an increase in the nurse's own stress levels when required to special more than one person. Expressions such as "intervening", "constant attention", "eyes in the back of your head" used by the nurses suggest a custodial, supervisory approach to specialling. Care in these instances was framed in terms of mainly preventing people from falling. Besides a mention of the difficulties with maintaining individual privacy when providing care, at no point did the nurses suggest their preferred method of one-to-one specialling may be a better way to provide care which acknowledged the uniqueness of each older person and addressed their individual support needs.

Most older person specialling observed in this study was conducted as one-to-one (89.7%). However, in the few instances of cohorting, all interactions were observed as positive, and responses to that care mainly comprised of helpfulness (although two responses were neutral). This suggests that there are still ways to provide PCC to a cohort of older people.

In relation to Brooker's (2007) VIPS Framework, care and support plans that promote individual identity and acknowledge each person's uniqueness, hopes, fears, strengths and needs is indicative of PCC provision (I1). While this indicator was positively noted in the data in terms of QUIS codes of positive social and positive care, in relation to the

decision and practice of one-to-one or cohort specialling it was negatively noted in the data.

Brooker and Latham's (2016) states that services should have strategies in place that support staff really getting to know a person, including what is important for them by way of emotional, spiritual and physical needs. However, nothing in this study's findings suggest that the practices of cohorting or one-to-one specialling were carried out with a view to acknowledging these needs – the concerns were mainly around falls prevention.

According to Kitwood (1997), the delivery of PCC involves staff having a compassionate presence, shared decision-making and the provision of physical needs. However, the essential component of PCC is for staff to be "fully present without distraction or disturbance" for psychological healing' (Kitwood, 1997, p 119). Specialling one-to-one can offer the unique opportunity for staff to be fully present without competing demands on time from attending to other patients.

The unexpected demands from cohorting patients might not allow the compassionate presence of staff, patient participation and shared decision-making and may evoke reactions from staff to deliver care that can be custodial and controlling. Kitwood (1997) describes this as "malignant social psychology" (p. 3) where traditional care for people with cognitive impairment is depersonalised, labelling and patronising. This raises concerns when staff are cohorting patients, as these circumstances may not offer the opportunity for the compassionate presence of staff, patient participation and shared decision making that is optimal for PCC to be delivered. Therefore, in keeping with Brooker's (2007) VIPS framework the acute care setting should be responsive to support and workload relief when additional staff allocation is needed when older people are specialled. This responsiveness extends first, to deciding whether or not cohorting patients during specialling is truly in the best interests of each individual older person and if so, how this practice can acknowledge each person's uniqueness, hopes, fears, strengths and needs.

5.2.3. Specialling not always an exclusive practice

Specialling was observed as not always being an exclusive practice for the older person requiring extra care and support, suggesting a service which does not necessarily value its staff as a human resource or empower staff to provide direct PCC. In 13 of the 58 observations (i.e., 22.4%) specials were observed to care for other people in addition to the older person for whom one-to-one specialling was required. Additional duties were especially evident when the aged care wards were short staffed, busy or overall patient acuity on the wards was high, and specials were allocated from those already working on the ward (i.e., an additional staff member not recruited for specialling). Moreover, all RN specials were observed to assume care for all patients in the four-bedded rooms. This is reflected in the ERIC, where RNs were prominent in 'helpfulness' but absent in the 'pleasure' or 'affection' descriptors.

Although additional duties were observed in the positive social (n=5, 8.6 %) and positive care (n=8, 13.8 %) in the QUIS, the patient acuity and ward busy-ness was noted on only five observations in the field notes during the recording of these descriptors. This may be due to the location of the specialling, which, because of the aged care wards' layout (only four single rooms usually allocated for barrier nursing), occurred mainly in four-bedded rooms. Notable exceptions were when these rooms contained empty beds, or when the specialling was conducted in a single room. In fully occupied, four-bedded rooms, additional tasks undertaken by the special included medication administration, toileting, feeding other people and completing documentation unrelated to the specialled older person. These data suggest that the environment and layout of the ward are key factors for altering care provision during the specialling process. However, it also suggests institution of a service which does not value their staff as a human resource or empower them to provide direct PCC.

In relation to Brooker's (2007) VIPS Framework, a system that explicitly values and cares for staff as a precious human resource is indicative of PCC provision (V2). Staff need to feel supported to do their jobs, and when they feel 'cared for', they are more likely to care for others (Brooker & Latham 2016). However, expecting staff to attend to other patients in addition to the person that they had been assigned to special suggests that the nurse participants were not valued or supported by their managers – in fact, in

being obliged to perform duties additional to the specialling role meant they had to fully extend themselves. According to Kitwood (1997), continued overworking of caregiving staff places them at risk of burnout, resulting in staff detachment from persons for whom they are caring. Furthermore, Kitwood (1997) warns that staff in caring roles whose needs are not acknowledged by their managers and organisations can be quick to label care recipients as having 'problem behaviour' and to request medications to address this behaviour (Brodaty et al. 2018). Therefore, in keeping with Brooker's (2007) VIPS framework, acute care settings should be attuned and responsive to the needs of their staff, with flexibility to support additional care that is required. This could include stipulating whether or not it is acceptable to attend to other patients in addition to the specialled patient, and the circumstances under which this is permissible e.g., emergency situations, deteriorating patients, staff qualifications and nursing experience. A clear process for reporting changes in acuity and concerns with impact on standard staffing could also demonstrate to staff that their needs are considered.

5.2.4. Special staff not always the best fit for the role

Special staff in the aged care wards of this study were often inexperienced, unlicensed, new to the ward and/or hospital (i.e., casual or agency staff) and sometimes assigned based on gender, suggesting that the practice of person-centred specialling of older people in acute aged care is not valued above cost cutting or custodial care.

5.2.4.1. Gender

One of the male RNs in the focus group expressed frustration and resentment at being allocated the role of special because of his gender, implying that strength and physicality were paramount when specialling older people who exhibited agitated or challenging behaviours. This is an important consideration for specialling older people in acute hospital wards. It appears that restraining people in these settings is preferable over PCC that considers and addresses behaviours from the unique perspective of the individual, i.e., preventing the bio/socio-psychological triggers that give rise to agitation and other behaviours in the care experience.

In their study of special observations in psychiatric practice, Mason et al. (2009) concluded that gender can be a sensitive issue in specialling, causing embarrassment for both the patient and the nurse when a patient is being 'watched' by a staff member of the opposite sex. In relation to older person specialling, Dewing (2013) also flags gender of the special as an issue worthy of consideration. To date, no research can be located that reports on gender influence on older people specialling in acute care for those with dementia, delirium and/or physical comorbidities, and Phase Two of this study did not note the gender of the special in the observations.

5.2.4.2. Qualifications

Inexperienced and/or unlicensed staff (i.e., AINs) undertook most of the specialling in the acute aged care wards in this study. This is consistent with studies that report unlicensed staff undertaking specialling (Adams & Kaplow 2013; Wilkes et al. 2010; Moyle et al. 2010; Wood et al. 2018), largely due to economic imperatives.

The issue of who should undertake the specialling role is contentious. Concerns have been raised about the lack of educational preparation and skills of unlicensed staff to provide comprehensive PCC to older people. For example, Wilkes et al. (2010) report AINs' lack of training and preparation for the specialling role, leading to the provision of detached, non-person-centred nursing care. Bittner et al. (2011) identified that unlicensed staff have been associated with missed nursing care such as mobilisation, nutrition support and late detection of clinical deterioration. These concerns were echoed by the RNs in this study, who reported that unlicensed, or inexperienced, staff are fearful of older patients who exhibit challenging or agitated behaviours, often adopting a custodial model of specialling "…to keep someone sitting down" rather than trying to understand the underlying reasons for the person's responses, e.g. experiencing pain/discomfort, or needing to toilet or to find someone/something that is familiar.

Assistants in Nursing varied in the QUIS and ERIC coding according to how confident they were in giving care to the specialled older person. Those who were familiar with the wards e.g., procedures, policies, staff and regular ward work, were observed to provide positive care. However, those who were unfamiliar with the ward, such as agency or casual pool staff, appeared less prepared to take on the specialling role. These

were those staff who, according to focus group nurses, constantly told patients to "sit down, sit down" rather than trying to provide positive care and/or understand the underlying cause of older peoples' agitated behaviours. These staff also avoided asking others for assistance or support when needed.

The implication here is that unlicensed, new or inexperienced staff may not be the most suitable caregiving staff to special the older person and to provide them with PCC. However, positive interactions and responses were observed between most of the specials and older people, including staff who were less experienced and qualified for the role i.e., RNs, ENs and AINs. This is an important finding, suggesting that it is not necessarily the qualifications of the staff undertaking the specialling, but their familiarity with the ward routine, pace and patient requirements that correlates with the type of care provided and responses to that care. The clinical nursing experiences and knowledge of the AINs played a role as well.

For example, AINs who were undergraduate nursing students understood and recognised the symptoms of delirium and appeared more confident in their care giving. A number of the AINs observed were familiar with the routine and staff of the acute aged care wards and this positively facilitated their specialling role. This familiarity enabled them to ask for assistance, when needed, as they perceived themselves as part of the nursing team. This finding suggests that when nursing staff feel more confident in their knowledge of care recipient's conditions and needs, and are more familiar with the care environment, they are more likely to provide care in ways that are person-centred.

Brooker's (2007) VIPS Framework states that staff are a valuable resource and should be supported and encouraged in skill development (V2). Management should empower staff to give care that is person-centred by ensuring a systems culture that values the skills of staff (V3). Systems should encourage staff training to increase workforce skills such as communication pathways whilst acknowledging the importance of a culture of reflective practice (V4). The recognition of communication both verbal and non-verbal as a key element in the care provision of the older person with cognitive impairment (P1) including challenging behaviour as a form of communication when needs cannot

be expressed (P5). While these indicators were mostly negative in the data, there is nothing in Brooker's VIPS framework (2007) that stipulates the gender or exact qualifications of the staff for providing PCC; it is more about workforce support and skills development.

Nursing staff need to have opportunities for workforce development and ongoing training in addition to a systems culture that acknowledges, supports and values the specialised skills involved in the delivery of care that is person centred to the cognitively impaired older person (Brooker & Latham 2016). Staff who display negativity in attitude and practices toward the older person should be supported by nurse colleagues and effectively counselled to reflect on their practice and be enabled to communicate feelings of stress and difficulties in the role. As advised by Kitwood (1997) caregiving staff need education, skills development and emotional support to practice PCC, thereby avoiding staff burnout and negative responses to challenging patient behaviour. Critical incidents, too, can be used as a catalyst for investigating the systems which give rise to poor nursing practice, and an opportunity to supervise and support staff in their roles (Brooker & Latham 2016).

According to Kitwood (1997) having the right attitude is the key in selecting suitable staff to provide care to the older person with a cognitive impairment. Staff who have embedded negative opinions about older people, especially those with a cognitive impairment, expressed through ageist attitudes and behaviours, and being rigid in their expectations of the older person's capabilities and rights, can be barriers to the learning process of upskilling. In addition, Kitwood (1997) believes that a workplace which designs practices around low expectations of care quality (e.g., for people with a cognitive impairment), will not attract and retain caregiving staff who place high value on quality care for all people. Kitwood (1997) warns not to dismiss potential staff with no formal qualifications in care of the person with a cognitive impairment, as some people lacking in experience can show an aptitude in the PCC approach. Conversely, highly qualified staff might need to unlearn outdated practices that are informed by a more medical and functional approach to caregiving, if they are to embrace the PCC approach (Kitwood 1997).

In keeping with Brooker's (2007) VIPS framework, nursing staff who special older people in acute care settings should be treated as a valuable resource, and this treatment extends to providing them with targeted training and preparation for the role. Importantly, the focus of training and support should be on the positive interactions staff need to have with the older person. This training will need to focus specifically on developing the right attitude towards vulnerable older people and developing an appreciation of the value of the care they provide to the person and their family.

5.2.5. Staff not always trained or prepared to special older people

Study findings report specials' knowledge and skills deficits in understanding, recognising and responding to challenging behaviours of older people in their care and in particular, appropriate communication skills in these situations. These deficits were flagged by the focus group RNs but also noted on the QUIS and ERIC. Some specials were concerned that the older person in their care might fall and inadvertently, would restrict the patient's movements e.g. continually telling the older person to sit down, or trying to replace medical equipment such as oxygen masks without explanation. Due to the busy-ness of the wards some AINs failed to alert registered nurses for assistance when they needed it. For example, two of the AINs observed were new to the hospital and as it was their first time on the ward, they looked to the researcher/observer for guidance and support. In relation to Brooker's (2007) VIPS framework, these data suggest staff were unskilled in providing PCC to older people, mainly because they did not know these patients and what might be expected from them (V4), managing and reacting to patient behaviours rather than seeking to understand and act on what the older person may be trying to communicate (P1, P5), and a service which does not necessarily or consistently create a socially supportive environment for older people being specialled (S1, S2, S4).

Care provision for a person with cognitive impairment can be emotionally and physically intense (Brooker 2007). Caring for an older person in crisis with cognitive impairment is a specialist skill and inexperienced staff will require practical support and supervision in gaining these skills (Brooker & Latham 2016). Person-centred verbal and non-verbal communication skills are key to responding to and supporting the older

person with a cognitive impairment, who may not be able to communicate their preferences or needs in understandable ways (Brooker 2007). Staff need to validate an older person's feelings when expressing agitation or anxiety, which may be affected by past experiences, and support the person's emotional wellbeing by responding empathetically to their fears and anxieties. Sustaining positive interactions during care provision when patients express agitation and other difficult behaviours requires staff with not only the right attitude, but also specialised knowledge and skills. Staff who lack these requirements will feel anxious and ineffectual, which may give rise to even further behavioural responses in patents such as extreme agitation, verbal and/or physical preservation, and noncompliance with care or treatment (Kitwood 1997).

The specialling role is often unpopular due to staff anxiety about managing these challenging behaviours in older adults while endeavouring to provide PCC (Dewing 2013; Flynn et al. 2016). Misunderstandings around PCC and lack of PCC education and exposure are also barriers to staff practising PCC (Oppert et al. 2018). Moreover, untrained specials with no skills in PCC may be subjected to physical and verbal abuse from their specialled patients, making them feel vulnerable and undervalued in the role (Wilkes et al. 2010; Schoenfisch et al. 2015). With appropriate educational preparation, confidence and job satisfaction levels in undertaking specialling duties can improve, as can quality of care (Bateman et al. 2016; Flynn et al. 2016; Griffiths et al. 2013). A number of studies support the positive effects of PCC training on outcomes for older people. For example, Fossey et al's. (2006) evaluation of the effectiveness of a PCC training and support intervention for nursing home staff in reducing the proportion of residents with dementia who are prescribed neuroleptics found a significantly lower use of these drugs. Brooker et al. (2007) trained nursing home staff in a PCC activity program and found a significant increase in the number of positive staff interventions, along with a reduction in depression amongst the older people who participated in the study.

Ideally, the training of staff in PCC provision should include such pedagogies as experiential learning, continuing reflection and feedback from both positive and negative critical incidents (Kitwood 1997). In relation to PCC and older person specialling, suggested topics for inclusion are recognising and responding to delirium (see section 5.4.2.1), communication (5.4.2.2) and individual care planning (5.2.4.3).

Above all, and in keeping with Brooker's (2007) VIPS framework, training and development strategies must communicate to staff that supporting people with cognitive impairment is skilled and important work (Brooker & Latham 2016). They must emphasise that communication is key to providing effective support to older people who are specialled, including the importance of recognising, acknowledging and responding to the emotions of older people, and create a socially supportive environment (Brooker & Latham 2016). In fact, Oppert et al. (2018) claim that the entire VIPS framework can serve as a training model for PCC provision.

5.3. What essential care is required when specialling older people in acute care settings?

Most older people in this study were specialled for delirium. Despite evidence of the absence of a person-centred approach when specialling in the acute aged care wards, positive care and interactions were the most frequently reported descriptors. Quality specialling for older people was seen when staff who were familiar with the ward routine and procedures provided such care as bathing, toileting and giving medications, while engaging with the older person and providing reassurance and encouragement. The presence and engagement of the older person's family members, too, resulted in positive care and interactions, as did the presence of a number of personal possessions e.g., photos, grooming items, and diversional activities e.g., reading material, 'fiddle' mats in the person's environment. Poor quality specialling was seen when staff who were unfamiliar with the ward simply sat by the bedside and did not engage with the older person, engaged with the person's family members only, or remained detached from the patient while family members talked amongst themselves. These specials also tried to restrict the movements of older people and/or keep medical equipment such as oxygen masks in place, without explanation or reassurance. A 'hospital-like' clinical environment, characterised by the absence of personal items, was also noted in these situations. In overview, study findings suggest some essential care practices which could be further developed, honed and maintained to support a person-centred approach to specialling older people in acute care settings.

5.3.1. Recognising and responding to delirium

Study findings support delirium as the major indicator for commencing specialling of older people in acute aged care wards. These results are consistent with literature that also identifies delirium as the main reason for commencing specialling in these settings (Carr 2013; Dewing 2013; Wood et al. 2018). In fact, the older patient is at high risk of developing a delirium during an admission to hospital and has been estimated as great as 30% for people with an undiagnosed cognitive impairment or dementia (ACSQHC 2014). Whilst delirium is normally reversible, the symptoms can persist for prolonged periods and have permanent and serious consequences. Poor outcomes for patients with delirium include functional and cognitive decline, increased lengths of hospital stay, hospital acquired complications, institutionalisation and death (Inouye et al. 2014). Mortality rates are high, increasing by 11% for every additional 48 hours of active delirium (Witlox et al. 2010) and failure to detect delirium is associated with increased mortality following discharge (Ryan et al. 2013). Therefore, early recognition and management of both predisposing and precipitating risk factors for delirium in older people in acute care settings is vital.

Above all, the incidence of delirium is considered a quality indicator of inpatient care (Inouye 2006) and is linked with increased costs to the healthcare system and longer lengths of stay in hospital (Sockalingam et al. 2014). In Australian hospitals alone approximately 22,700 hospital-acquired episodes of delirium occur each year (ACSQHC 2018). Regular monitoring of behavioural/cognitive changes and clinical deterioration afforded by specialling is an important non-pharmacological intervention to reduce the incidence of delirium (ACSQHC 2018).

The ACSQHC outlines in their Delirium Clinical Care Standard (2018) that all hospitals should be working towards the reduction of the incidences of delirium occurring during admission. The aim is for clinicians to improve the early recognition of risk factors in older people and to development a comprehensive care plan, in partnership with family and carers and consistent with an individual's values (ACSQHC 2018). Comprehensive assessments and promotion of PCC are a way to achieve this aim (Lundstrom et al. 2005; Mudge et al. 2012). If a patient is assessed as requiring specialling, the opportunity arises for PCC needs to be met such as mobilising, toileting, hydration and

orientation strategies to reduce agitation or anxiety. Specialling gives the necessary time for staff to manage the risks associated with delirium such as physical injury including falls, seeking to leave the confines of the ward and pressure injury (ACSQHC 2018). The therapeutic potential of specialling is that the staff have the opportunity to engage one-on-one with the person experiencing delirium, in order that the person can make sense of and connect with the environment they are in (Dewing 2013).

Data collected in this study did not record the events leading to the person's delirium or the length of time that the older person had been experiencing the condition at the time of observation, however the nurses did flag that early recognition and response were important. This is consistent with Brooker's VIPS framework indicators (2007) I2 – regular reviews, where staff recognise and respond to change, and P4 – physical health needs, where staff are alert to, responsive to and are working to optimising peoples' physical health and wellbeing. However, Brooker's (2007) VIPS Framework indicators P1 – understanding how people with cognitive impairment communicate and responding skilfully and appropriately, and P5 – considering what people with cognitive impairment are trying to communicate through their behaviour and trying to understand the underlying reasons for it, were less obvious in relation to recognising and responding to delirium.

The nurse participants did not elaborate on their comments about "watching early signs before…behaviour escalates", "pre-empting what [older people] are going to do" and "understand[ing] the mechanism of what is relating to the falls" with any person-centred strategies for supporting older people experiencing delirium. They referred mainly to the difficulties with managing their workload while also maintaining supervision and safety of their patients. These findings suggest that some of the participants were less concerned with how to prevent agitated behaviours and how to make the person feel safe and comfortable; rather they placed blame on the patients for being confused. "Absconding" was a word frequently used in the focus group, which suggests that that they were focused on the physical aspects of older person care (i.e., trying to stop them from wandering off or leaving the ward), rather than acknowledging ways to support their patient's personhood and trying to understand the underlying reasons for this behaviour. What these participants failed to recognise is that 'absconding' is a symptom

of patient distress, illness, boredom or confusion and is not simply a feature of being 'difficult' (Kitwood 1997).

Staff need to recognise and acknowledge that behavioural changes in the older person can be symptomatic of deteriorating physical health and emotional distress (Brooker & Latham 2016). They should also be mindful that sensory impairments (e.g., visual and hearing) and older persons from a non-English speaking background can further impede communication pathways and alter the perspective of the person with cognitive impairment (Brooker & Latham 2016). According to Kitwood (1997) the symptoms of delirium where the person experiences a "clouding of consciousness" will heighten the behaviour of the older person with dementia (p. 33). Therefore, early recognition and management of the symptoms of delirium in older people in acute care settings is fundamental.

Nurses acknowledge that the acute hospital setting is multifaceted and challenging, and frequently vocalise the constant pressure of prioritising their time between patients with acute needs such as chest pain and high-risk patients with delirium (Ayton & O'Brien 2017). Many studies (e.g., ACSQHC 2016; Moyle et al. 2010; Portelli et al. 2016; Wilkes et al. 2010; Wood et al. 2018) recognise the unpredictable behaviours associated with delirium such as calling out, extreme agitation, wandering, exit seeking, and verbal/physical aggression as strong indicators for specialling to prevent accident, injury and patient adverse events. These behaviours can challenge nurses with the current staff to patient ratios when workload allocation may not factor in the additional care required by the delirious older person (Portelli et al. 2016).

While PCC was not evident in relation to recognising and responding to delirium, nurses did discuss the importance of remaining calm and creating a "safe space" for older people, suggesting that staff who special receive training in understanding the pathophysiology of delirium, how to communicate appropriately and how to provide positive care for older people experiencing this condition. So, perhaps the staff wanted to provide PCC, but were in need of training and support to provide the person-centred, therapeutic elements of specialling. When greater engagement with older people is promoted through education, special staff may view the role more positively and patient outcomes (e.g., nutrition and hydration, pain management, falls reduction, length of

stay) are improved (Ayton et al. 2017; Bateman et al. 2016; Flynn et al. 2016). In this way, elements of the VIPS framework e.g., valuing the older person and their staff, acknowledging the individual, and appreciating their unique perspective when they respond to their environments, are upheld (Brooker 2007).

5.3.2. Positive, PCC

In overview, of the 58 observations undertaken in the study, 45 were positive (77.5%). That said, there is still work to do to ensure that all occasions of care are person-centred. It is important to assess care practices regularly and make appropriate changes (Brooker 2007; Fazio et al. 2018).

Positive care practice (n = 25, 43.9%) was the most frequent descriptor observed in this study. These practices involved positive verbal interactions and the delivery of appropriate care between staff and the older people being specialled. Care provided included toileting, bathing, administration of medication and treatment. Positive social (n = 20, 35.1%) was the second most frequent type of interaction observed and comprised of positive interactions where productive staff-patient conversations and companionship took place in the care process. Objects in the older person's immediate environment that may have facilitated these interactions included family photographs, newspapers and other reading material, and personal grooming items such as hairbrushes and shaving equipment. The presence of patients' personal possessions is considered to be an important component of person-centred care, assisting older people with cognitive impairments to feel more comfortable and less agitated in unfamiliar environments such as hospitals (Brooker 2007).

According to Kitwood (1993) the prime objective of care is to maintain personhood in the face of deteriorating cognition. The QUIS (Dean et al. 1993) gives the opportunity to evaluate the actual process of care, opening up an opportunity for care review and quality improvement (Kitwood 1997). Staff being 'present' with the patient when giving care, free of any other distractions from outside that caregiving interaction, distinguishes positive care and positive social interactions (Kitwood 1997). This 'presence' is an absolute prerequisite of essential care practices and is the quality that

inspires positive interactions (Kitwood 1997). Furthermore, being truly present with the person opens up the types of interactions that skilled staff will incorporate into their care provision. As a counterpoint to the signs of 'malignant social psychology', Kitwood (1997) identified 12 person-centred interactions conducive to personhood and wellbeing. Termed "positive person work", these interactions comprise celebration, collaboration, creation, facilitation, giving, holding, negotiation, play, recognition, relaxation, timalation (i.e., stimulating the senses) and validation (p. 120). These interactions can all be enacted in acute care settings whilst specialling an older person.

One example of this interaction was when a special quietly and calmly provided encouragement and an explanation of care goals to the older person. Here the staff used Kitwood's (1997) positive interactions of negotiation and collaboration. Brooker's (2007) VIPS framework indicator of S1 – inclusion, where people are helped to feel part of what is going on around them is also evident in this interaction.

Another observation included a special brushing an older person's hair whilst engaging with her about her past occupation. In this interaction, the special simply picked up the patient's hairbrush from the locker and asked if she could brush her hair for her. The patient's husband had informed staff that she had been a dedicated schoolteacher for over 40 years, and so began a conversation about teaching. Prior to this interaction the older person was observed to be pacing, agitated and seeking a way to leave the confines of the ward. However, through positive communication and therapeutic touch a positive relationship evolved. The special valued the life story of this older person and showed empathy for her situation, using Kitwood's (1997) positive interactions of recognition, negotiation, collaboration, celebration and relaxation. Brooker's (2007) VIPS framework indicators of I3 – having favourite and important possessions around the older person (e.g., the hairbrush), I5 – knowing about and referencing a person's life story, and S3 – creating a warm and accepting atmosphere for the older person, were evident here.

Regular reorientation and reassurance, proving patients with cups of tea, mobilising them, providing oxygen therapy and cognition-stimulating activities, were also observed as positive care practices for specialled older people in this study. This also suggests the presence of positive VIPS framework indicators I6 – purposeful activity, engagement

and occupation, P4 – responding to physical health needs, and S1 – inclusion (Brooker 2007). These caregiving measures have proven to be effective in managing delirium-associated risks such as falls, increased lengths of hospital stay, institutionalisation and death (ACSQHC 2016; Kratz et al. 2015; Hshieh et al. 2015; Rape et al. 2015; Portelli et al. 2016; Schroeder 2016).

The presence of family members was also reported in the positive care category, providing evidence of Brooker's (2007) VIPS framework indicator of S7 – knowing about, welcoming and involving the people who are important to an older person. Family members and carers are viewed as an integral part of specialling, which is consistent with the 'Partnering with Consumers' standard of care for Australian acute care facilities (ACSQHC 2018). Flexible family rosters to encourage family/carers in assisting with the increased care needs associated with delirium (Tzeng et al. 2008) have been implemented with positive patient outcomes. Kitwood (1997) is also of the view that when families and staff "share the care" (p. 116), barriers between staff and care recipients are lowered, channels of communication develop, and attitudes towards staff from care recipients and their families are more positive. Family members and other caregivers are also pivotal in offsetting a person's memory fragmentation and continually replenishing their personhood (Fazio et al. 2018).

However, although not observed in this study, Worley et al. (2000) cautions that using family members to provide increased observations must be approached thoughtfully and in consultation with family members, as their relationship with the patient may cause them to underestimate the increased risks associated with delirium (Tzeng et al. 2007). Likewise, a family member could exacerbate familial conflict, or may not be at ease with balancing other family and employment commitments (Worley et al. 2000). In any case, when considering the presence of family members and loved ones for older people requiring specialling, recognising the importance of close relationships in promoting a patient's wellbeing is important (Brooker & Latham 2016).

5.3.3. Barriers to positive care provision

Despite the positive care reported, data recorded on the QUIS and ERIC also revealed details regarding negative staff-patient interactions. Of the 58 observations recorded, nine were recorded in either the neutral or the negative category (15.5%). These data endorsed the difficulties that can be encountered with the delivery of care during the specialling process and the factors that can alter the provision of that care. Four main factors were noted to influence care provision and often overlapped: the special's familiarity with the ward, overall patient acuity, busy-ness of the ward, and the patient's surroundings.

Negative care and neutral descriptors were observed when specials were unfamiliar with the ward environment and relatively unknown to the regular ward nursing staff. High patient acuity (i.e., a significant number of acutely ill or deteriorating patients) was an additional reoccurring feature that affected the engagement of regular staff on the ward with special staff. Closely linked to patient acuity at times (but not in all cases), ward busy-ness (e.g., short staffed, heavy workload) and a hospital-like environment (e.g., presence of medical devices, absence of personal possessions) also affected specialled older peoples' reactions to care. Both patient acuity and ward busy-ness were repeatedly aligned with the qualitative data on the QUIS and ERIC with Anger, Discomfort and Neutral descriptors. Anger and Anxiety were also seen when older people were tethered by medical devices such as oxygen masks, IV therapy, TED stockings and urinary catheters. In a number of these instances, regular ward RN presence was reduced because many patients on the ward were sick and/or workload was heavy.

The issues reported here are representative of the constraints of acute care settings, which largely focus on efficiency, throughput and curative care (Bail et al. 2015; Bail & Grealish 2016). This system is not set up to meet the complex care needs of older people (Bail et al. 2015), and indeed can be a source of great stress. Disorientation, confusion and agitation, including delirium, are often caused by the busy-ness of the hospital environment, with disruptions in daily routine and multiple bed moves (Koch et al. 2009; Duffield et al. 2009). Although they may be necessary to provide appropriate care, medical devices such as IV therapy, oxygen masks and urinary catheters make it difficult to provide positive care such as mobilisation. These devices can cause adverse

physical and emotional responses (Koch et al. 2009), are associated with increased rates of delirium and falls, and often remain in place far longer than needed (Mattison et al. 2013). Moreover, the absence of personal comforts in hospitals can undermine older peoples' identity, especially when they are experiencing cognitive impairment (Clissett et al. 2013).

Nurses working in acute care settings find it challenging to respond to older peoples' care needs and provide comprehensive care in a system which is cost-contained, with limited resources (e.g., time, staff, expertise) for addressing them (Gray-Siracusa et al. 2011). This has led to a 'rationing' of care where nurses who are required to multitask and continually reprioritise their time (Nobili et al. 2011) complete only those tasks which they deem to be necessary e.g., medication administration, taking vital signs, but omitting others such as mouth care, mobilisation, hydration and emotional support (Bail & Grealish 2016). Moreover, these constraints can lead to 'missed' care, where care tasks are completely omitted (Jones et al. 2015; Papastavrou et al. 2014). Rationing of nursing care, or missed care is likely to lead to further functional and cognitive decline in older patients, along with an increase in hospital-acquired complications (Bail & Grealish 2016).

In relation to Brooker's (2007) VIPS framework, the data reported here provide evidence that V2 – human resources, and V3 – management ethos were lacking in participating wards. Overworked, busy staff, struggling to deal with the demands of the job may have led to negative or neutral care, or obstructed staff from providing PCC. Kitwood (1997) warns that these situations can easily lead to burnout, suggesting that staff who are afforded little support or assistance in caring for people with a cognitive impairment, often exist in a chronic state of burnout. It is essential then, that organisations striving to provide PCC create an environment where staff feel supported and nurtured (Kitwood 1997).

AIN specials who were unfamiliar with the ward were observed to be reluctant to seek assistance when initiating care needs in response to the ward busy-ness and sparse resources. In these observation periods, specials were observed not to attempt to connect with, or be approached by, regular staff. Two of the AINs observed were new

to the hospital and as it was their first time on the ward, and they looked to the researcher/observer rather than the ward nurses for guidance and support. Negative care was also seen when staff, regardless of qualifications, were new to the ward (i.e., agency staff, casual pool). In this study, new staff were observed to be sitting alone while specialling. They were not engaging with others, including the patients, nor did regular staff approach them during their shifts to offer advice or support, or to seek information about the patient they were specialling.

Focus group RNs also expressed concern about the skills, experience and lack of support for staff undertaking the specialling role, and were worried about the impact of inexperienced staff on patient outcomes, the regular staff's workload and the special's personal safety. Staff often feel isolated when specialling due to a lack of support and understanding of how to give positive care to the older patient they were specialling (Dewing 2013; Wilkes et al. 2010). They also held concerns for the personal safety when they are subjected to physical and verbal abuse from patients with a cognitive impairment (Wilkes et al. 2010, Portelli et al. 2016).

The safety aspect of specialling is also discussed by Schoenfisch et al. (2015), who remark that a lack of research on the health and wellbeing of specialling staff is of concern when faced with challenging behaviour, such as resistance to care, in people with a cognitive impairment. This can be a barrier to providing PCC when specialling older people when specialling staff feel unprepared, uncomfortable and anxious about approaching such patients.

The scenarios described above may also be indicative of hospital constraints. However, they also suggest that Brooker's (2007) VIPS framework indicator V1 – vision, was missing. By sitting alone and not being approached by, or by not being provided the opportunity to engage with other staff, they were unaware of the overarching goals for care of older people on the acute aged care ward. These specials did not necessarily feel valued as a precious resource (V2) (Brooker 2007). This is concerning, because new staff in the study would not have necessarily been able to identify what action to take if they were worried that a patient's health was deteriorating. Further, they did not appear to be empowered to deliver PCC (V3), knowledgeable or skilled in its provision (V4) (Brooker 2007).

Brooker & Latham (2016) acknowledge the difficulties for hospital management in providing PCC, including the fine balance of meeting the needs of overworked staff, covering vacant shifts and orientating new staff to the ward. However, Kitwood (1997) advocates for teambuilding in providing PCC, suggesting that care in these situations is more than just a matter of "individuals attending to individuals" (p. 110), and that teams with shared visions and objectives for care should be created and sustained. He warns that neglecting teambuilding can lead to the formation of small cliques, which appears to have been the case in this study (Kitwood 1997). This risk here, is that these individuals may collude to avoid providing PCC (Kitwood 1997). To promote teams with a shared vision for PCC, new staff, including specials in acute care settings, require proper integration and induction into the ward team (Kitwood 1997). A team approach to specialling is a recommendation from this study and is discussed in 5.4.3.

5.4. Recommendations

Specialling of older people in the acute aged care wards in this study is characterised by an ad-hoc approach to initiating and discontinuing the practice. Specialling consisted largely of supervision and keeping patients safe, and it was sometimes carried out while caring for other people at the same time, particularly if the wards were busy, overall patient acuity on the ward was high, or if the staff member specialling was an RN. Staff allocated to special were not always the most appropriate, with new, unlicensed and/or inexperienced staff undertaking most of the specialling. In relation to Brooker's (2007) VIPS Framework, these results indicate a system that does not value its staff or acknowledge that specialling is skilled and important work, does not always support practices that acknowledge the individual lives or the personal perspective of older people who are specialled, or consider the importance of a socially supportive environment when specialling the older person in hospital.

Positive care and responses to specialling were observed, although these could be improved. Forty-five of the 58 observations (77.6%) undertaken in the study noted care and interactions that supported individual lives took into account the personal stories and uniqueness of each older person being specialled and engaged them in meaningful

activity and displayed warmth towards older people. However, a lack of communication skills, especially in situations of delirium and/or challenging behaviours, were evident.

These results highlight the absence of a person-centred approach to specialling in the acute care setting, and they suggest a lack of clarity and support for the specialling role. Consequently, three recommendations are proposed: the development of formal tools and/or care guidelines to inform specialling older people in acute care settings, targeted training and preparation for the specialling role, and fostering an inclusive, team approach to specialling in acute care settings.

5.4.1. Recommendation one: formal tools and/or care guidelines

A specific set of guidelines is needed to inform older person specialling in acute care settings. By way of introduction, these guidelines should: clearly set out the service's vision for providing person-centred specialling of older people in acute care settings; outline how specialling is initiated and ceased; the staff who are permitted to undertake specialling, both the mandatory and recommended training for all specials; where specialling should be conducted; what kind of workload support/relief the organisation will provide to support specialling; and the essential care practices for specialling older people in acute hospital settings. Quality assurance processes, aimed at knowing and acting upon the needs and concerns of the person being specialled, along with other stakeholders e.g., staff, families, are also an important part of person-centred specialling and should be outlined. A draft set of guidelines, a principle aim of this research, can be found at Appendix 3 and are discussed in Chapter Six.

5.4.1.1. Guidelines for initiating and discontinuing specialling

Administrative details such as outlining the person(s) responsible for initiating and discontinuing specialling, person(s) from whom permission is required to initiate specialling, a risk assessment checklist for the person responsible to complete, along with the frequency with which completion is required (e.g., on initiation, every 24 hours until cessation, alterations in patient's condition) should be included in a set of guidelines. As suggested by Spiva et al. (2012), an algorithm for all staff to follow which outlines the process to follow if staff consider a special is appropriate (e.g., who to contact, appropriate time frames for assessment, measures/care to be considered

while waiting for assessment) could also be included as part of the administrative processes for initiating and discontinuing specialling.

Above all, however, this process should ensure that the older person is always at the centre of care. Any documentation should include/confirm that consultation has been undertaken with the older person requiring specialling and/or their family members during this process.

Documentation should also include and confirm that the specialling process e.g., rationale, how it is conducted, care expectations has been fully explained to the patient and/or their family members and that they have the opportunities to ask questions about their care for the duration of specialling.

5.4.1.2. Guidelines for staff who special

Guidelines could make explicit exactly how staff are allocated or recruited for specialling, with a strong emphasis on the need to allocate staff who are appropriately trained, orientated and committed to providing PCC of older people. Qualifications of staff who are permitted to undertake specialling of older people in acute care settings should be clearly outlined, along with any specific training required e.g., mandatory in-service sessions, orientation (see 5.4.2). Services should decide if casual pool or agency staff are appropriate for specialling and, if deemed appropriate, the orientation requirements for these staff should be stipulated.

As specials' familiarity with the ward routine, pace and patient requirements is more likely to correlates with PCC provision and positive responses from older people to care during specialling, guidelines should emphasise the importance of including special staff in general ward handovers (see 5.4.3).

5.4.1.3. Guidelines for location of specialling

Guidelines should consider a clear location for specialling, aimed at creating a supportive and inclusive social and physical environment for the older person, and

based on an individual assessment of their hopes, fears, strengths and needs. For example, ward staff should be prompted to consider whether older people who are in need of specialling may benefit from being moved closer to the nurses' station, whether specialling can be undertaken in multiple bed bays, whether specialling is appropriate in side or single rooms and the conditions under which this may be required. An individual assessment should also include potential environmental factors and risks e.g., the need to reduce stimulation, the need to maintain social contact with others, infection risks, disturbances to other patients. In considering a person-centred model for specialling, guidelines should also outline whether cohorting of specialled patients is permissible, including the exact staff to patient ratios if cohorting is undertaken.

5.4.1.4. Guidelines for workload support

Concerns noted in the study results around how the specialling is conducted (i.e., one-to-one or cohorted) and the care often provided to patients in addition to those who are specialled suggest a lack of clarity and support for the specialling role (Wood et al. 2018). Ward RNs admitted that they often remained silent about an older person's need for specialling because of the detrimental impact on ward staffing, i.e., the special would be recruited from the existing staff allocation. This is supported by Dewing (2013), who affirms that hospital administrators are often reluctant to support specialling as the high costs of one-to-one staff are absorbed by, and adversely impact on ward budgets, or are identified mostly in terms of staffing costs per shift (Wood et al. 2018). However, there are other costs to consider in relation to specialling. Staff who feel assured that their patient to staff ratios will not be adversely affected by flagging the need for specialling are likely to experience increased job satisfaction (Portelli et al. 2016; Wood et al. 2018). This, in turn, may reduce the costs of both staff turnover, and also reduce costly adverse events (e.g., falls).

Consequently, there is a need for more organisational support for specialling in terms of workload relief. Guidelines that make explicit the workload support that is provided e.g., whether additional duties are expected, staff ratios etc. may serve to reduce costs through more stringent justification and closer monitoring of the process. A clear outline of how to escalate changes in acuity, concerns with impact on standard staffing should also be provided.

5.4.1.5. Guidelines for essential care practices

Guidelines should stress that older person specialling is underpinned by a person-centred approach. Some suggestions for positive care practices e.g., using 'My Story' (see section 5.4.2.2) to incorporate the person's important relationships and key events into their care, family rosters, diversional activities that are consistent with a person's preferences and encourage meaningful engagement could be given. Personal possessions and the creation of a less hospital-like environment should be supported in care guidelines. Personal belongings and meaningful objects are helpful conversation and activity starters, assisting both the nurse in reminding them of the uniqueness of each older patient, and the older person in feeling more included and valued as an individual (Clissett et al. 2013)

Other care considerations that may reduce physical injury e.g., moving the patient closer to the nurses' station, alarm cushions and Lo-lo beds, could also be listed in this section, along with a caution about weighing up the risks and benefits before burdening older patients with tethering devices, and alternatives e.g., IV fluid boluses should be considered (Mattison et al. 2013).

In summary, developing and enacting the set of formal tools and/or care guidelines proposed here (Appendix 3) is in keeping with Brooker's (2007) VIPS framework, in that they propose an overall vision for person-centred specialling (V1), support a system that values the staff that undertake the specialling role (V2, V3), advocate for a process which values the older person, their individual lives (I1, I2, I4, I5, I6), and appreciate the older person's personal perspective (P3, P4, P6). Moreover, quality assurance processes outlined in a set of guidelines ensure that acute care settings strive to improve their older person specialling practices (V6). The suggestions for these guidelines are also informed by Kitwood's (1997) guiding PCC principles of creating positive relationships with older people, respectful communication, acknowledging each person as unique, viewing the person's world from their perspective, and assisting in maintaining social connections to others. The guidelines are also consistent with Kitwood's (1997) positive person work, particularly collaboration, where partnerships

are fostered between health care professionals and the older person to assist them with their individual, person-centred activities of daily living.

5.4.2. Recommendation Two: targeted training and preparation

Tools or guidelines for specialling that outline a targeted program of training are needed (Portelli et al. 2016; Schroeder 2016). In addition to mandatory hospital training and orientation, topics for inclusion should include recognising and responding to altered cognition, e.g., dementia and delirium (Bateman et al. 2016; Flynn et al. 2016), and appropriate communication. The curriculum and pedagogies for training of specials should be underpinned by the need for care which acknowledges and preserves the personhood of the older person in hospital.

5.4.2.1. Training in recognising and responding to delirium

Given that delirium is the most common reason for specialling older people in hospitals (ACSQHC 2018; Portelli et al. 2016; Wood et al. 2018), which is also supported by this study's findings, training first needs to address the early recognition and ongoing assessment of delirium in these settings. In this way, the need for specialling may actually be reduced.

Nurses are apprehensive about maintaining patient safety and specialling has been acknowledged as a staff model to address these concerns and to avoid adverse events (Griffiths et al. 2013; Moyle et al 2010; Wilkes et al. 2010; Carr 2013; Dewing 2013; Kerr et al. 2013; Wood et al. 2018). Yet, many health professionals feel ill-prepared and lack confidence to care for older people with cognitive impairment (Travers et al. 2018; Griffiths et al. 2013). Consequently, training around how specialling should be conducted e.g., strategies to minimise harm to both patients and staff, the types of interactions that constitute positive and PCC for people experiencing delirium, might improve outcomes for older people and empower staff to competently undertake the role. Delirium training should focus on valuing the older person as an individual, positioning them at the centre of their care by seeking to understand the underlying causes of any behavioural changes. Other topics to be conveyed in training sessions for specials include extreme agitation and de-escalation strategies (Bateman et al. 2016; Flynn et al. 2016; McPhail et al. 2009); gentle mobilisation and diversional activities

(Ayton et al. 2017; Bateman et al. 2016; Flynn et al. 2016), and appropriate pain management (Achterberg et al. 2013).

5.4.2.2. Communication training

Communication skills are also vitally important when specialling the older person. Meaningful communication with older people who live with a cognitive impairment (temporary or ongoing) can be challenging from the perspectives of both the older person in making their needs known, and staff in terms of conveying information to patients (Griffiths et al. 2013). Obtaining the cooperation and consent of older people in these situations is also an area where health professionals feel they lack skills (Griffiths et al. 2013). Therefore, specialised, person-centred strategies for communicating with people with cognitive impairment should be included as part of targeted training and preparation for older person specialling. Content could include how best to provide emotional support and reassurance to reduce patients' uncertainty and fear (Ayton et al. 2017; Bateman et al. 2016; Flynn et al. 2016; Griffiths et al. 2013), communication skills for preventing or reducing aggression (Griffiths et al. 2013) and strategies for communicating calmly and reassuringly to patients during clinical procedures (Griffiths et al. 2013). The importance of non-verbal communication in these situations should also be emphasised (Griffiths et al. 2013).

5.4.2.3. Nurse-carer communication tools: 'my life story'

Tools that document a person's life story may improve the quality and safety of care for older people with cognitive impairment being specialled in hospital (Luxford et al. 2015). Use of these tools are an important way of increasing engagement with families and carers to obtain the unique personal story of the person and to build rapport with family members. The documented 'stories' are then used to mutually develop personalised, non-clinical tips and care strategies to aid communication and support PCC. Kept at the bedside, using and integrating these stories addressed some of the inadequacies of clinical handovers for conveying such information, and provides more of a personalised, rather than medical, background about the older person (Luxford et al. 2015). Communication with family members in developing the person's life story

and key ways of supporting their needs, may also serve the purpose of getting families more involved in care delivery and monitoring.

The NSW Clinical Excellence Commission's (CEC) 'TOP 5' (T: Talk to the Carer; O: Obtain the Information; P: Personalise the Care; 5: Five strategies developed) is an example of one such life story which has improved both the family and clinician experience of care for people with cognitive impairment in acute hospital settings (Luxford et al. 2015). A study that asked 798 clinicians and 240 carers across 21 Australian hospitals about their experiences with the introduction of the TOP 5 found that patients recovered at faster rates, and their agitation and distress was reduced, along with the need to actually initiate specialling (Luxford et al. 2015). Staff confidence in caring for people with dementia also improved with the use of TOP 5, along with their ability to communicate effectively with both the person and their family (Luxford et al. 2015). Moreover, TOP 5 increased the confidence of carers with the care being provided, as they considered that staff listened and took notice of the personalised information provided to them, and actually implemented the tips provided (Luxford et al. 2015).

In summary, providing targeted training and preparation for staff who special older people in acute care settings is in keeping with Brooker's (2007) VIPS framework, in that it acknowledges specialling as skilled and important work and demonstrates to staff that they are a precious resource in undertaking the specialling role (V4). More specifically, information conveyed in training sessions seeks to improve the skills of staff in communicating with people with cognitive impairment (P1, P2, P5) (Brooker 2007). The importance of creating a supportive and inclusive acute care setting is also emphasised in the recommended training (V5), which extends to acknowledging individual preferences (I4), viewing personal possessions as an integral part of care (I3), and ensuring that the acute care settings facilitates meaningful social interactions (S1 – S6) (Brooker 2007). Targeted training around PCC may also work to negate some of Kitwood's (1997) "malignant social psychology" (p. 3), by emphasising the poor outcomes associated with older people who are labelled, stigmatised, deceived, disempowered, objectified or ignored in hospital settings (p. 3). As a counterpoint, Kitwood's (1997) positive person work of celebration, collaboration, creation, facilitation, giving, holding, negotiation, play, recognition, relaxation, timalation (i.e.,

stimulating the senses) and validation can be highlighted during training as effective interactions between staff and older people being specialled.

5.4.3. Recommendation Three: a team approach to specialling

Study results suggest that a more inclusive, team approach to care could be taken when specialling older people in acute care settings. In all observations related to positive care and positive social interactions, the specials were familiar with the ward. Similarly, the positive responses of the older people to care when specialled e.g., pleasure, affection, helpfulness were observed when that care was provided by a staff member who was familiar with the ward and its routine, policies, procedures, patients and staff.

The National Institute for Health and Clinical Excellence (NICE) has published guidelines for delirium care (O'Mahony et al. 2011) which encourage a multidisciplinary team approach to care of patients experiencing delirium. In Griffiths et al's (2013) study of preparedness to care for confused older patients, a team approach, which included knowledge of the availability and role of colleagues in the hospital who could provide support when staff felt out of their depth was important. Team members should include health professionals trained in delirium management (Sockalingham et al. 2014) and dementia (McPhail et al. 2009; Travers et al. 2018). These health professionals could be nurses, allied health personnel e.g., diversional therapists, social workers, physiotherapists, occupational therapists, and medical officers, all with specialised knowledge of older people and the common conditions for which they require specialling e.g., delirium, cognitive impairment (Traynor et al. 2018). As discussed previously, family members are also an integral part of a team approach (ACSQHC 2018; Tzeng et al. 2008).

A multidisciplinary team approach is considered to positively impact on PCC (Brooker 2007; Kitwood 1993; 1997), by providing opportunities for all parties involved to share in problem solving. For example, Adams & Kaplow's (2013) team approach recommends regular 'safety huddles' of approximately five to ten minutes, to identify patients with safety risks and advocate for appropriate PCC interventions. Regular multidisciplinary team meetings are highly valued (Griffiths et al. 2013). Central

computerised information systems have also been suggested as a means of facilitating a multidisciplinary team approach to care of older people with cognitive impairment (Griffiths et al. 2013).

Staff who feel part of the team and have a shared philosophical mindset for their work are more likely to provide positive patient care, which is linked to an overall increase in patient safety, reduction in errors and reduced patient mortality (Polis et al. 2017). Moreover, confidence and job satisfaction can also increase when specials feel part of the ward team and confident in making approaches to members of the team for support (Ayton et al. 2017; Bateman et al. 2016; Flynn et al. 2016). Teamwork in this instance involves special staff taking part in standardised orientation and training for the role (Polis et al. 2017), being familiarised with ward policies and procedures (Bateman et al. 2016), being encouraged to communicate openly with ward staff, both informally and formally (e.g., involvement in clinical handover) and feeling as though they have the back-up of others on the ward (Polis et al. 2017). These kinds of interventions are also likely to better facilitate knowledge of patients and their families, and how to deliver PCC (Flynn et al. 2016). The caring experience can, therefore, be improved by encouraging meaningful interactions with patients and families.

In summary, adopting a team approach to older person specialling in acute care settings is consistent with Brooker's (2007) VIPS framework, in that it reinforces a person-centred vision for care of the older person (V1). The team approach also demonstrates to staff that they are valued (V2) and empowers, supports and develops them to deliver PCC (V3, V4)) (Brooker 2007). A team may be better able to recognise and respond to individual change (I2), facilitate effective communication between team members, families and care recipients (P1, P5), advocate on behalf of older peoples (P6) and foster meaningful social interactions (S1, S2, S4, S5 S6, S7). The team approach is also supported by Kitwood (1997), who states that teams with united values are essential for PCC. Kitwood's (1997) positive person work, particularly recognition (i.e., knowing and greeting the person by their preferred name), holding (i.e. creating a safe space), collaboration and facilitation (i.e., focusing on strengths and enablement), may also be evident in a team approach to specialling where partnerships are fostered between health care professionals and the older person to assist them with their individual, person-centred activities of daily living.

5.5. Study Limitations

5.5.1. Literature review limitations

Due to the diverse nature of the literature reviewed for this study a quality appraisal tool was not used. However, there was no critique of the various methodologies used, meaning that the extent to which findings are useful is difficult to determine. Articles were limited by date of publication, so articles published April 2018 onwards were not included in the review. Although multiple broad search terms were used, it is possible that articles referring to specialling older people using other terms were missed. Articles were also excluded by language, so the review may have missed potentially important contributions to the topic of specialling.

5.5.2. Phase One limitations

The nature of qualitative description creates limitations in the scale, scope and transferability of the focus group interview findings (Sandelowski 2000). While the original intention was to obtain qualitative data from nurses with varying qualifications in several focus groups, due to time constraints and heavy nursing workloads this was scaled back to one interview with permanent ward RNs. These constraints have been previously reported as challenges in nursing research (Weierbach et al. 2010). For these reasons also, participant and site selection were non-random and based on convenience. As it turned out, all focus group participants were relatively experienced RNs. Still, the mix of seniority/positions within the group (e.g., CNS, CNE, former NUM) potentially means that they may have been reluctant to voice their views (Fusch & Ness 2015). Despite conducting most of the specialling, focus group data were not collected from AINs. There is also a lack of data from nurse managers or others responsible for existing policy or regulation related to specialling. Moreover, as foreshadowed in Chapter Three, a regrettable limitation of this phase is the absence of explicit questions about the PCC approach to specialling within the focus group questions.

All of these factors potentially limit the study in voice, time and location, and may not reveal the full extent of the issues faced by nurses when specialling older people in acute care settings. Moreover, the explicit views of the nurses on PCC for older people,

including the challenges and constraints associated with its provision in acute hospital settings are also not fully known from this study. Even so, LeCompte & Goetz (1982) suggest that while findings from these kinds of studies may be limited, they are still valuable and informative. The conclusions drawn here represent only one experience – a 'snapshot' which, when combined with further research, might contribute to a holistic picture of the issue (Fusch & Ness 2015; LeCompte & Goetz 1982). In essence, the findings from this first phase should be viewed as tentative and exploratory.

5.5.3. Phase Two limitations

The way in which the patient participants were approached may be considered a limitation of the study. Ideally, a completely detached third-party approach to participants is preferable. However, because the observations occurred on a variety of shifts (including nights) and also because of the general busy-ness of the hospital wards during the period of observation, such a third party e.g., a ward clerk was not available and potential participants were approached by another nurse. To completely allay any concerns about coercion, future studies of this nature could consider a research assistant or volunteer to approach and consent patient participants.

The small convenience sample of older patients (n = 12) and study sites (n=4 wards) limit the generalisability of the Phase Two findings, even though this patient cohort and study setting are reflective of the care requirements of older people who require specialling in acute care setting. In view of the small sample, piloting and honing of the data collection tools ensured that comprehensive data were collected from each participant.

The findings are also limited by the very small number of observations undertaken (n = 58) and the short observation timeframes. Usually, observations using the QUIS (Dean et al. 1993) and ERIC (Fleming 2005) tools are recorded over longer periods of time, up to 8-10 hours of observation per individual undertaken over 3-4-hour periods at different times from 7.00am till 9.00pm (Chenoweth et al. 2014). Consequently, the less-than-usual number of observation time-frames and periods may not adequately reflect the full nature of the care interactions and responses that occurred.

The findings here also represent only one observer's (student researcher) perspective, whose perspectives on the requirements of older people specialling are no doubt biased on account of her extensive aged care nursing experience. Participating nurses may have changed their specialling practices because they were being observed by an expert aged care nurse, which is likely to have compromised the external validity of the study (Norman & Streiner 2008). The student researcher assumed the role of aspirant-participant when obtaining observational data described by Stenhouse (1988) as a situation where the observer is "seeking to achieve acceptance in an unusual participant role such as researcher" (p. 51). It was clear to the study participants that they were being observed, even though the student researcher played an active part by working alongside the staff if needed. In fact, staff appeared to welcome the assistance and support that an additional expert nurse could potentially provide. The use of validated observation tools i.e., the QUIS (Dean et al. 1993) and the ERIC (Fleming 2005) were intended to minimise these biases, and considering that a range of positive, negative and neutral interactions and responses were observed suggests that the results reflect routine older person specialling in the participant cohort. Nevertheless, as with Phase One data, the results of this second study phase should be viewed as tentative and exploratory.

5.6. Conclusion

In conclusion, constraints on the acute care setting such as a focus on throughput and efficiency, and a lack of clarification for various aspects of the specialling role have resulted in an ethos which, for the most part, supports a technical, custodial approach to older person specialling. A focus on physical care and 'managing' the deficits associated with cognitive impairment may have influenced the relationships between the older person being specialled and the staff member, resulting in a set of functional, task-driven care practices (Coyle & Williams 2001) which diminish personhood (Kitwood 1997). These practices may have also been in part due to the experience of staff allocated to special and their familiarity with the ward.

In order to improve outcomes for older people being specialled in acute care settings, a person-centred approach is needed. Rather than simply meeting the demands of the health care service, specialling must, above all, support personhood by paying equal

attention to the person's psychosocial and physical care needs (McCormack & McCance 2006). This approach firmly places the uniqueness of each person at the centre of care, "…respectful of what they have accomplished and compassionate to what they have endured…emphasis[ing] the fact that our existence is essentially social' (Kitwood 1997, p.135).

Brooker's (2007) VIPS framework serves as a useful tool for evaluating systems-wide PCC. In this study, some of the VIPS indicators were adhered to, while others were negatively noted (see Table 4.9). In order for older people to receive person-centred care when specialled, a set of formal tools and guidelines for staff are needed. These tools should clearly outline a program of targeted training and preparation and support a team approach to specialling in acute care settings. The following chapter provides a conclusion to the thesis, which includes suggestions for further research for gaining more understanding and insight into the essential care for older person specialling in acute care settings.

6. Conclusion

6.1. Chapter introduction

This chapter draws the thesis to a close by first, recapping the study background, aims and guiding questions. Key findings are then revisited, along with an outline of the significance and impact of the research. Recommendations for practice are recapped briefly, followed by a discussion of how the results of this study have informed my own practice. Finally, suggestions for further research are also proposed and then a brief, overall conclusion section is provided.

6.2. Study background, aims and questions revisited

This study aimed to examine specialling of older people in acute care settings and inform the development of a set of evidence-based care guidelines for specialling older people in these settings.

People over 65 years of age are now the major consumers of acute health services (AIHW 2017). Older peoples' multiple co-morbidities, associated poly-pharmacy and complexity make them susceptible to complications and adverse events (e.g., urinary tract infections, falls, pressure injuries, pneumonia, delirium) during hospitalisation (Bail et al. 2015; Portelli et al. 2016), the incidences of which are increased for older people with cognitive impairment (Bail & Grealish 2016). Specialling has been acknowledged as a model to reduce this susceptibility and to avoid adverse events (Griffiths et al. 2013; Moyle et al 2010; Wilkes et al. 2010; Carr 2013; Dewing 2013; Kerr et al. 2013; Wood et al. 2018).

Specialling an older person in the acute care setting lies within a multifaceted and complex context. Constraints in acute care settings such as a prevailing focus on efficiency, throughput and care pathways for single conditions (Bail & Grealish 2016), and the prioritisation of curative and acute care over non-technical care have resulted in a system and models of care that do not meet the complex and holistic needs of the older person (Bail et al. 2015; Dewing & Dijk 2016; Jackson et al. 2017), including

specialling. Nurses find it difficult to meet the care needs of older people while working within the constraints of the acute care setting (Gray-Siracusa et al. 2011). Moreover, they often feel ill-prepared and lack confidence to care for older people with acute or pre-existing cognitive impairments (Travers et al. 2018; Griffiths et al. 2013). These challenges are compounded by a lack of guidelines and procedures for specialling the older person in hospital and there are considerably varying expectations of the role, including what constitutes positive, PCC for hospitalised older people.

Consequently, in examining specialling of older people in acute care settings and informing the development of a set of evidence-based care guidelines for specialling older people, this study set out to answer two questions:

1. What characterises older person specialling in the acute care setting?
2. What essential care is required when specialling older people in acute care settings?

A concurrent mixed methods design was adopted for this study, where both the quantitative and qualitative phases were predetermined and planned at the onset of the research process. This design provided a depth of findings that would not have been achievable with the sole use of either qualitative or quantitative methods – the findings of one phase were not dependent on the results of another (Creswell & Plano Clark 2011). While most mixed method researchers strive for congruency between quantitative and qualitative findings, it is proposed that divergent findings can uncover new insights (Creswell et al. 2008). With this in mind, the results of the quantitative and qualitative components were not consolidated at the data interpretation stage until both sets of data had been analysed separately. Research design, methodology and procedures were informed by the conceptual framework of Kitwood's (1993) SPTPD, and Brooker's (2007) VIPS framework for evaluating PCC at the systems level was used to analyse the study results.

6.3. Key results

All patients in this study were specialled due to delirium and/or falls risks. The majority of this work was undertaken by AINs. Good quality specialling, evidenced by patients' smiling, pleasure, affection and/or helpfulness was observed when staff engaged with older people, providing companionship through conversation, reading, walking, while

also providing reassurance and reorientation. Therapeutic touch, including assistance with personal hygiene and grooming was also considered to be part of essential care when specialling older people in acute care settings. These activities were enabled by the proximity of personal items such as reading material and personal grooming items, and family members.

Poor quality specialling, evidenced by neutral or negative interactions and responses was seen when staff tried to prevent older people from removing medical devices, restrict them to bed, or ignored/did not engage with the patients at all. Some special staff were more focused on providing the physical aspects of care (i.e., trying to stop older people from wandering off or leaving the ward), rather than acknowledging personhood, trying to understand the underlying reasons for challenging behaviours and making the person feel safe and comfortable). Poor quality specialling was influenced by the busy-ness of the ward, the overall acuity of patients on the wards, the familiarity of the special with the ward and the need for the special to undertake additional duties for other patients whilst specialling. In a number of cases, the absence of personal items, presence of medical equipment, and non-engaged family members were also observed in association with poor quality specialling.

6.4. Recommendations

Three specific recommendations have emerged from this study: (a) formal tools and guidelines to support the process of older patient specialling; (b) targeted training and preparation for the specialling role; and (c) the need for a team approach to specialling. Each of these recommendations are firmly grounded in a PCC approach, and together, are proposed to meet each of the indicators of Brooker's (2007) VIPS framework. The recommendations have also been developed with a view to negating Kitwood's (1997) "malignant social psychology" (p. 3), through his "positive person work" (p. 120).

6.5. Significance and impact of the research

This research has the potential to significantly improve nursing care and health outcomes for older people being specialled. It complements the existing body of

evidence on older person specialling and addresses a knowledge gap on the specialling of older patients in acute hospital settings. The research reports on what is required to ensure a positive person-centred experience for older people who are specialled in acute hospital wards.

Results from this research will be used to change the practice in my own acute aged care setting, and hopefully across the local health district. The results are currently informing the development of a set of care guidelines for older person specialling in acute hospital wards (see Appendix 3). Some content for these guidelines includes the process for initiating and ceasing specialling, the staffing/workload allocation for specialling and the required qualifications and experience of those who are allocated to special. The guidelines also make recommendations for a targeted training program for all staff who are required to special older patients in the acute aged care wards.

6.6. Moving forward: draft care guidelines

Undertaking this study has informed my own practice and helped me to move forward with transforming specialling practices to a person-centred approach. A principal aim of this study was to develop a set of evidence-based care guidelines for older person specialling in acute care settings. The three recommendations proposed from this study: formal tools and guidelines, targeted training and preparation, and a team approach to older person specialling have all been incorporated into a draft guidelines document which can be found at Appendix 3. This document is set out in sections: an introduction to older person specialling, the purpose of the guidelines, followed by specific sections on initiating and ceasing specialling, staff, training, environment, care considerations, and related policies/documents. Key content for each of these sections is suggested. Work underway or already completed in relation to these guidelines is detailed, and action items to ensure that they continue to progress beyond this program of study are stated.

At the time of preparing this chapter, I can report that I remain actively involved in the development and refinement of these guidelines, and improving the experience of older person specialling in acute care settings in general, through a number of channels both internal and external to the hospital. Within the hospital, I am a member of a formal working party set up to provide feedback on these draft guidelines and on older person

specialling in general. I have also made recommendations to the hospital's Clinical Practice Committee, Quality Improvement Committee and Centre for Education and Workforce Development to ensure that implementing guidelines for essential care practices for older person specialling remain at the forefront of the hospital's agenda for improving patient care. More informally within the hospital, I liaise regularly with senior clinicians on the acute aged care wards regarding upskilling their staff in specialling older patients and improving the handover process for specialled older people.

External to the hospital, I participated in the early stages of the development and review of draft care guidelines for patients with delirium and specialling in general by the New South Wales Agency for Clinical Innovation (ACI) and on completion of this thesis plan to renew this participation to ensure that older people are given appropriate focus. I have also been involved in the wider local health district's review of a general specialling specially to ensure that it meets needs of older patients in acute care wards and includes principles of PCC. It is anticipated that these external activities will further inform the development of my care guidelines. In summary, I plan to continue this work to ensure a demonstrable and positive output from my research.

6.7. Suggestions for future research

The conclusions drawn from this mixed methods study represent only one experience – a 'snapshot' of older person specialling. However, when combined with further research, they might contribute to a holistic picture of the issue (LeCompte & Goetz 1982). Consequently, much more research is needed into specialling older people in acute care settings.

As there are many different conceptions of PCC in acute hospital settings (Delaney 2018; Grealish et al. 2018; Kogan et al. 2016), it would be useful to evaluate the implementation of one model. Brooker's (2007) VIPS framework, for example, used as an evaluative framework in this study, could be used to inform and then evaluate facility and staff practices around PCC.

6.7.1. Alternative focuses

This study focused on the characteristics and essential care practices for older person specialling. This area is worthy of more extensive research however, there are other areas that have emerged from this study which are also in need of closer scrutiny.

6.7.1.1. Improving care and patient outcomes

In view of an ageing population (AIHW 2017) and increasing incidence of delirium (ACSQHC 2016) more overall research in this area is needed. There is some research in terms of specialling for falls prevention (e.g., Boswell et al. 2001; Donoghue et al. 2005; Giles et al. 2006) and specialling for cost reduction (e.g., Harding 2010). However, more is needed on the patient and family's experience of care provided during specialling, and kinds of outcomes (e.g., health outcomes, financial implications) that may be seen with various experiences. Short and long-term patient outcomes from specialling could also be measured (e.g., length of stay, morbidity and mortality). A stronger case for PCC of older people in acute care settings needs to be made through research in this area.

6.7.1.2. Staff

In terms of staff who special, characteristics of the staff member could be explored in terms of whether the staff member is the most appropriate for the role, staff views and patients' experiences in relation to the gender of the staff member undertaking the specialling. Given that older people may be specialled by inexperienced or unlicensed staff members, and also may be prone to challenging or aggressive behaviours, health and safety outcomes for staff who special could be investigated. Results from this study also propose that specialling is best undertaken by staff who are included as part of the ward team. Therefore, more work is required to establish the most effective team approach to older person specialling in acute care settings.

6.7.1.3. Environment

Studies which specifically compare specialling types e.g., one-to-one vs. cohorting, comparisons of nurse specialling with alternatives e.g., technology, closed monitoring, beds etc., may also provide more insight into care practices, patient outcomes and the

financial implications of older patient specialling. The best location for specialling e.g., single rooms, special monitored rooms, multiple-bed bays could also be studied.

6.7.2. Different methodological approaches

Even though the patient cohort and setting for this study are reflective of the care requirements of older people who require specialling in acute care settings, future studies could involve larger cohorts of older patients in an effort to produce more reliable and generalisable results. The QUIS and ERIC were considered to be valuable tools in this study and could be used in other studies of older patient specialling. However, in keeping with other studies (e.g., Chenoweth et al. 2014) longer timeframes for observation of individual patients over several different shifts may provide more comprehensive data. Comparative analyses (e.g., of specialling practices, patient outcomes costs) in different hospitals could be considered. In terms of staff, more surveys, interviews and observations of all staff involved in specialling may also provide more insight.

6.8. Conclusion

This study aimed to examine specialling practices for hospitalised older people in acute aged care wards, with a view to developing a set of evidence-based care guidelines to support this practice. The study is grounded firmly in the principles of PCC (Brooker 2007; Kitwood 1993; 1997). To the best of my knowledge, this is the first study designed to observe the actual care practices involved in the process of specialling older people in acute care settings.

This research intends to complement the existing body of knowledge on older patient specialling and specifically address a gap on specialling in acute care settings. Findings are currently being used to change practice in my own clinical setting, with a view to implementing positive changes across the health district. Ultimately, this study is intended to ensure a positive person-centred experience for older patients who are specialled in acute hospital wards.

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Appendix 1: List of included articles about specialling

Citation/ country	Article type	'Specialling' terms/ description	Sample/setting	Study Aim	Study Design/Methods	Findings	PCC (according to Kitwood's [1997] guiding principles)
Adams & Kaplow (2013) USA	Report	'Sitter': direct observation	General hospital	To reduce sitter use by 50% in 1 year	Hospital database examined by a subgroup of experts as to why sitters had been used; patient outcomes	Decreased sitter use without impact on patient falls Alternatives to specialling implemented e.g., rehabilitation companion, day rooms, with therapeutic cognitive stimulation activities.	**Yes** – study emphasised principles 2, 4 and 5, e.g., safety huddles held by staff to identify patients at risk. Environmental changes were made to enhance patient's social environment whilst in hospital. A subcommittee was set up for communication between patients and carers including regular feedback of on improving care
Blumenfiel d et al. (2000) USA	Empirical study	'Constant observation': one-to-one monitoring	620 bed general hospital All patients (n =119) who required specialling during a 9-month period	To identify patient factors and costs associated with specialling	Retrospective chart review using 127-item data collection form	Patients with a diagnosis of dementia and delirium were the largest category of patients who required specialling Disorientation, psychiatric medication, and alcohol withdrawal were the predictors of the need for specialling	**No –** only identifies the characteristics of older people who may require specialling

Citation/ country	Article type	'Specialling' terms/ description	Sample/setting	Study Aim	Study Design/Methods	Findings	PCC (according to Kitwood's [1997] guiding principles)
						The use of intensive psychotherapeutic intervention and psychosocial interaction with the patient's family were proposed as approaches that may reduce the need for specialling Specialling a costly practice	
Boswell et al. (2001) USA	Empirical study	'Sitter': staff in close proximity to assist patients from falling and to respond to patient's needs	641 bed general hospital. Inpatients from 7 medical/ surgical units (critical care, obstetric, psychiatric units excluded) – study spanned 21months .	To investigate the costs and benefits of specialling in relation to patient falls and patient satisfaction	Retrospective study design using routinely collected patient data	Falls did not decrease. Patient satisfaction improved, although this data not separated from non-specialled patients as researchers wanted to take into account effect of sitters on whole hospital environment. Specialling may be perceived as a higher level of nursing care = increased patient satisfaction = increased revenue.	**Yes –** study referred to principles 1 and 2, e.g., patient and carer feedback was obtained in regards to care to individualise care plans

Citation/ country	Article type	'Specialling' terms/ description	Sample/setting	Study Aim	Study Design/Methods	Findings	PCC (according to Kitwood's [1997] guiding principles)
Carr (2013) Canada	Literature review	'Sitter': unregistered staff, one-to-one care	N/A	Review of effectiveness of sitters as part of management of patient with delirium	N/A	Evidence to support sitters in the management plan of a patient with delirium Most cost-effective sitters would be volunteers Guidelines required to provide safe and effective care Minimal evidence of patient outcomes Strong evidence only from the use of fully trained sitter in multi interventional program	**No -** evaluating the effectiveness of specialling staff only no reference given to the type of care given to the older person
Dewing (2013) UK	Literature review	'Special Observation' ; 'Constant observation': one-to-one staff	N/A	Review of research on special observation on the older patient.	N/A	Most studies related to mental health facilities Variance in the use of the terms to describe specialling the older person with dementia and or delirium	**Yes –** literature review concentrates on absence of Kitwood's (1997) PCC guiding principles in the literature reviewed
Dick et al. (2009) New Zealand	Empirical study	'Specialling': one-to-one care by special or care assistant	General hospital. All patients admitted to five acute medical/ surgical wards over 12 months who were	Determine the effectiveness of an education program for staff aimed at reducing incidence and	Retrospective study of patient documentation data taken pre and post education sessions. Data collected	Mean age of patients requiring specialling = 71 years Reduction in incidence and duration of specialling	**No** – concentrates on the education of the specialling staff with reference to PCC

Citation/ country	Article type	'Specialling' terms/ description	Sample/setting	Study Aim	Study Design/Methods	Findings	PCC (according to Kitwood's [1997] guiding principles)
			specialled (n = 449)	costs of specialling	from two forms in use – specialling request form and record of number of hours of specialling required form	Reduction in hospital costs Patient outcomes e.g., incidence of falls data not collected.	
Donoghue et al. (2005) Australia	Empirical study	'Companion observers': volunteers trained in close monitoring and supervision; non-nursing duties	Aged care ward, general hospital, A total of 128 companion-observer volunteers were recruited	Investigate the impact of specialling done by volunteers on the rate of falls	Prospective descriptive study of recorded falls incidents before and after the volunteer companion-observer intervention	Falls rate decreased by 44% Using volunteers is an effective strategy to reduce falls in hospitalised patients admitted in an acute aged care ward.	**Yes** – use of volunteers in specialling role incorporating all five guiding principles when giving care.
Feil & Wallace (2014) USA	Service improvement	'Sitter': one-to-one direct and constant observation	N/A	N/A	N/A	Reports a strong correlation between sitter programs and reduction in falls	**No** – evaluated specialling to reduce falls in the older person only
Giles et al. (2006) Australia	Empirical study	'Volunteer': unpaid staff providing care assistance	General hospital, Australia. Two 4-bedded rooms within two identical medical wards.	Examine the effectiveness of volunteer companions to prevent falls among older patients in hospital	Falls incidents compared over three months pre and post introduction of volunteers	No falls occurred in the rooms where volunteers were present. Volunteers can play an important role in reducing falls in the older patient	**Yes** – Volunteers used as companions encouraged to engage patients in social interactions/therapeutic activities/assisting the patient and diversional activities. Included all five principles

Citation/ country	Article type	'Specialling' terms/ description	Sample/setting	Study Aim	Study Design/Methods	Findings	PCC (according to Kitwood's [1997] guiding principles)
						Cost effective to the hospital.	
Goldberg (1990) USA.	Empirical study	'Observational assistants'; 'sitters', 'constant observers': provide one-to-one direct observation to prevent patient from harm, may/may not provide nursing care	179 bed general hospital. 80 adult patients' charts randomly selected out of 415 patients who had been specialled in the last 12-month period	Identify indicators for specialling. Inform health policy and management	Retrospective data collection of patients' charts who had been specialled over a 12-month period: diagnosis, length of stay, demographics, indication for specialling.	58% of specialled patients were male; mean age 46.3yrs Delirium (51%) and agitation (26%) main indications for specialling, usually no past psychiatric history Medical wards had a higher proportion of patients specialled compared to surgical wards. Average duration of specialling 3.8 days Use of physical restraints common in management of older patients with agitated behaviour. Possibility of cohorting patients with one special discussed	**No** – *NB this study is prior to the publication of Kitwood's SPTPD (1993) and principles of PCC (1997).
Harding	Service	'Sitters':	General	Measure sitter	Quantitative data	Sitters	**No –** concentrates on the

Citation/ country	Article type	'Specialling' terms/ description	Sample/setting	Study Aim	Study Design/Methods	Findings	PCC (according to Kitwood's [1997] guiding principles)
(2010) USA	improvement	agency staff who constantly monitor patients at high risk of falling	hospital.	effectiveness in terms of patient outcomes. Trial use of an assessment tool for initiating specialling. Identify categories of patients at risk	collected on hours of sitter use and financial cost to the hospital.	ineffective/expensive for patient safety - no correlation between fall rate and use of sitters Assessment tool beneficial for education of staff in the sitter role At risk patients for specialling are falls risk, psychiatric crisis.	effectiveness of specialling staff and financial costs to the hospital
Kerr et al. (2013) Australia	Empirical study	'Special observation': one-to-one care	General hospital 17 bed ward	Develop a working definition of special observation in acute aged care	Qualitative approach - focus groups, document analysis	Special observation to include interventions that are patient-centred interventions and promote safety Therapeutic activities may play a role – no evidence to date	**Yes –** this study refers to all five principles to develop a working definition of specialling the older person, to improve person-centred therapeutic practice interventions
Lang (2014) USA	Literature review	'Sitters': unregistered staff, one-to-one care	N/A	Review effectiveness of sitters in preventing patient falls in acute care	N/A	Studies using sitters showed conflicting evidence as to a reduction in falls Sitter use can affect patient satisfaction	**No –** literature review concentrates on the relationship between specialling and patient falls reduction in hospital
LaPage &	Service	'Constant	General hospital	Evaluate the	12-month	Delirium main reason for	**No –** study concentrates on

Citation/ country	Article type	'Specialling' terms/ description	Sample/setting	Study Aim	Study Design/Methods	Findings	PCC (according to Kitwood's [1997] guiding principles)
Bjorlund (2010) USA.	improvement	observation' (CO); 'sitter'; staff member who monitors patients who are a danger to themselves or others e.g., delirious, confused, impulsive, high fall risk, intoxicated	15 medical units	use of a psychiatric liaison nurse (PLN) to reduce constant observation of medical patients	performance improvement project PLN tracked number of CO consults and use	specialling Nursing staff lack time and skills to assess patients with behavioural disturbances PLN a role model for nurses – 50% reduction in need for specialling	reducing the financial costs to the hospital of providing specialling.
Moyle et al. (2010) Australia	Empirical study	'Specials': one-to-one care	General hospital, 13 staff	Explore management options for older patients with dementia in the acute hospital setting	Descriptive qualitative method: audiotaped interviews	Specialling identified as the most common approach to the management of patient with dementia in acute care Challenges included recognizing acute and chronic confusion; cultural barriers; optimal care provision; lack of training and skills for assistants in nurses	**Yes** – study includes principles 2 and 4.

Citation/ country	Article type	'Specialling' terms/ description	Sample/setting	Study Aim	Study Design/Methods	Findings	PCC (according to Kitwood's [1997] guiding principles)
Nadler-Moodie et al. (2009) USA	Service improvement	'Sitter'; 'constant observer'; 'therapeutic companion': terms are used interchangeably – defined as non-professional staff, family or volunteers; close monitoring of patients who require safety checks	General hospital. Patients admitted to a 6-bedded Specialized Adult-focused environment (S.A.F.E.) unit requiring special observation	Evaluate effectiveness of S.A.F.E unit in reducing sitter use		Improved nursing care to vulnerable older adults Successful cohorting of patient with similar symptoms Reduced sitter hours in general wards Further S.A.F.E units opened after the success of the project	**No –** identifies the characteristics of older patients who may require specialling but does not apply PCC principles
Portelli et al. (2016) Australia	Empirical study	'Nurse specialling': one-to-one staffing	General hospital. Patients requiring specialling in an emergency department in one calendar year (2014)	Examine the use and patterns of specialling requests in an emergency department	Retrospective review of specialling requests in an emergency department	14,021 8-hour nursing shifts requested for patient specials Adverse impact on nurse ratios when specials allocated within staff numbers Potential for compromised patient safety	**No –** study concentrates on the patterns of the allocation of staff for specialling

Citation/ country	Article type	'Specialling' terms/ description	Sample/setting	Study Aim	Study Design/Methods	Findings	PCC (according to Kitwood's [1997] guiding principles)
						Specialised nursing skills needed in patient aggression management.	
Rape et al. (2015) USA	Service improvement	'Sitters" : one-to-one monitoring – Constant observation (CO)	General Hospital	Cohort patient population that required CO in the emergency department	Quality improvement project	Sitters hours reduced by environmental changes in emergency department	**Yes –** this study incorporates principles 4 and 5. A toolkit was made available for staff to personalise patient interactions
Rausch et al. (2010) USA	Service improvement	'Constant observation': one-to-one monitoring	800 bed general hospital.	Psychiatric Liaison Nurse employed to reduce sitters use	Quality improvement project	Reduction in need for constant observation, reduction in falls, cost savings to hospital.	**No** – study concentrated on the reduction of specialling to reduce costs to the hospital
Rochefort et al. (2012) Canada	Empirical study	'Sitters': unregistered staff who provide close observation of at-risk patients. Main purpose is to notify health staff when a patient's behaviour deteriorates	General hospital. 1151 medical/surgical patients requiring sitters	Understand factors that influence sitter use	Quantitative study; secondary analysis of data base	Psychogeriatric patients main users of high sitter use e.g., delirium, dementia Improved staffing levels with psychogeriatric patients can lower costs associated with specialling	**No –** concentrates on the characteristics of the registered nurses and the incidence of specialling in the hospital

Citation/ country	Article type	'Specialling' terms/ description	Sample/setting	Study Aim	Study Design/Methods	Findings	PCC (according to Kitwood's [1997] guiding principles)
Schoenfisch et al. (2015) USA	Empirical study	'Sitters': staff who provide one-to-one patient observation	110 staff participants across six hospitals	Explore sitters' experiences in regards to their health and wellbeing	Surveys, focus group interviews	Majority of sitters were female, non-white. High incidences of physical assault, threats, verbal abuse. Sitting represents an occupational health and safety risk.	**No –** study concentrated on the OH & S of the specialling staff only
Schroeder (2016) USA	Empirical study	'Sitters': provide one-to-one monitoring	Five participants in a general hospital	To examine the lived experience of sitters	Interviews	Identified themes around bearing witness, support and acceptance of patients	**No –** study concentrated on the lived experience of the specialling staff to give care
Shever et al. (2011) USA	Empirical study	'Sitters': constant monitoring	41 Nurse Managers from 148 units in general hospitals	Describe assessments, interventions around falls prevention in hospital	Semi structured interviews	Sitters used in 68% of cases, other interventions included bed alarms and relocating patients closer to nurses' station. Physical restraints used in some cases. Few reports of patient ambulation as a strategy.	**No –** this study concentrates on the lived experience of the specialling staff not the patient
Skrowonsky et al. (2015) USA	Service improvement	'Sitters' or 'constant companion': provide close observation	N/A	N/A	N/A	Specialled patients had longer lengths of hospital stay, no difference in falls rates	**No -** study concentrated on the ability of the special staff to attend patient to prevent falls. The study did not elaborate on the quality of the care that was being given
Spiva et al.	Empirical	'Sitters':	633 bed general	Evaluate the	Descriptive study;	Using the program	**No** –study evaluates

Citation/ country	Article type	'Specialling' terms/ description	Sample/setting	Study Aim	Study Design/Methods	Findings	PCC (according to Kitwood's [1997] guiding principles)
(2012) USA	study	one-to-one staffing	hospital	outcomes of using a sitter reduction program (use of algorithm for nursing staff when considering sitter).	secondary analysis of database	reduced sitter hours and costs without negatively impacting falls rates	specialling does not take into account the 'personhood' of the patient
Torkelson & Dobal (1999) USA	Empirical study	'Constant observation': implemented for patient safety risks/risks to others	84 general hospitals in USA. 52 responses from nursing executives	Develop comprehensive tools to support nurses in initiating specialling	Descriptive exploratory research design Structured interviews	All hospital used constant observation Main conditions requiring specialling were dementia, high risk behaviour, falls risk Constant observers part of staff workload and not supernumerary.	**No** – identifies that specialling staff may have few skills to manage the patient during specialling
Tzeng & Yin (2007) Taiwan	Empirical study	'Sitters'; 'volunteers': one-to-one monitoring	General hospital 112 participants sitting with family members	Describe experiences of caring for family members in hospital	Cross-sectional survey; one-page questionnaire	Most sitters were patients' children Some family members hired a private aide to assist the patient in hospital Patients assessed as being at high risk for falls were cared for in an observation room staffed	**Yes** – the study involved principles 1 and 5 in involving families/carers involved in the care of the specialled person

Citation/ country	Article type	'Specialling' terms/ description	Sample/setting	Study Aim	Study Design/Methods	Findings	PCC (according to Kitwood's [1997] guiding principles)
						by volunteers 44% reduction in falls	
Tzeng et al. (2008) USA	Empirical study	'Sitters': agency staff who constantly monitor patients at risk of falls	General hospital. 2 acute adult medical units	Measure outcomes and sitter effectiveness Improve the process of specialling Identify categories patients at risk	Retrospective descriptive study design over 18 months to evaluate tool to guide the use of sitters. Outcome indicators included use of sitters, number of restraints ordered and total number of falls per 1000 patient day	Sitter expertise related to patient outcomes Restraint use decreased Falls rate higher Sitter use not cost effective	**Yes** – The patient attendant assessment tool incorporated principles 2, 3, 4 and 5. The assessment tool emphasised PCC to guide staff before requesting specialling
Weeks (2011) USA	Comment ary	'Sitters'; 'therapeutic companions': constant and direct observation	General hospital.	N/A	N/A	Nurses empowered through education to make decisions about specialling – led to reduction in number of sitter hours and costs.	**No** – study concentrates on reducing specialling
Wilkes et al. (2010) Australia	Empirical study	'Specialling': one-to-one nursing and close observation	General hospital.	Reports on a two- phase pilot study exploring the concept of specialling the	Mixed methods: interviews, secondary analysis from database	Documentation to request and monitor specialling inadequate; gaps in service provision for adults with behavioural disturbances; need for	**No -** the qualitative phase of the study identifies the lack of service provision and lack of staff education with patients with behaviours of concern from

Citation/ country	Article type	'Specialling' terms/ description	Sample/setting	Study Aim	Study Design/Methods	Findings	PCC (according to Kitwood's [1997] guiding principles)
				older patient with behaviours of concern in the acute hospital setting		education	senior nurses
Wood et al. (2018) UK	Literature review	'Specialling'; 'Sitters'	N/A	Explore the literature on one to one specialling and sitters in acute care hospitals	N/A	Wide variation in the process of specialling; lack of clarity in terminology; lack of economic evaluations; quality outcomes needed to support specialling	**Yes** – this literature highlighted the lack of studies that emphasise PCC and the need to address the quality of care given.
Worley et al. (2000) USA	Empirical study	'Sitters'; 'constant observation': one-to-one monitoring and observation	355 General hospitals.	National survey to assess the use of one to one specialling	Quantitative, survey	Decreases in sitter costs after the implementation of cost-saving interventions such as cohorting, relocating patients near nursing stations, placing at-risk patients in bed enclosure devices, and regularly assisting patients to the toilet.	**No –** survey results showing incidences of specialling in USA hospitals
Wright (2006) Australia	Service improvement	'Sitters': not otherwise defined	General hospital	Pilot study on the trial of a gender neutral high fall risk room – 4 beds	Evaluation of a Quality improvement project - 6months	Use of sitters decreased after implementation of a high risk falls room. Fall rate decreased with cohorting patients	**No –** patients cohorted who are at high risk of falling. Quality improvement project to decrease the use of specialling

Appendix 2: Quality of interactions schedule (QUIS) & emotional response in care (ERIC)

Facility Code:_____ Research Assistant: 1 2 3 4

QUIS Descriptors		ERIC Descriptors		
1.	**PS** Interaction principally involving "good, constructive, beneficial" conversation and companionship, e.g. greeting directed to individual.	1.	**P** Pleasure The person smiles, laughs, makes happy noises or expresses pleasure in words	**Strength**
2.	**PC** Interactions during the appropriate delivery of physical care, e.g. general explanation of procedure, but no general conversation.	2.	**AF** Affection The person shows or verbally expresses a liking or affection to some one or responds with liking or affection when approached	Mild **1**
3.	**N** Brief, indifferent interactions not meeting the defi categories e.g. putting plates down without verbal or non-verbal contact.	3.	**H** Helpfulness The person attempts to assist someone with a task or to assist someone trying to help him/her.	Moderate **2**
4.	**NP** Providing care, keeping safe or removing from danger, but in a restrictive manner, without explanation or reassurance	4.	**AG** Anger The person glares, clenches teeth, shouts, curses, insults, pushes, threatens to be, or is aggressive.	Strong **3**
5.	**NR** Interactions that oppose or resist residents' freedom of action without good reason, or which ignore resident as a person.	5.	**AX** Anxiety The person has a furrowed brow, is restless, makes repeated or agitated movements, sights, withdraws from a person or situation, trembles, has tight facial muscles, calls repetitively, wrings hands, jiggle legs, has wide open eyes.	
6.	**IO** Interactive with others-residents, visitors	6.	**D** Discomfort The person grimaces, yells, moans, or groans, has noisy laboured breathing, a rigid body, fists clenched or knees pulled up.	
		7.	**N** No Sign The person shows no emotional response to the situation, may be withdrawn or simply looking on with no apparent feeling about what is going on.	

Date	Resident Code	Time	QUIS	ERIC / Strength		Detail / Description

Date	Resident Code	Time	QUIS	ERIC / Strength		Detail / Description

QUIS Codes						ERIC Codes						
1	**PS**	*Positive Social:*	**4**	**NP**	Negative Protective	**1**	**P**	Pleasure	**4**	**AG**	Anger	**Strength**
2	**PC**	Positive Care:	**5**	**NR**	Negative Restrictive	**2**	**AF**	Affection	**5**	**AX**	Anxiety	Mild **1**
3	**N**	Neutral	**6**	**IO**	Interactive with Others	**3**	**H**	Helpfulness	**6**	**D**	Discomfort	Moderate **2**
									7	**N**	No Sign	Strong **3**

Date	Resident Code	Time	QUIS	ERIC / Strength		Detail / Description

Appendix 3: Draft care guidelines for older patient specialling in acute hospital wards

Sections	Key Content	Work Completed/ in Progress	Action Items
Purpose	These guidelines are intended to be an information resource and guide to consistent practice for health professionals in NSW who are responsible for assessment and care of older people who are specialled or may require specialling in acute hospital wards. These guidelines have been developed in consultation with health professionals and other key stakeholders.	During this study, a working party has been established to review and provide feedback on existing specialling policy and these draft care guidelines. Working party currently consists of hospital executive members and senior clinicians in aged care, e.g., aged care CNC, Local Health District [LHD] dementia care CNC, and member of Aged Care in Emergency Services Team (ASET). Working party meets monthly, three meetings held to date. Initial involvement in NSW Agency for Clinical Innovation's (ACI) drafting of care guidelines on delirium and specialling in general.	Multidisciplinary team members e.g., geriatrician, allied health – aged care occupational therapist, diversional therapist, ward nursing staff, older health care consumers to be recruited for working party. Table draft guidelines at Clinical Practice Committee meeting (meets three-monthly). NSW Agency for Clinical Innovation (ACI) currently drafting care guidelines on delirium and specialling in general – review when available in full draft.

Sections	Key Content	Work Completed/ in Progress	Action Items
Introduction	People over 65 years of age are now the major consumers of acute health services. Many older people present to with multiple co-morbidities and are susceptible to further complications during hospitalisation. During hospitalisation, older people can quickly become disoriented, confused and agitated. These patients may also be physically unwell and/or require increased frequency of observations. In these instances, care provision beyond what comprises general ward care may be required. Often referred to as 'specialling', this care involves close monitoring and observation of the person to prevent accidents, injuries and clinical deterioration. The following care guidelines have been developed to: • Outline an overall vision for person-centred specialling of older people • Promote a consistent understanding of what constitutes safe, efficient and effective specialling of older patients in acute hospital wards • Ensure that the approach to the specialling process is above all, person-centred • Provide links to reference and policy documents relevant to the older patient specialling in acute		Table draft guidelines at Clinical Practice Committee meeting (meets three-monthly).

Sections	Key Content	Work Completed/ in Progress	Action Items
	hospital wards • Promote good clinical and corporate governance • Be used in the orientation and training of new hospital clinicians • Facilitate continuous quality improvement of older patient specialling in acute hospital wards		
Initiating and ceasing specialling	*Suggestions for this section include:* • Person(s) responsible for initiating and discontinuing specialling • Person(s) from whom permission is required to initiate specialling • A risk assessment checklist for the person responsible to complete, along with the frequency with which completion is required (e.g., on initiation, every 24 hours until cessation, alterations in patient's condition) • An algorithm for all staff to follow which outlines the process to follow if they consider a special is appropriate (e.g., who to contact, appropriate time frames for assessment, measures/care to be considered while waiting for assessment) • Risk assessment checklist and algorithm must include/confirm that consultation has been undertaken with the patient and/or their family members during this process	During this study, a risk assessment checklist for patients who are considered high risk for need specialling was trialled as a QI project. With the introduction and increasing digitalisation of health care, consideration is currently being given to the development of an online specialling request form.	Follow up with QI committee re progress. Feedback/discussion re progress of same on agenda for next working party meeting.

Sections	Key Content	Work Completed/ in Progress	Action Items
	• Documentation must also include/confirm that the specialling process e.g., rationale, how it is conducted, care expectations has been fully explained to the patient and/or family members and that they have the opportunities to ask questions about their care for the duration of specialling		
Staff	*Suggestions for this section include:* • Qualifications of staff who are permitted to undertake specialling • Training requirements of the staff who are permitted to undertake specialling e.g., mandatory in-service sessions, orientation • Orientation requirements for casual pool or agency staff who are assigned to special • The importance of ensuring that special staff are included in general ward handovers	In-services currently being conducted at ward level regarding the importance of orientation of all new staff, including agency and casual pool. Importance of involving special staff in general ward handovers is currently being emphasised at ward team meetings and ward in-service sessions.	Survey feedback to be collected from specials regarding their experiences on the ward, support provided, whether they feel part of the ward team as a QI project. To be tabled at next QI committee meeting.
Training	*Suggestions for this section include:* *Targeted training:* • Common causes of neurological confusion in older people • Delirium and dementia – understanding the differences	Currently in the planning stages with Centre for Education and Workforce Development (CEWD) for development of a mandatory study for staff who special. Due for completion and	Continue to work with CEWD. Liaise with Nursing Unit Managers for staff release off wards to attend courses.

Sections	Key Content	Work Completed/ in Progress	Action Items
	• Recognising and responding to delirium • Positive, PCC strategies e.g., gentle mobilisation, diversion, pain management, de-escalation strategies for agitated behaviours • The importance of communication *Mandatory training:* • 'Reducing Harm' incorporating delirium, falls and pressure injuries • Manual handling • CPR	rollout 2019. Ward level in-services being conducted for all nursing staff on falls prevention, early detection of delirium, communication techniques for de-escalating behaviour, the 'Top Five' approach. Currently involved in Working Party developing a mandatory education program for aged care nurses regarding safe handling and grasping to patients to de-escalate aggressive behaviour and avoid patient injury e.g., skin tears, falls. Due for completion and rollout 2019.	
Environment for specialling	*Suggestions for this section include:* • An outline of where specialling should/should not be conducted • Examples could be: moving patients closer to nurses' station, specialling to be undertaken in multiple bed bays, whether specialling is permissible in side or	Patients at risk of accidental injury are identified at handover and possible strategies discussed e.g., moving patients (if multiple bed moves have not already been carried out –	Discuss with Nursing Unit Manager to formally include items around risk management and appropriateness of cohorted specialling on handover document.

Sections	Key Content	Work Completed/ in Progress	Action Items
	single rooms and the conditions under which this may be required • Environmental considerations and risks e.g., the need to reduce stimulation, infection risks, disturbances to other patients • An outline of whether cohorting of specialled patients is permissible, including the exact staff to patient ratios if cohorting is undertaken • An outline of how staff are allocated or recruited for specialling, with a strong emphasis on the need to allocate staff who are appropriately trained, orientated and committed to providing PCC of older people. • A stipulation around whether or not it is acceptable to attend to other patients in addition to the specialled patient, and the circumstances under which this is permissible e.g., emergency • How ward staff should report changes in acuity and concerns with impact on standard staffing	increased risk of delirium). Currently an ad-hoc process, but to be added to existing handover document. Falls huddles involving medical staff, nursing unit manager, CNC and ward nurses undertaken following a patient fall to discuss management/prevention strategies. A process in place for cohorted patients where reviews are conducted by ward CNC over three shifts to determine if this mode of specialling is appropriate. Ward nursing team leader also maintains communication with special so that any concerns can be escalated.	
Care considerations	*Suggestions for this section include:* • An emphasis on the importance of individualised (i.e., PCC)	A sticker for patients' notes has been proposed to the hospital executive that would prompt	Follow up with QI committee re progress.

Sections	Key Content	Work Completed/ in Progress	Action Items
	• Reference to 'My Story' to incorporate the person's important relationships and key events into their care, • Examples of positive care practices e.g., family rosters, diversional activities consistent with individual preferences • Emphasis on meaningful engagement • Practical measures that can be undertaken e.g. moving the patient closer to the nurses' station, family rosters, trial of alarm cushions and Lo-lo beds.	staff to consider alternatives to commencing specialling e.g., lo-lo beds, alarm cushions, moving patient closer to nurses station but is still under consideration. Falls and safety huddles in place (see entry in relation to 'environment')	Feedback/discussion re progress of same on agenda for next working party meeting. Survey feedback to be collected from specialled older patients and/or family members regarding their experiences of being specialled on the ward, care provided, whether they considered the care to meet their individual needs.
Quality assurance processes	*Suggestions for this section include:* • Outline process for evaluating and improving administrative processes associated with specialling e.g., financials, staffing issues, initiating and discontinuing specialling • Outline process for evaluating care practices – patient/family satisfaction surveys, health outcomes, adverse events, length of stay • Outline process for evaluating staff practices – staff satisfaction, number of staff undertaking training etc.		
Linked policies and	Links to: • Acute to Aged Related Care Services Practice	ACI currently drafting care guidelines on delirium and	Provide feedback on draft LHD policy when circulated to

Sections	Key Content	Work Completed/ in Progress	Action Items
documents	Guidelines • Clinical Excellence Commission documents • LHD falls policy • LHD delirium policy • Delirium Clinical Care Standard (ACSQHC 2016)	specialling in general. LHD general specialling policy (not older person specific) currently in draft.	ensure that it meets needs of older patients in acute care wards and includes principles of PCC.