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Preparation to care for confused older patients in general hospitals: a study of UK health professionals

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Abstract

Background and Objective: in the UK, two-thirds of patients in general hospitals are older than 70, of whom half have dementia or delirium or both. Our objective was to explore doctors, nurses and allied health professionals' perceptions of their preparation to care for confused older patients on general hospital wards.

Methods: using a quota sampling strategy across 11 medical, geriatric and orthopaedic wards in a British teaching hospital, we conducted 60 semi-structured interviews with doctors, nurses and allied healthcare professionals and analysed the data using the Consensual Qualitative Research approach.

Results: there was consensus among participants that education, induction and in-service training left them inadequately prepared and under-confident to care for confused older patients. Many doctors reported initial assessments of confused older patients as difficult. They admitted inadequate knowledge of mental health disorders, including the diagnostic features of delirium and dementia. Handling agitation and aggression were considered top priorities for training, particularly for nurses. Multidisciplinary team meetings were highly valued but were reported as too infrequent. Participants valued specialist input but reported difficulties gaining such support. Communication with confused patients was regarded as particularly challenging, both in terms of patients making their needs known, and staff conveying information to patients. Participants reported emotional and behavioural responses including frustration, stress, empathy, avoidance and low job satisfaction.

Conclusion: our findings indicate that a revision of training across healthcare professions in the UK is required, and that increased specialist support should be provided, so that the workforce is properly prepared to care for older patients with cognitive problems.

Keywords: dementia, delirium, workforce, education, general hospitals, older people

Introduction

The World Health Organisation (WHO) reports 7.7 million new cases of dementia each year worldwide [1]. In the UK, two-thirds of patients in general hospitals are older than 70, of whom half have dementia or delirium or both [2]. Health outcomes for these patients are worse than for those without cognitive impairments [3]. There are concerns about the quality of care these patients receive in general hospitals [4]. The English National Dementia Strategy emphasised the need for improvement [5], echoed in a high-profile report on a failing English hospital (the Francis report), which made recommendations on caring and compassionate nursing for elderly patients [6]. A study of the learning needs of hospital staff regarding delirium indicated shortcomings [7], but otherwise there is little evidence to inform developments in staff education and training [8]. Further research exploring the learning needs of healthcare professionals is required [9, 10].

Best practice in the design, implementation and evaluation of training involves formal training-needs analysis, including detailed consultation with stakeholders, a review of organisational culture and support for learning, role requirements, and team-working context [11]. This study presents the first step of a training-needs analysis: consultation with healthcare professionals working with confused older patients.

Method

An interview study was undertaken using the Consensual Qualitative Research (CQR) approach [12] comprising: (i) semi-structured data collection using open-ended questions; (ii) multiple judges throughout data analysis; (iii) judges arriving at consensus about the meaning of data; (iv) an auditor to check the work of judges; and (v) analysis that clusters data into categories, provides summaries of each category and examines differences in responses between different groups of participants.

Setting and participants

The research was conducted in a large general teaching hospital in the UK, admitting >20,000 people per year aged over 75 from an urban and rural catchment population of 650,000. About 70% of cognitively impaired older patients were managed on specialist geriatric medical wards. Access to old age psychiatry services was by consultant referral as the hospital did not have an old age liaison psychiatry service that might routinely assist in educating and supporting staff to manage the care of confused older people. Eleven hospital wards were identified that admitted unselected patients for acute care, representing five sub-specialties: respiratory medicine (three), rheumatology (one), trauma orthopaedics (two), acute geriatric medicine (two) and diabetes and endocrinology (three). We recruited 12 participants from each sub-specialty: three doctors, including a senior specialist

(consultant), registrar (middle-grade doctor in specialist training) and a junior doctor in pre-specialist training; two senior nurses (ward manager and deputy); three registered nurses; two healthcare assistants; one occupational therapist; and one physiotherapist (Table 1). We recruited consultants and ward managers using random sampling and all other groups using typical case purposive sampling. The majority of participants (*n* = 44) were White British.

Procedures

A semi-structured interview guide was developed (see Supplementary data in *Age and Ageing* online, Appendix 1). Participation was voluntary, informed consent was obtained and transcripts were anonymised. Two individuals withdrew after briefing. Replacements with similar characteristics were recruited. Individual interviews lasted 20–70 minutes (mean 39 minutes), were recorded and transcribed. Interviewers (A.G. and A.K.) were academic occupational psychologists with no clinical or managerial role.

Data analysis

Coders (A.G. and A.K.) undertook a thematic analysis of the interviews using CQR [12] to identify patterns of responses (categories) using NVivo 8 software. Each category captured a discrete element of participants' reported thoughts, feelings, behaviours or experiences. The coding scheme was tested on a purposive sample of 3 interviews. The auditor (J.G.) examined categories, groupings and descriptions, and recommended alterations. A revised coding scheme was agreed, and tested on another purposive sample of three interviews. This process was repeated until no new categories were needed to code new interviews, and the auditor had no more recommendations (after 12 interviews had been coded). Utterances were coded into more than one category where necessary.

Results

Categories grouped into three overarching themes. Illustrative quotations are given in Table 2.

Table 1. Demographic characteristics of participants

Professional group and grade	Male (*n* = 12)	Female (*n* = 48)	Mean age	SD
Senior specialist (consultant)	3	2	44.4	8.50
Middle-grade doctor in specialist training (registrar)	2	3	27.6	2.41
Junior doctor in pre-specialist training	2	3	24.2	2.68
Senior nurse (ward manager)	1	4	38.2	7.05
Senior nurse (deputy ward manager)	1	4	32.8	4.60
Nurse	1	14	41.1	10.05
Healthcare assistant	1	9	40.8	19.32
Occupational therapist	1	4	28.8	4.55
Physiotherapist	0	5	29.8	5.89

Knowledge and skills necessary for the job

Education and training

There was consensus among staff from all disciplines and levels of seniority that education, induction and in-service training left them inadequately prepared to care for cognitively impaired patients. Participants indicated that lack of preparedness led them to providing suboptimal care. Many suggested such training should be on-the-job, alongside senior colleagues or specialists and mandatory.

Junior doctors unanimously agreed on the inadequacy of their education, particularly in relation to older patients with complex co-morbidities. Middle-grade doctors suggested that all doctors should gain experience in geriatric medicine during training. Consultants considered training curricula to be out-of-date regarding core competencies required of hospital doctors. They noted their own lack of confidence to train juniors.

Healthcare assistants reported little formal training. Nursing groups recounted inadequate knowledge about confusion and mental health problems and skills in handling

Table 2. Illustrative quotations from staff

Knowledge and skills necessary for the job	Interactions with patients and colleagues	Effects on staff
Education and training: 'I think the emphasis in certain subjects is out of proportion. The notion that every junior doctor has to do four months surgery, I'm not quite sure what the value of that is. The fact that everyone has to do four months medicine, I can see the value of that, because whatever specialty you go into, there's a certain amount of medicine. Psychiatry, psychology, delirium, dementia is a fairly important part of what a lot of people will end up doing or dealing with. I don't know how much people have sat down and said, "Well, what are we training people to be and therefore what are the core competencies that our doctors need?"' (Interview 58, Consultant)	Initial assessment, clerking: 'If you had a sort of pro forma or something like that which you could work your way through, then it would guide what you do in a more structured way. And it would standardise your care a bit better because every single person, when they're confronted by an agitated patient will do something different. Or they would deal with that situation in a different manner.' (Interview 60, Consultant)	Emotional responses and psychological well-being: 'For any health professional involved with a patient who is either being aggressive or very vocal and agitated, I think it's distressing. I think in a general busy medical ward, they are high maintenance, high input patients that actually generate a lot of angst.' (Interview 40, Consultant)
Job expectations: 'There is a stigma isn't there? When I said to people "I used to work on the neurosurgical ward", it was like, "Oh wow". I don't get that reaction now when I say I work with the elderly, no: "Oh right".' (Interview 30, Nurse)	Handling aggression and violence: 'If you don't have that life experience and the awareness of your own body language and how you may be perceived by somebody else you can get yourself in a tricky situation, or not be aware that something's going to happen, because you can't see the triggers.' (Interview 51, Occupational Therapist)	Behavioural responses: 'I think sometimes, it's to ignore them, sometimes it's to do the bare minimum, sometimes you do see people losing their temper, getting short with patients. So it can be quite negative. I think neglect sometimes happens.' (Interview 59, Consultant)
Experience outside formal settings: 'I think people who haven't had personal experience like I've had struggle, like, I know friends who struggle. Because it's difficult to know how to deal with patients, especially aggression and things like that' (Interview 4, Health-care Assistant)	Communication with patients: 'Sometimes you're more veterinary in your approach. And then you perhaps may not be treating them in the same way as someone else that you can talk to. Are the patients given the same respect and dignity, because they can't talk to you and converse with you in the same way?' (Interview 37, Consultant)	Job satisfaction: 'If you're doing it, and because you're not properly trained, and there is no satisfaction because the patient isn't responding because they, you're not speaking the same language and it becomes frustrating. And then, it just ended up worse and you just sort of resent those patients because you cannot deal with it.' (Interview 16, Nurse)
	Teamwork: 'You have to make a real effort to say "Let's have an MDT about that person". And it does happen, but if they were on a ward where the MDT met twice a week, and you know, they were all specialists in that area, I think those people would probably do a lot better. That's often what's lacking on a non-geriatric ward is you don't have that MDT.' (Interview 40, Consultant)	Confidence in competence: 'It should be mandatory that you have some form of training, not just what the illness is about, but ways of actually being able to nurse properly and to talk to the patient, ways of dealing with patients that you might find difficult. I think if more nurses were confident about dealing with it, they wouldn't shy away from it so much.' (Interview 16, Nurse)
	Specialist support: 'Quite often, senior doctors don't really know how to manage these patients either, and so you end up just having to refer, making a phone call to the psycho-geriatricians. When you get it, it's helpful but it's quite difficult to get. If you had a more specialist team coming in, then they might be able to get on top of things quicker and recognise the needs that this patient might have.' (Interview 26, Junior Doctor)	

such patients. More experienced staff explained how knowledge about confusion and underlying conditions helped them understand patients' actions, handle aggression and manage challenging behaviours (e.g. discarding clothing, interfering with other patients and rummaging in clinical waste bins). Nurses and healthcare assistants reported researching material on the internet and undertaking training in their own time. Ward managers were largely unaware of suitable training courses in the hospital, reported limited budgets for training and difficulties releasing staff from the ward or arranging training for night staff. They noted a disconnection between what newly qualified nurses learned as students and what was required of them on the ward. Physiotherapists and occupational therapists testified to variations in the suitability of their education, the arbitrary nature of experience at work and inconsistent exposure to experienced colleagues.

Job expectations and career aspirations

Many staff were initially surprised to find that such a large proportion of patients were confused older people. They reported that their training did not prepare them for this. Ward managers reported difficulties recruiting nurses to geriatric medical wards and referred to stigma attached to this work.

Experience outside formal settings

Staff who expressed most confidence were often those with experience of caring for older people with dementia in their family or through previous employment in nursing homes. Many suggested that experience helped them approach patients, understand the importance of routine and appreciate subtle aspects of communication. Experience was thought particularly valuable when handling challenging behaviour and appreciating difficulties facing patients' families.

Interactions with patients and colleagues

Initial assessment

Many doctors reported initial assessments of confused older patients as difficult because their training prepared them for dealing with one condition at a time. They admitted inadequate knowledge of mental health disorders, including the diagnostic features of delirium and dementia. They reported difficulty accessing specialist services without a diagnosis. Many doctors and nurses noted that these patients were seen as a non-urgent group who often waited for investigations. Doctors thought that protocols or guidelines to assist with assessing and treating patients would be useful.

Handling aggression and violence

Staff viewed aggression and violence from confused older patients as part of the job. They reported being hit, punched, kicked, spat at, jumped on, bitten, pinched, scratched and having objects thrown at them. Aggression was reported predominantly by nursing staff. Many noted that these behaviours were related to patients' conditions and reactions to the hospital environment rather than wilful or malicious acts. With increasing experience, staff could better anticipate aggressive behaviour and take evasive action. Less experienced staff found patients unpredictable and reported sustaining injuries. Handling aggression and violence was considered a top priority for training, particularly for nursing staff. Participants noted that aggressive behaviour demanded their attention, possibly to the detriment of undemanding patients, some of whom they believed could be suffering from depression.

Communication with patients

Communication with confused patients was regarded as particularly challenging, both in terms of patients making their needs known and staff conveying information to patients. Staff described themselves as lacking skills in approaching patients and gaining cooperation and consent. Doctors explained how practising medicine without much communication sometimes led to a 'veterinary' approach, transforming the usual doctor–patient relationship (Interview 37, Consultant). Nurses referred to the importance of communication in reducing patients' uncertainty and fear, and in avoiding or reducing aggression. They felt they needed communication tools, particularly during medical procedures to help explain to patients what was happening and to reassure them. Experienced staff attributed success in gaining patients' cooperation partly to enhanced awareness of non-verbal aspects of communication.

Teamwork

Knowledge about the role of colleagues elsewhere in the hospital, and whom to contact, were described as important when staff felt out of their depth. However, nurses and ward managers recounted difficulties accessing junior doctors. Junior and middle-grade doctors reported lack of supervision from consultants, although acknowledged that consultants were not always able to advise. These difficulties were severe at night, when confused older patients were most agitated and disrupted other patients; in the absence of specialist support, junior doctors felt under pressure to sedate them. Therapists, based off-ward, reported inadequate information. Centralised computerised information systems were suggested to facilitate multidisciplinary working and reduce duplication. Multidisciplinary team (MDT) meetings were highly valued but were reported to be too infrequent.

Specialist support

Participants appreciated the support of specialists: geriatricians, old age psychiatrists, orthogeriatricians, psychiatric nurses and 'specialling' (additional nurses providing one-to-one care) but reported difficulties gaining such support. All professional groups commented that early involvement of a specialist team would be invaluable. The need for specialist advice to deal with complex co-morbidities was raised in

Interview 37 by a consultant, who noted it might prevent these patients 'being dealt with as left-overs in the system'.

Effects on staff

Emotional responses and psychological well-being

Participants variously recounted feeling daunted, challenged, sad, upset, worried, demoralised, hopeless, scared, anxious, frustrated and sorry for patients and their families. A few described their experience of aggressive patients as frightening. Caring for these patients was thought upsetting for student nurses, some of whom were described as stressed, tearful, taking sick leave or not turning up for work. Junior doctors worried they may have missed something important or felt pressure to treat patients in ways that made them uncomfortable. Nurses found it stressful dealing with angry co-patients and their families who did not understand why confused and disruptive older patients were on the same ward. The majority of participants expressed considerable empathy with the plight of these patients.

Behavioural responses

Participants commented on inappropriate staff behaviours they had observed in relation to challenging patients. These included not knowing what to do, treating them as patients without confusion or mental health problems, panicking, shouting, being 'sharp', delaying attending to or avoiding them. Less experienced nursing staff, and those who had experienced aggression from patients, admitted a reluctance to attend to such patients on their own, or even at all. Some noted the development of adaptive behaviours such as being patient, deliberating actions carefully and appearing calm. Colluding with patients' delusions was described by some as being helpful in making patients feel comfortable, but made some staff feel uneasy.

Job satisfaction

Staff reported low job satisfaction working with patients when they did not feel they were 'the right person' to do the job or they had insufficient resources. Those who were more experienced or who felt more competent appreciated their ability to make a difference and recognised the subtleties in patients' improvements.

Confidence in competence

Many staff in all occupational groups, including those on geriatric medical wards, admitted not feeling confident to care for confused older patients on acute wards. This was often related to reported inadequate education and training, and lack of experience. In general, they felt more confident about patients' medical problems rather than about behaviour, cognitive or mental health problems. They also felt more confident if they knew where to seek specialist support.

Discussion

By sampling a range of professional groups, our results provide a credible snapshot of issues facing staff caring for confused older patients in hospitals. Intrapersonal factors (knowledge and skills necessary for the job) and interpersonal factors (interactions with patients and colleagues) were identified that influenced their perceived competence. Knowledge deficiencies included uncertainty about cognitive and mental health problems. Skill deficiencies included communication and dealing with aggressive or disruptive behaviour. Interpersonal factors included assessment and handling aggression, perceived under-use of MDT meetings, and lack of support and access to specialist advice. Staff reported a variety of emotional and behavioural reactions to caring for confused older patients, and how this impacted negatively on job satisfaction and well-being. Such reactions may have significant implications for staff engagement, sickness absence and retention [13, 14]. Staff appeared to be aware of their lack of knowledge and skills, and were frustrated by being unable to provide the quality of care that they would wish.

This study has two major strengths. First, it provides a multi-professional perspective on workforce preparation to care for confused older patients in general hospitals. Second, interviews were carried out by independent researchers; responses were likely to be more frank than if they had been conducted by hospital employees. Two limitations may restrict the generalisability of our findings. First, we only studied participants in one hospital; our work requires replication. Second, the study was conducted in a hospital without a liaison psychiatry service, and findings may not be representative of hospitals with such services. Further, we did not explore patient and carer perspectives on staff education and training [9, 15].

Our findings support the need for better access to specialist support (e.g. liaison psychiatry, geriatricians, etc.) and their potential for staff education and training. However, their effects on staff and patient outcomes remain to be understood [16, 17]. They also support previous findings that doctors reported poor knowledge of delirium [18], and medical students were not sufficiently prepared to care for patients with dementia [19]. Our results support the report of the Commission on Education of Health Professionals for the 21st Century, which noted a mismatch of competencies to clinical need [20] and the need to prioritise mental health provision in healthcare services worldwide [21, 22]. Our study suggests that medical, nursing and allied health professionals experience similar problems. The WHO report 'Dementia: a public health prority' [1] highlighted the importance of multidisciplinary working in the care of older patients. Our results support this; MDTs were widely viewed as beneficial for both staff and patients.

These findings are important for policy makers and hospital managers, emphasising the need to prioritise training and awareness of cognitive and mental health problems among older patients, embracing expertise from specialist services. Our findings are also useful for educators. Care of older people with delirium and dementia must be included in the

undergraduate, generic and specialist training of healthcare staff, including higher medical training, and post-registration nursing education programmes. Revision of both content and delivery of training should be explored. Improving quality of care will not be possible without substantial development of the workforce [23]. Educational interventions regarding delirium have proved effective [7, 24] and might be further explored with regard to dementia. These findings support the UK's Department of Health's report on workforce development [25] and national policy initiatives [5, 26].

This study represents an important first step in the design of training for the workforce. Further work is required to delineate the nature of those interventions so that the workforce is well prepared for the growing number of older patients with cognitive and mental health problems.

Key points

- There are concerns about the quality of care received by confused older patients in general hospitals in the UK.
- To date, no detailed training-needs analysis has been conducted with a multi-professional staff group to explore what staff need by way of preparation to care for these patients.
- Our study found that staff from all disciplines and levels of seniority reported education, induction and in-service training did not adequately prepare them.
- Workplace-based training, more support from senior colleagues, and better access to specialist mental health services and geriatric medicine were identified as priorities for action.

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Conflicts of interest

None declared.

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Ethical statement

The study was approved by the Bradford Research Ethics Committee (08/H1302/127). All participants gave informed consent.

Supplementary data

Supplementary data mentioned in the text are available to subscribers in *Age and Ageing* online.

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