The experiences of registered nurses seeking support to care for a person living with dementia: A Hermeneutic Phenomenological Study

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Declaration

I declare the work in this thesis to be my own, except where otherwise stated.

Monika Rybacka
Date: Monday 4th November, 2024

Acknowledgments

62, 673 hours

Divorce, New Job, IVF, Miscarriage, Marriage, Dream Home, Pregnancy, Baby, Molly, Surgery, Doctorate

Professor. Boo. Peers

Time, immersion, creating knowledge

"Words are, in my not-so-humble opinion, our most inexhaustible source of magic. Capable of both inflicting injury, and remedying it." – Albus Dumbledore

Table of Contents

Table of Abbreviations

Abbreviation	Full Details of Abbreviation
NHS	National Health Service
ED	Emergency Department
BGS	British Geriatric Society
NMC	Nursing and Midwifery Council
MS Teams	Microsoft Teams
GDPR	General Data Protection Regulation
BPSD	Behavioural and Psychological Symptoms of Dementia
NHS HRA	National Health Service Health Research Authority
NICRS	NHS, Invasive or Clinical Research Committee
GCP	Good Clinical Practice
RNs	Registered Nurses
RESUS	Resuscitation
WHO	World Health Organisation
FTD	Frontotemporal Dementia
bvFTD	Behaviour Variant Frontotemporal Dementia
PPA	Primary Progressive Aphasia
NICE	National Institute for Health and Care Excellence
MHLTs	Mental Health Liaison Teams
NDAA	National Dementia Action Alliance
RCPsych/RCoP	Royal College of Psychiatrists
ICSs	Integrated Care Systems
DoH	Department of Health
CQC	Care Quality Commission
HCA	Healthcare Assistants
PRISMA	Preferred Reporting Items of Systematic Review & Meta Analysis

Abstract

Title: How do registered nurses seek support to care for a patient with dementia in an acute hospital: A hermeneutic study.

Background: People with dementia are usually admitted to acute hospitals for management of an acute medical illness, and rarely for management of dementia. People with dementia admitted to a hospital stay five to seven times longer than other patients with the same conditions. The care received by people with dementia can be impacted by staff, who can feel undertrained and lacking confidence in providing care for patients with dementia.

Aim: To explore the experiences of nurses seeking support to care for a patient with dementia in an acute hospital. Research questions were developed focusing on the lived experience of nurses and dementia specialist nurses in seeking support, types of support accessed and whether the support was implemented.

Design and Methods: A hermeneutic phenomenological qualitative study was completed. The study involved eleven nurses working in older adult wards, oncology, emergency department and dementia specialist services. Nurses participated in a one-to-one semi-structured interview. Interviews were transcribed verbatim and analysed thematically through the lens of hermeneutic phenomenology (Braun and Clarke, 2021).

Findings: Data from nurses created three themes and nine subthemes were identified: 1; need for an appropriate infrastructure to care for a patient with dementia, 2; need for support from others and 3; lack of support. Data from dementia specialist nurses identified four themes and ten subthemes. The four themes were 1; dementia specialist services (DSS) providing support, 2; where dementia specialist services seek support, 3; the infrastructure of DSS and 4; nurses lacked understanding of dementia and willingness to engage with DSS. The findings discussed the support needs and challenges experienced by both nurses and dementia specialist nurses.

Conclusion: Support was sought by nurses, and occasionally this was from dementia specialist nurses, however the issue was the availability at time of need. Dementia specialist nurses felt unsupported and unable to provide the support needed. Education is not simply the answer, dementia specialist nurses need recognition for their role and what they do by nurses and the

infrastructure of acute hospitals. Dementia needs to be highlighted as significant need and have the support needed for patients with dementia, nurses and dementia specialist nurses.

Overview of Thesis

This thesis explored the experiences of nurses seeking support when caring for a person with dementia in an acute hospital setting. Chapter one introduces dementia care through a chronological description of policies and publications over the last twenty years, and the development of support structures for nurses, such as the provision of education and the implementation of specialist roles. As this study is conducted in England, publications are related to initiatives that are supported in England. This chapter concludes with an overview of my own clinical background, experience of dementia care, and how I am positioned within this research.

Chapter two, introduces a systematic literature review, which explored how nurses working in an acute hospital seek support for a clinical need. The chapter outlines the systematic literature review framework used, discussing the search strategy and how the literature was explored, critiqued, analysed and discussed. The gaps within the literature were discovered and discussed, and the development of my research questions is presented.

Chapter three, introduces philosophy, methodology and methods of my study, including the justification for applying hermeneutic phenomenology. My own pre-conceptions are introduced before discussing the application of a hermeneutic phenomenology and how this approached informed the development of each element of my study. The methods are described in depth and include data collection through semi-structured interviews, recruitment and participants, data analysis, and ethical considerations.

Chapter four, introduces my findings, commencing with an overview of the participants. The findings are presented in two parts, the first part explores three themes on how nurses caring for patients with dementia sought support, which included 1; need for an appropriate infrastructure, 2; need for support from others and 3; lack of support. The second part explores four themes regarding the experiences of nurses from specialist dementia services, which included 1; support dementia specialist services (DSS) provided, 2; where nurses from DSS sought support, 3; the infrastructure of DSS and 4; nurses caring for patients with dementia lacked an understanding of dementia and willingness to engage with DSS.

In chapter five the findings are explored through discussion and the implication of these findings for practice and policy. The chapter starts with an overview of the key findings and then the interruption of the themes is discussed. The findings are discussed in relation to wider literature and the findings of the literature review. This chapter concludes with a summary of the interpretive whole.

Chapter six concludes my thesis with the recommendations for future research and practice. The strengths and limitations of the study are highlighted. A reflexive and reflective account of my experiences during the study have been discussed. The chapter and thesis then concludes with a summary of the research.

Chapter 1: Introduction

This section will explore dementia as a syndrome, the most common types of dementia, followed by a discussion of the potential impact of dementia on individuals. The chapter maps the legislation pathway relating to dementia within the England since the Prime Minster 's Challenge in 2009. The chapter gives background on the impact of dementia in acute hospitals including how nurses and other healthcare professionals are currently supported to care for people with dementia including current education frameworks. The chapter ends with an overview of my own clinical background and by providing a rationale to my thesis.

1.1 Background and Context for the Research

1.1.2: Dementia

Traditionally, the term 'dementia' has been used to describe a syndrome characterised by a wide range of symptoms due to brain dysfunction (Emmady, et al, 2022), and includes a variety of sub-diagnoses and prognoses. It is important to understand the impact that dementia has on an individual, to be able to understand how to care for the individual's needs. Globally, over 55 million people are living with dementia, and nearly 10 million new cases are diagnosed each year (WHO, 2023). The prevalence of dementia increases with age, with approximately 5-8% of people over the age of 60 affected at any given time (Global Burden of Disease, 2022). The economic impact of dementia is substantial, with the global cost estimated to be $1.3 trillion in 2019, a figure expected to rise significantly as the population ages (Alzheimer's Research UK, 2023).

Alzheimer's disease is the most prevalent form of dementia, accounting for approximately 60-70% of all cases (WHO, 2023). It is characterised by the gradual onset of memory loss and cognitive impairment that worsens over time. The pathophysiology of Alzheimer's disease involves the accumulation of amyloid-beta plaques and tau tangles in the brain, leading to neuronal damage and loss (Kumar et al, 2024). Key clinical features include difficulties with recent memory, disorientation, and impaired judgment. As the disease progresses, patients may experience significant changes in behaviour, language difficulties, and problems with complex tasks (WHO, 2023).

Vascular dementia is the second most common type of dementia and results from impaired blood flow to the brain, often due to stroke or other vascular conditions, it accounts for about 20% of dementia cases (Heinsen and Grinberg, 2010; WHO 2023). The condition is characterised by a sudden or stepwise decline in cognitive function, which may be associated with a history of cerebrovascular events. Symptoms can vary depending on the location and extent of brain damage but often include problems with planning and organising, difficulties with memory, and a reduced ability to make decisions. The progression of vascular dementia can be influenced by managing risk factors such as hypertension, diabetes, and high cholesterol (Sander et al, 2023).

Lewy body dementia is a type of dementia that is associated with the presence of Lewy bodies, which are abnormal protein deposits found in the brain. This form of dementia accounts for approximately 10-15% of all dementia cases (Outeiro et al, 2019). Clinical features include fluctuating cognitive abilities, visual hallucinations, and Parkinsonism, which involves tremors, stiffness, and difficulty with movement. People with Lewy body dementia often experience significant fluctuations in attention and alertness, and they may have severe sensitivity to neuroleptic medications (Kane et al, 2018). The disease can also cause issues with autonomic functions, such as blood pressure regulation and body temperature.

Frontotemporal dementia (FTD) encompasses a group of disorders characterised by progressive damage to the frontal and temporal lobes of the brain (Olney et al, 2017). FTD represents about 5-10% of all dementia cases. It is characterised by changes in personality, behaviour, and language. There are two main subtypes: behavioural variant frontotemporal dementia (bvFTD), which involves significant changes in social behaviour and personality, and primary progressive aphasia (PPA), which affects language abilities. (Seeley, 2019; Botha and Joseph, 2019). FTD often presents earlier than other types of dementia, typically in individuals between the ages of 45 and 65 and can significantly impact social and occupational functioning (Mesulam et al, 2012).

1.1.3 Impact of dementia

Dementia has a profound impact on both individuals and their families, affecting nearly every aspect of life. As the condition progresses, the physical decline experienced by individuals with dementia becomes more noticeable. Cognitive abilities, such as memory, attention, and language, deteriorate, leading to significant challenges in daily functioning. This decline is not limited to cognitive abilities but extends to motor skills as well (Cipriani et al, 2020). Many people with dementia experience a loss of coordination and balance, which increases their risk of falls and other injuries. Additionally, as dementia progresses, physical health complications can occur (Fernando et al, 2017). These can include difficulties with swallowing, which may lead to malnutrition and dehydration, as well as a heightened susceptibility to infections due to a weakened immune response (Kamikado et al, 2012). Behavioural changes are also common in dementia, including increased agitation, aggression, and anxiety. These changes can impact social interactions and relationships, leading to further isolation for the individual (Riley et al, 2015). For families, witnessing these changes in their loved one can be emotionally impactful, adding to the stress and possible burden of caregiving.

When individuals with dementia are admitted to hospital, their symptoms can become significantly amplified due to a combination of cognitive and environmental stressors, increased risk of delirium, and the impact of medications (Fong and Inouye, 2022). Understanding this phenomenon is important for nurses to manage and mitigate these effects effectively. Acute illnesses such as infections or metabolic imbalances can exacerbate dementia symptoms by increasing the cognitive load on an already compromised brain. Research has shown that conditions like dehydration or infection can precipitate sudden cognitive declines, often referred to as acute on chronic changes, where the acute illness worsens pre-existing dementia symptoms (Singh et al, 2019).

The sudden shift from a familiar home environment to the often chaotic and sterile atmosphere of a hospital can be profoundly disorienting for someone with dementia. This environmental change can lead to increased confusion, agitation, and anxiety, making it harder for patients to orient themselves, which in turn exacerbates dementia-related behaviours (Waller and Masterson, 2015). A hospital admission can also increase the risk of delirium in patients with dementia. These individuals are two to five times more likely to develop delirium during an acute illness or hospital stay (Fong and Inouye, 2022). Delirium, characterised by a sudden onset of confusion, fluctuating levels of consciousness, and sometimes hallucinations, can significantly worsen the cognitive and behavioural symptoms of dementia (Wilson et al, 2020).

Medications used to treat acute illnesses during hospitalisation can also amplify dementia symptoms. Drugs such as sedatives or anticholinergics can increase confusion and drowsiness, further impairing cognitive function in patients with dementia (Liu et al, 2020). The combination of these factors; cognitive and physical stress, environmental disorientation, delirium, and the effects of medication; can create a scenario where symptoms of dementia are significantly amplified during acute illness. The importance of careful management and tailored care for patients with dementia in these settings is needed to minimise the risk of exacerbation and ensure better outcomes.

1.1.4 Gold Standard Dementia Care

Dementia care has evolved over the years, with a growing emphasis on the need for care approaches that go beyond addressing physical symptoms to also consider the emotional, psychological, and social needs of individuals. The gold standard in dementia care is now widely recognised as person-centred care, a model that prioritises the individual’s experience and well-being over clinical outcomes (Kitwood, 1997; McCormack, 2012; Brooker. 2007). Kitwood’s theory developed from social psychology research shows the role that healthcare professionals around a person with dementia are important in maintaining their sense of self and social roles (Hennelly et al, 2018). The findings of this research resulted in a shift from the bio-medical model to the bio-psycho-social model of dementia care (O’Shea and Carney, 2016). This model incorporates the understanding of a person as a whole and examines the range of factors that can impact on a person’s subjective experience (Hennelly et al, 2018). Kitwood (1997) argued that dementia should not be viewed solely through a biomedical lens, where the focus is on the loss of cognitive function and the deterioration of the brain. Instead, he proposed that dementia care must emphasise the person's whole experience, including their emotional and social needs. Kitwood introduced the concept of "personhood," which he defined as a status conferred on one human being by others, in the context of relationship and social being. This concept underpins the importance of recognising and respecting the individuality and humanity of those living with dementia, rather than reducing them to their diagnosis (Kim and Park, 2017).

Kitwood’s approach has been foundational in shaping modern dementia care practices, particularly the emphasis on maintaining the dignity, autonomy, and identity of individuals with dementia (Hennelly et al, 2018; Caddell and Clare, 2010). The goal is to provide care that supports the person’s sense of self and fosters a positive quality of life. This is achieved by creating environments and care practices that are responsive to the person’s needs, preferences, and history, rather than imposing routines or standardised care protocols that might overlook the uniqueness of each individual.

McCormack and McCance (2006) further developed the principles of person-centred care, emphasising the importance of relationships and the care environment in the delivery of effective dementia care. McCormack and McCance (2010) highlighted that person-centred care is not just about the actions of caregivers but also about the systems and structures that support these actions. They argued that for care to be truly person-centred, it must be embedded in the organisational culture, supported by policies, and enabled by leadership that values and prioritises this approach. McCormack and McCance's (2010) work builds on the idea that person-centred care requires a holistic approach that includes not only direct interactions with patients but also the broader context in which care is delivered (McCormack, 2012; McCormack and McCance, 2010; Byrne et al, 2020). Below is the framework supporting the implementation of person-centred care in nursing (Figure 1).

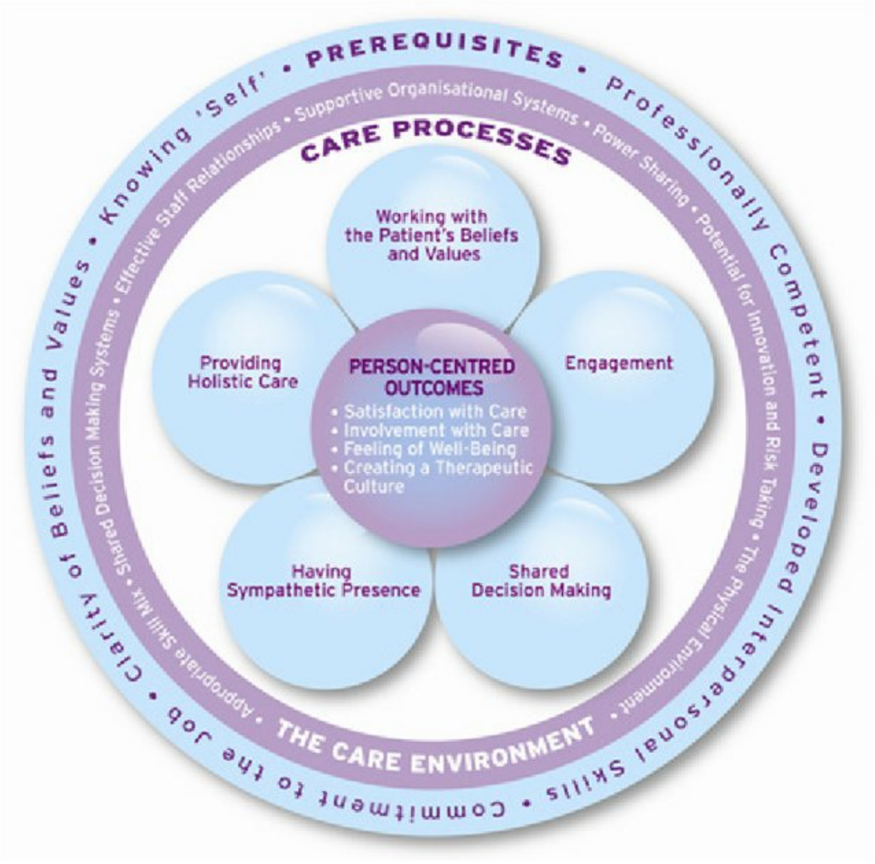


Figure 1: Person-centred Nursing Framework (McCormack and McCance, 2010)

The implementation of person-centred care as the gold standard in dementia care has impacted on how support and care is provided for both individuals with dementia and their families. Research has shown that person-centred care can lead to better outcomes, including reduced agitation and aggression, improved mood, and enhanced quality of life for individuals with dementia (Brooker, 2007).

In practice, person-centred care involves tailoring care plans to the individual's preferences and life history, engaging in meaningful activities, and ensuring that physical environment are supportive. Recognising and responding to the emotional and psychological needs of the person with dementia is also important, such as their need for connection, security, and respect (Coulter and Oldham, 2016). This approach contrasts sharply with bio-medical models, which may focus primarily on managing symptoms and maintaining physical health, often at the expense of the person's emotional and social well-being (McCormack, 2012; McCormack and McCance, 2010).

1.2: Dementia related Guidance and Policies

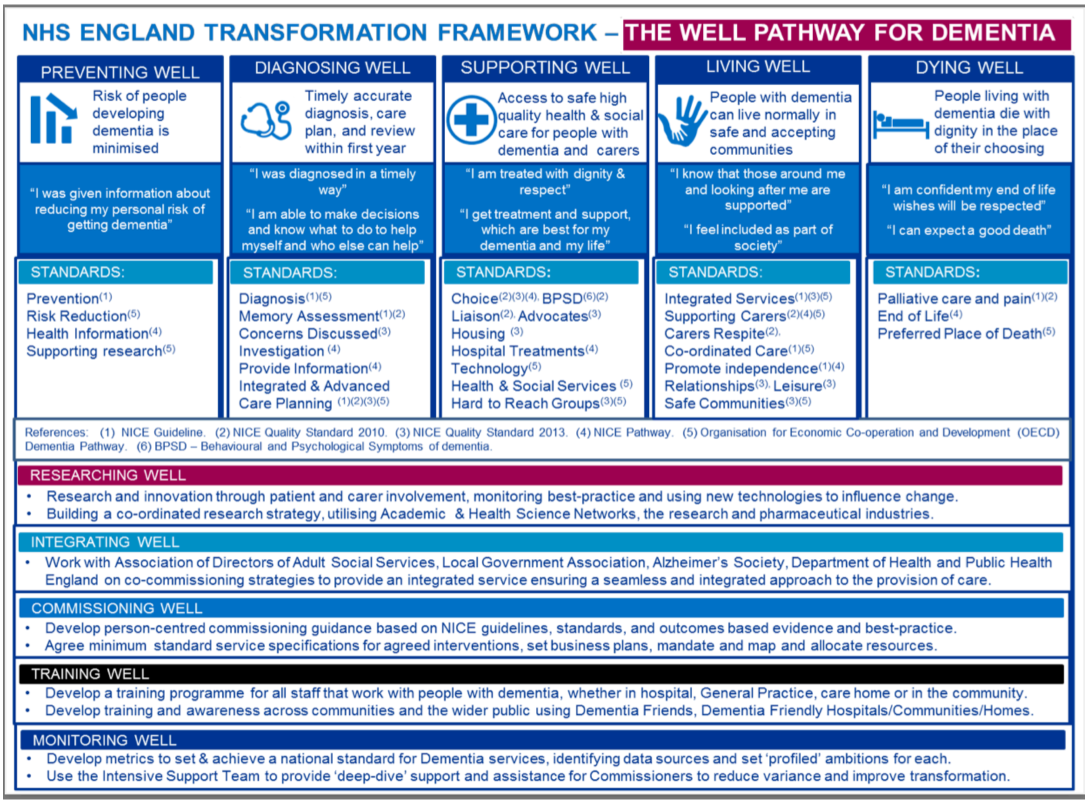
The **Living Well with Dementia: A National Dementia Strategy** (DoH, 2009) laid the foundation for dementia care improvements in England, focusing on awareness, early diagnosis, and quality of care. It stressed the need for person-centred care and emphasised the importance of tailored healthcare for individuals with dementia, even when they could not fully express their needs. The strategy also recommended for better training for healthcare professionals, acknowledging the significant role of family carers and recommending better support services and respite options. It recognised dementia as a progressive, terminal condition, highlighting the need for compassionate end-of-life care.

The **Prime Minister's Challenge on Dementia 2020** (2012; renewed 2015) expanded on the 2009 strategy by setting goals for improving dementia care, research, and public awareness. A key component identified early diagnosis, with the goal of ensuring two-thirds of people with dementia receive a diagnosis. Research funding grew significantly, and the initiative aimed to position the UK as a global leader in dementia research. The Dementia Friends programme aimed to reduce stigma and raised public understanding, while dementia-friendly communities were expanded. The 2015 update reinforced the commitment to better post-diagnosis care, tailored care plans, and expanded dementia-friendly initiatives.

The **Fix Dementia Care: Hospitals report** (2016) by the Alzheimer's Society highlighted issues in dementia care within hospitals. It pointed out gaps in staff training, poor discharge coordination, and environments that were not suited to patients with dementia. The report called for mandatory dementia training for health and social care staff, improved co-ordination between health and social care services, and the publication of hospital dementia care data to increase transparency. The report aimed to improve patient care and reduce the adverse effects of hospital stays on people with dementia.

In 2016, NHS England introduced the **Well Pathway for Dementia**, a structured approach to dementia care. It encompassed five key domains: Preventing Well, Diagnosing Well, Supporting Well, Living Well, and Dying Well. These domains focused on reducing the risk associated with developing dementia, ensuring timely diagnoses, providing ongoing support for patients and caregivers, and improving quality of life through personalised care. The pathway also emphasised the importance of end-of-life care, ensuring individuals with dementia receive comfort and dignity during the final stages of life.

Figure 2: The Well Pathway for Dementia, as featured in the 2020 Challenge on Dementia Implementation Plan (DoH, 2016)



NHS ENGLAND TRANSFORMATION FRAMEWORK – THE WELL PATHWAY FOR DEMENTIA

PREVENTING WELL	DIAGNOSING WELL	SUPPORTING WELL	LIVING WELL	DYING WELL
Risk of people developing dementia is minimised	Timely accurate diagnosis, care plan, and review within first year	Access to safe high quality health & social care for people with dementia and carers	People with dementia can live normally in safe and accepting communities	People living with dementia die with dignity in the place of their choosing
"I was given information about reducing my personal risk of getting dementia"	"I was diagnosed in a timely way" "I am able to make decisions and know what to do to help myself and who else can help"	"I am treated with dignity & respect" "I get treatment and support, which are best for my dementia and my life"	"I know that those around me and looking after me are supported" "I feel included as part of society"	"I am confident my end of life wishes will be respected" "I can expect a good death"
STANDARDS:	STANDARDS:	STANDARDS:	STANDARDS:	STANDARDS:
Prevention(1) Risk Reduction(5) Health Information(4) Supporting research(5)	Diagnosis(1)(5) Memory Assessment(1)(2) Concerns Discussed(3) Investigation (4) Provide Information(4) Integrated & Advanced Care Planning (1)(2)(3)(5)	Choice(2)(3)(4), BPSD(6)(2) Liaison(2), Advocates(3) Housing (3) Hospital Treatments(4) Technology(5) Health & Social Services (5) Hard to Reach Groups(3)(5)	Integrated Services(1)(3)(5) Supporting Carers(2)(4)(5) Carers Respite(2), Co-ordinated Care(1)(5) Promote independence(1)(4) Relationships(3), Leisure(3) Safe Communities(3)(5)	Palliative care and pain(1)(2) End of Life(4) Preferred Place of Death(5)

References: (1) NICE Guideline. (2) NICE Quality Standard 2010. (3) NICE Quality Standard 2013. (4) NICE Pathway. (5) Organisation for Economic Co-operation and Development (OECD) Dementia Pathway. (6) BPSD – Behavioural and Psychological Symptoms of dementia.

RESEARCHING WELL

- Research and innovation through patient and carer involvement, monitoring best-practice and using new technologies to influence change.
- Building a co-ordinated research strategy, utilising Academic & Health Science Networks, the research and pharmaceutical industries.

INTEGRATING WELL

- Work with Association of Directors of Adult Social Services, Local Government Association, Alzheimer's Society, Department of Health and Public Health England on co-commissioning strategies to provide an integrated service ensuring a seamless and integrated approach to the provision of care.

COMMISSIONING WELL

- Develop person-centred commissioning guidance based on NICE guidelines, standards, and outcomes based evidence and best-practice.
- Agree minimum standard service specifications for agreed interventions, set business plans, mandate and map and allocate resources.

TRAINING WELL

- Develop a training programme for all staff that work with people with dementia, whether in hospital, General Practice, care home or in the community.
- Develop training and awareness across communities and the wider public using Dementia Friends, Dementia Friendly Hospitals/Communities/Homes.

MONITORING WELL

- Develop metrics to set & achieve a national standard for Dementia services, identifying data sources and set 'profiled' ambitions for each.
- Use the Intensive Support Team to provide 'deep-dive' support and assistance for Commissioners to reduce variance and improve transformation.

The **State of Care in Acute Hospitals report** (2017) by the Care Quality Commission (CQC) examined how well hospitals were meeting the needs of people with dementia. It highlighted considerable variation in care quality, particularly in staff training, hospital environments, and the co-ordination of care. Some hospitals demonstrated excellent care, but many-faced challenges, including inadequate training for staff and environments that were confusing for people with dementia. The report recommended comprehensive dementia training for all staff and better care coordination to improve outcomes.

The **NICE Dementia Management Guidelines** (2018) emphasised person-centred care and the importance of individualised care planning. The guidelines recommended using non-pharmacological interventions as first-line treatments and cautioned against the routine use of antipsychotics for managing changes in behaviour. The guidelines also stressed the importance of supporting family carers with training and respite services and ensuring seamless care transitions across services.

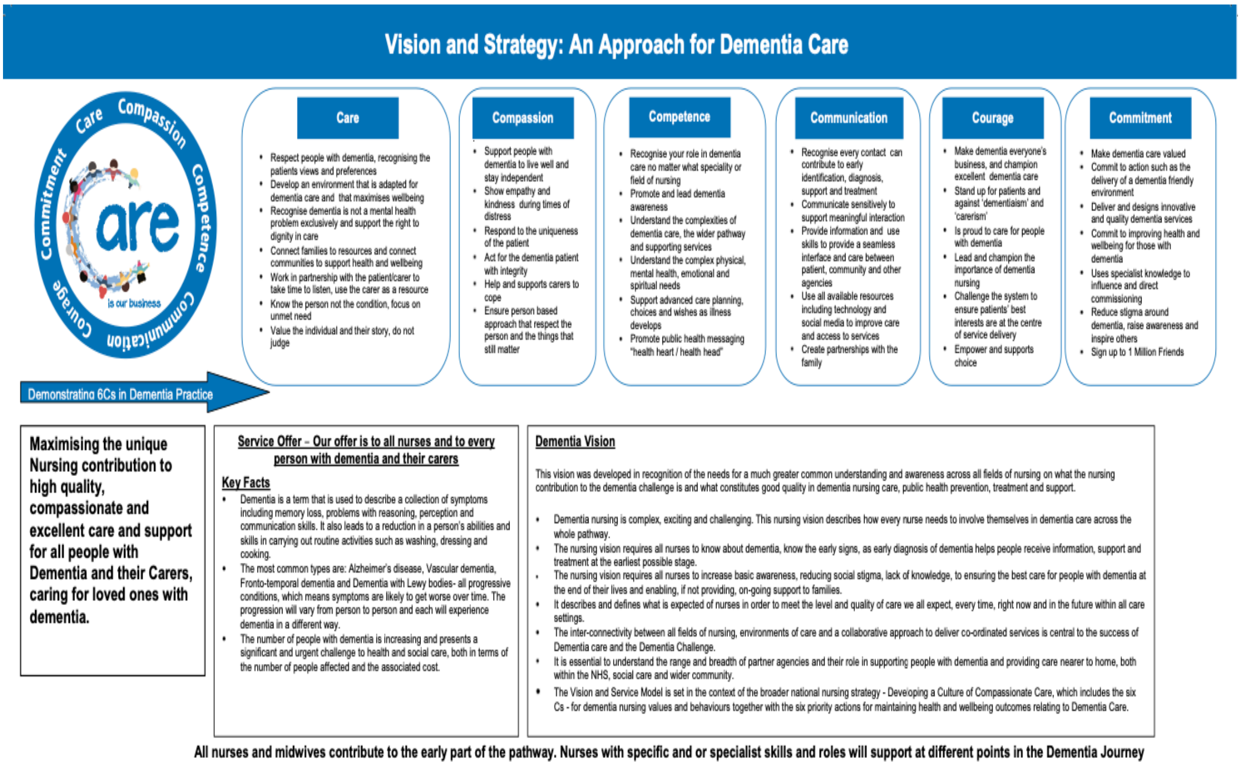
The **Dementia-Friendly Hospital Charter** (2018), developed by the National Dementia Action Alliance (NDAA), aimed to provide a structured framework for hospitals to improve dementia care. It focused on three core principles: person-centred care, staff training, and dementia-friendly environments. Hospitals were encouraged to involve people with dementia and their families in care planning, ensure staff received dementia-specific training, and make physical changes to hospital environments to reduce confusion. The charter also emphasised collaboration with community health services and social care providers to provide continuity of care.

The **National Audit of Dementia Care in General Hospitals** (2019), published by the Royal College of Psychiatrists, assessed how well hospitals were adhering to dementia care standards. It found that while some hospitals had made progress, many faced challenges in providing person-centred care. Issues included inconsistent staff training, inadequate care plans, and insufficient family involvement. The audit recommended improving training, regular care plan reviews, and prioritising leadership in dementia care to drive improvements.

The **NHS Long Term Plan** (2019) outlined a strategy for transforming healthcare in England, focusing on early detection and diagnosis, integrated care, and workforce development. The plan set targets for dementia diagnosis rates and emphasised the importance of post-diagnostic support. It also advocated for integrated care systems that combine health and social care to provide seamless, person-centred care. Families and carers were recognised for their role, with provisions for better information, respite care, and involvement in care planning.

The **Vision and Strategy for Dementia Care** (NHS England, 2019) aimed to improve dementia care through person-centred approaches, focusing on early diagnosis, public awareness, and the integration of health and social care services. The strategy called for significant investment in workforce development, including specialised training to support staff to provide compassionate care. It also emphasised research and innovation to advance treatments and foster collaboration between healthcare providers and the pharmaceutical industry. The strategy addressed health inequalities and included a framework for monitoring progress and ensuring accountability in dementia care.

Figure 3: NHS England: Vision and Strategy: An Approach to Dementia Care (NHS England, 2019)



Vision and Strategy: An Approach for Dementia Care

Care
- Respect people with dementia, recognising the patients views and preferences
- Develop an environment that is adapted for dementia care and that maximises wellbeing
- Recognise dementia is not a mental health problem exclusively and support the right to dignity in care
- Connect families to resources and connect communities to support health and wellbeing
- Work in partnership with the patient/carer to take time to listen, use the carer as a resource
- Know the person not the condition, focus on unmet need
- Value the individual and their story, do not judge

Compassion
- Support people with dementia to live well and stay independent
- Show empathy and kindness during times of distress
- Respond to the uniqueness of the patient
- Act for the dementia patient with integrity
- Help and supports carers to cope
- Ensure person based approach that respect the person and the things that still matter

Competence
- Recognise your role in dementia care no matter what speciality or field of nursing
- Promote and lead dementia awareness
- Understand the complexities of dementia care, the wider pathway and supporting services
- Understand the complex physical, mental health, emotional and spiritual needs
- Support advanced care planning, choices and wishes as illness develops
- Promote public health messaging "health heart / health head"

Communication
- Recognise every contact can contribute to early identification, diagnosis, support and treatment
- Communicate sensitively to support meaningful interaction
- Provide information and use skills to provide a seamless interface and care between patient, community and other agencies
- Use all available resources including technology and social media to improve care and access to services
- Create partnerships with the family

Courage
- Make dementia everyone's business, and champion excellent dementia care
- Stand up for patients and against 'dementiaism' and 'carerism'
- Is proud to care for people with dementia
- Lead and champion the importance of dementia nursing
- Challenge the system to ensure patients' best interests are at the centre of service delivery
- Empower and supports choice

Commitment
- Make dementia care valued
- Commit to action such as the delivery of a dementia friendly environment
- Deliver and designs innovative and quality dementia services
- Commit to improving health and wellbeing for those with dementia
- Uses specialist knowledge to influence and direct commissioning
- Reduce stigma around dementia, raise awareness and inspire others
- Sign up to 1 Million Friends

Demonstrating 6Cs in Dementia Practice

Maximising the unique Nursing contribution to high quality, compassionate and excellent care and support for all people with Dementia and their Carers, caring for loved ones with dementia.

Service Offer – Our offer is to all nurses and to every person with dementia and their carers

Key Facts
- Dementia is a term that is used to describe a collection of symptoms including memory loss, problems with reasoning, perception and communication skills. It also leads to a reduction in a person's abilities and skills in carrying out routine activities such as washing, dressing and cooking.
- The most common types are: Alzheimer's disease, Vascular dementia, Fronto-temporal dementia and Dementia with Lewy bodies- all progressive conditions, which means symptoms are likely to get worse over time. The progression will vary from person to person and each will experience dementia in a different way.
- The number of people with dementia is increasing and presents a significant and urgent challenge to health and social care, both in terms of the number of people affected and the associated cost.

Dementia Vision

This vision was developed in recognition of the needs for a much greater common understanding and awareness across all fields of nursing on what the nursing contribution to the dementia challenge is and what constitutes good quality in dementia nursing care, public health prevention, treatment and support.

- Dementia nursing is complex, exciting and challenging. This nursing vision describes how every nurse needs to involve themselves in dementia care across the whole pathway.
- The nursing vision requires all nurses to know about dementia, know the early signs, as early diagnosis of dementia helps people receive information, support and treatment at the earliest possible stage.
- The nursing vision requires all nurses to increase basic awareness, reducing social stigma, lack of knowledge, to ensuring the best care for people with dementia at the end of their lives and enabling, if not providing, on-going support to families.
- It describes and defines what is expected of nurses in order to meet the level and quality of care we all expect, every time, right now and in the future within all care settings.
- The inter-connectivity between all fields of nursing, environments of care and a collaborative approach to deliver co-ordinated services is central to the success of Dementia care and the Dementia Challenge.
- It is essential to understand the range and breadth of partner agencies and their role in supporting people with dementia and providing care nearer to home, both within the NHS, social care and wider community.
- The Vision and Service Model is set in the context of the broader national nursing strategy - Developing a Culture of Compassionate Care, which includes the six Cs - for dementia nursing values and behaviours together with the six priority actions for maintaining health and wellbeing outcomes relating to Dementia Care.

All nurses and midwives contribute to the early part of the pathway. Nurses with specific and or specialist skills and roles will support at different points in the Dementia Journey

In summary, various initiatives, reports, and guidelines from 2009 to 2019 have worked to improve dementia care in the UK. The strategies and policies developed over this period have laid a strong foundation for ongoing improvements in dementia care, supporting individuals with dementia and their families receive the support they need throughout the dementia journey.

1.2.1: Summary of Dementia Guidance and Policies

The National Dementia Strategy (2009) was the first document in the UK to focus on the development of services, including the memory services and the timely diagnosis. The Prime Minster's Challenge on Dementia 2020 (2012; 2015) published three years later expanded and focused again on prevalence and diagnosis, however the document started to explore research and implementing dementia friendly environments. This was the first document that started to discuss funding of dementia related research, including three hundred million for the "Join Dementia Research" programme that focused on increasing research recruitment.

Eight years after the first dementia related government document, National Dementia Strategy (2009), the care within acute hospitals was reviewed within the document Fix Dementia Care: Hospitals (Alzheimer's Society, 2016) the report continued to highlight inadequate care received by people with dementia and a lack of understanding from healthcare professionals. In response to these findings, the Fix Dementia Care: Hospitals report offered recommendations focusing on mandatory dementia training for all hospital staff, coordinated approach to discharge planning and better data collection and transparency regarding the quality of dementia care in hospitals. The need for education had been highlighted within the National Dementia Strategy (2009) and the Prime Minster's Challenge (2012; 2015) as an important factor that was needed to support staff providing dementia care and to improve the care of people with dementia.

The NHS Well Pathway (2016) was developed to support both people with dementia and healthcare professionals. The Well Pathway (2016) has been criticised by Alzheimer's Society (2020) who wrote a report that listed several concerns about its implementation. The report highlighted that people were being misdiagnosed, particularly younger people; the information that was provided at the point of diagnosis was not being delivered in an appropriate manner; people struggled to access services and the lack of acknowledgement that dementia is a terminal condition and people often struggle to access palliative care.

The State of Care in Acute Hospitals report (CQC, 2017) was a wider report focusing on older adults but included people with dementia. The report highlighted inadequate and inappropriate care received by people with dementia, however there is a decade of policies and initiatives that were implemented prior to this review that hoped to improve the care being provided by healthcare professionals.

NICE guidelines (2018) revisited previous data released in the National Dementia Strategy (2009) including prevalence. NICE guideline (2018), again, stresses the importance of diagnosis the same as National Dementia Strategy (2009), Prime Minster Challenge (2012; 2015) and The Well Pathway (2016). The NICE guidelines (2018) discussed for the first time the use of medication and non-pharmacological approaches to support people with dementia. The NICE guidelines (2018) started to discuss supporting the mental and physical well-being of carers in more detail, although this was mentioned briefly within the National Dementia Strategy (2009) and The Well Pathway (2016). The NICE guidelines (2018) also discussed end of life care needs of people with dementia, building on the Dying Well section of The Well Pathway (2016). The use of Memory Clinics identified within the National Dementia Strategy as a diagnostic method, was contradicted by the NICE guidelines (2018) recommending the use of MHLTs as an approachable source of consultation, support and training.

The Dementia-Friendly Hospital Charter (2018) again focused on the need for adequate education of healthcare professionals to recognise, support and care for people with dementia in different healthcare settings. The charter also discussed the use and need of dementia friendly environments to support people with dementia, which had been raised as an intervention within the Prime Minster's Challenge on Dementia 2020 (2015).

The National Audit of Dementia Care in General Hospitals (2019) was produced ten years after the National Dementia Strategy (2009) and reviewed the implementation of this strategy and the other policies produced since. The report highlighted the lack of understanding and knowledge of healthcare professionals as an unresolved concern, as previously reported in Dementia-Friendly Hospital Charter (2018); State of Care in Acute Hospitals report (CQC, 2017); The NHS Well Pathway (2016); National Dementia Strategy (2009) and the Prime Minster's Challenge on Dementia 2020 (2012; 2015).

The NHS Long Term Plan (2019) again discussed the need for a timely diagnosis repeating the same rationale and reasoning as the National Dementia Strategy (2009) ten years earlier. The plan reiterates the need for specialist care and introduced integrated care systems to reduce the fragmentation of services. Again, supporting carers and new initiatives to involve carers were also highlighted similar to the NICE guidelines (2018).

The Vision and Strategy: An approach for dementia care (NHS England, 2019) discussed a plan on transforming dementia care across England, again, focusing on early diagnosis, collaborative care, the role of carers, the support that healthcare professionals need and research. These elements have been repetitively discussed in the majority of the dementia related documents (NHS Long Term Plan, 2019; National Audit of Dementia Care in General Hospitals, 2019; Dementia-Friendly Hospital Charter, 2018; State of Care in Acute Hospitals report, CQC, 2017; The NHS Well Pathway, 2016; National Dementia Strategy, 2009; Prime Minster's Challenge on Dementia 2020 (2012; 2015).

An overview and understanding of these policies on dementia, which have been published since 2009 to improve the care and support of people with dementia, their carers and healthcare professionals and the evaluation of current dementia care as part of the introduction of this thesis is essential. The policies published identified the same factors and initiatives to address these factors, but the evaluations of changes within dementia care highlighted some good practices, but in general, inadequate dementia care and support was found for people with dementia, their families and carers and healthcare professionals.

1.3: The impact of Dementia in acute hospitals

The prevalence of dementia in acute hospital settings is significant, with studies estimating that approximately 20–25% of hospital patients are affected by dementia (Singh et al, 2019; Sampson et al, 2019). However, these numbers are likely underestimated, as many individuals with dementia go undiagnosed. Karrer et al. (2021) found in that around 56% of patients with dementia are not identified or recognised by healthcare staff during their hospital stay. This underdiagnosis or delayed recognition can contribute to suboptimal care, which is a growing concern in acute hospital settings (Fogg et al, 2018; Alzheimer's Association, 2024).

An unplanned admission for people with dementia can have detrimental effects on their health, exacerbating existing symptoms and contributing to poorer overall outcomes. Dewing and Dijk (2016) explain that busy, noisy, and disorienting hospital environments can be particularly harmful for people with dementia. Sensory overload from alarms, staff changes, and rigid routines can heighten confusion, anxiety, and agitation. The unfamiliar setting, combined with limited social engagement, may lead to distress, withdrawal, and worsening cognitive function.

Patients with dementia are more likely to experience physical complications, such as falls due to poor lighting or cluttered spaces, infections, and delirium, compared to other patients. These complications can contribute to extended hospital stays, which further increase the risk of negative outcomes (Livingstone et al., 2020; Davey et al, 2024; Fong and Inouye, 2022). One major factor contributing to these negative outcomes is the quality of care provided to people with dementia in acute hospitals. Studies consistently show that people with dementia often receive poorer care compared to those without the condition (CQC, 2024; CQC, 2018; Crowther et al, 2022; Livingstone et al, 2020). The Care Quality Commission (CQC, 2018) reports that more than a fifth of services that provide dementia care are rated as failing. Similarly, the Department of Health and Lord Darzi Report (DoH, 2016; Darzi, 2024) indicates that 49% of healthcare professionals agree that people with dementia receive worse care than those with other long-term conditions, such as cancer or heart disease. This disparity is attributed to a lack of understanding and insufficient knowledge about dementia care among healthcare professionals (NICE, 2018; Abbott et al., 2022). When staff are not adequately trained or equipped to recognise, manage and support people with dementia the care provided can be inconsistent, which ultimately affects patient well-being.

Nurses' education on dementia often lacks depth in behavioural management, communication strategies, and person-centred care. Many nurses receive only basic training, leaving them unprepared for the complexities of behaviour and psychological symptoms of dementia (Surr et al., 2017). There is also limited focus on non-pharmacological interventions, environmental adaptations, and interdisciplinary collaboration, leading to inconsistent care approaches (Handley et al., 2017; Wiener and Pazzaglia, 2021). Research has also pointed to the need for changes in acute care settings (Martin et al, 2018; Røsvik and Rokstad, 2020). Livingstone et al. (2020) highlight the need for specialised care approaches, including better communication strategies tailored to the needs of patients with dementia, effective management of behavioural and psychological symptoms, and improved discharge planning. Communication with individuals living with dementia is often hindered by cognitive impairments, including memory loss and difficulty with language.

The management of behavioural and psychological symptoms of dementia (BPSD), such as aggression, agitation, and depression, requires targeted interventions. Nurses often lack the specific resources and training needed to address these symptoms, leading to ineffective care and increased patient distress (Khademi et al, 2015). Griffiths et al. (2014) explored the barriers to effective dementia care in hospitals, identifying issues such as inadequate staff training, lack of awareness, and a hospital environment that is not dementia-friendly. They found that the physical environment of hospitals, including lighting, signage, and space design, often fails to accommodate the needs of patients with dementia leading to heightened stress for both patients and staff. These findings highlight the importance of adopting dementia-friendly hospital initiatives. Griffiths et al. (2014) advocate for a multidisciplinary approach to dementia care, emphasising that healthcare teams should be equipped with dementia-specific knowledge and work collaboratively to provide holistic care. Such initiatives can include adjustments to the hospital environment, such as using clearer signage, reducing noise, and incorporating familiar objects in patient rooms, all of which can help reduce disorientation and anxiety in people with dementia. Additionally, multidisciplinary teams, which might include specialists such as geriatricians, psychiatrists, and social workers, can work together to support the full spectrum of patient needs; physical, psychological, and social are addressed.

As part of this multidisciplinary approach, more research is also needed into improving discharge planning for people with dementia. Poor discharge planning is often cited as a significant contributor to hospital readmissions for patients with dementia (Browne et al, 2024; Pickens et al, 2017). These patients frequently face difficulties transitioning back to home or other care settings, and without adequate follow-up care, they are at increased risk of readmission or worsening symptoms. The integration of dementia care into discharge planning, with clear communication and coordination between hospital teams, patients, and families, could be helpful in improving post-hospital outcomes.

Nurses, doctors, and allied health professionals as part of their roles may be significant in recognising dementia-related symptoms, managing care effectively, and ensuring that patients receive adequate support throughout their hospital stay. Research has shown that even among healthcare professionals, awareness of dementia care practices is often insufficient (Yaghmour et al, 2021; Sideman et al, 2022). Abbott et al. (2022) highlight, many healthcare workers lack the necessary skills and knowledge to provide person-centred dementia care. This gap in expertise may contribute to inadequate symptom management, miscommunication with patients, and ultimately poorer patient outcomes.

Despite these challenges, recent developments in the field offer promising solutions. The implementation of hospital-wide dementia care programmes, such as the "Dementia-friendly hospitals" initiative in the UK, has led to improvements in care delivery, particularly when it comes to staff training, environmental modifications, and multidisciplinary teamwork (Livingstone et al., 2020). These initiatives aim to create a hospital environment that is more attuned to the needs of patients with dementia, offering a model for best practices that could be expanded across more hospitals to ensure that individuals with dementia receive high-quality, person-centred care.

1.4: Definition of Support

Support can be understood as the assistance, encouragement, or resources provided to individuals or groups to help them achieve a goal or overcome challenges (Drageset, 2021). It can take various forms, including emotional, informational, instrumental, and social support (Acoba, 2024). Emotional support involves offering empathy, care, and reassurance, helping individuals feel understood and valued (Bradshaw et al, 2022). Informational support includes providing advice, guidance, or knowledge to aid decision-making and problem-solving (Wu et al, 2019). Instrumental support refers to tangible assistance, such as physical help, or access to necessary resources (Schultz et al, 2022). Social support encompasses the relationships and networks that contribute to a sense of belonging and connectedness (Acoba, 2024).

In the context of this study, which explores how nurses seek support while caring for patients with dementia in an acute hospital setting, support is conceptualised as both a process and an outcome, shaped by the experiences and perspectives of the participants. As a process, support encompasses ongoing engagement, responsiveness, and adaptability, ensuring that nurses receive the assistance they need in real time. This process involves various forms of interaction, including peer collaboration, managerial guidance, access to educational resources, and emotional reassurance, all of which help nurses navigate the complex challenges associated with dementia care in a high-pressure hospital environment (Bridges et al., 2020; Dookhy and Daly 2021).

As an outcome, support manifests in tangible and intangible benefits that enhance the nurse's ability to deliver quality care. These outcomes may include increased resilience in managing the emotional and physical demands of dementia care, improved well-being through reduced stress and burnout, and greater efficiency in completing essential clinical tasks (Kyranou and Karanikola, 2025; Smythe et al., 2017). The study aims to explore how nurses define, seek, and experience support, shedding light on strategies that can improve their professional experiences and, in turn, enhance patient care outcomes in acute hospital settings.

1.5: Support for nurses working with patients with dementia

Providing adequate support for nurses working with patients with dementia in acute hospital settings is needed in providing high-quality care. This support encompasses training and education, emotional and psychological assistance, practical resources, and organisational infrastructure. Research consistently highlights the importance of these areas, noting both the benefits and challenges associated with their implementation (Brooke and Ojo, 2017; Moody et al, 2024).

Training programmes and educational resources are fundamental in equipping nurses with the knowledge and skills necessary for providing effective dementia care. A robust training framework ensures that nurses understand the complexities of dementia and are capable of providing person-centred care (Skills for Health 2015; 2018; Gkioka et al, 2020). According to Surr et al. (2017) and Gkioka et al. (2020), a variety of training models exist, but there is significant variation in their delivery and effectiveness across NHS Trusts. The introduction of the Dementia Training Standards Framework (Skills for Health 2015; 2018) aimed to address these variations, establishing consistent standards for dementia training. However, evaluations of the education provided across NHS Trusts reveal that the content, format, and impact of these programmes can differ widely. While some Trusts have successfully implemented comprehensive training, others have struggled with resource limitations and the lack of standardisation (Surr et al., 2017).

Featherstone et al (2019) found that nurses who participated in targeted dementia care training programmes reported increased confidence in managing dementia-related behaviours and improving communication with patients. However, the study also highlighted that while formal training is essential, it is often not sufficient on its own. Nurses also need ongoing support and practical application of the knowledge gained in training to effectively implement care strategies in real-world settings.

Effective dementia training should not only impart theoretical knowledge but also offer practical, hands-on learning experiences. Using simulation-based training, interactive workshops, and mentorship programmes have been found to be particularly effective in bridging the gap between theory and practice (Gkioka et al., 2020). Training should also be ongoing, with regular updates to support nurses remain informed about the latest evidence-based practices, treatment protocols, and advancements in dementia care (Evans et al, 2023). This supports nurses to be well-prepared to adapt to the changing needs of individuals with dementia throughout their care journey.

Structured debriefing sessions have been identified as an effective way to support nurses in coping with the emotional challenges of dementia care. These sessions provide an opportunity for nurses to discuss difficult situations, express their emotions, and receive guidance from peers or mental health professionals (Evans et al, 2023). Such support helps nurses process challenging experiences, reduces feelings of isolation, and fosters a sense of community among staff members.

Joo et al (2022) highlighted the significance of peer support networks for nurses as a method of support, as nurses who were part of structured peer support groups felt more resilient in the face of emotionally challenging situations. Peer support was particularly beneficial for sharing strategies for coping with difficult behaviours, alleviating stress, and promoting a sense of teamwork and shared responsibility.

Practical resources are another component that may support nurses working in dementia care. The availability of evidence-based guidelines and tools support nurses to deliver consistent and high-quality care. The National Institute for Health and Care Excellence (NICE, 2018) provides comprehensive guidelines on dementia care, which include recommendations for assessment, management, and support for individuals living with dementia. By providing access to these resources, healthcare organisations can equip nurses with the tools necessary for making informed decisions and delivering best practice care.

Organisational support plays a role in creating an environment that enables nurses to provide high-quality dementia care. Research suggests that well-structured organisations with clear protocols, strong leadership, and effective multidisciplinary teams are needed for delivering effective dementia care (Galvin et al, 2014; Ellis and Sevdalis, 2019). Nurses benefit from working in an environment where dementia care is a priority, and where there is a culture of support and collaboration across disciplines (Hult et al., 2023; Mabona et al., 2022).

A supportive organisational culture includes the development of clear care pathways, access to specialist dementia teams, and opportunities for collaborative practice with other healthcare professionals, such as occupational therapists, psychologists, and social workers (Reeves et al, 2017; Bergmann et al, 2022). This collaborative practice supports nurses to provide holistic care, addressing both the physical and emotional needs of individuals with dementia. Strong leadership within the healthcare setting can ensure that dementia care is prioritised, with sufficient resources allocated for training, staffing, and support (Reeves et al, 2017; Bergmann et al, 2022; Richards et al, 2024).

The NHS and acute hospital settings must also focus on creating a positive work environment that reduces stress and supports nurse well-being. This includes ensuring manageable workloads, providing adequate staffing levels, and promoting a culture of respect and recognition for the challenging work involved in dementia care (Henshall et al., 2020). Research shows that when nurses feel supported by their organisation and leadership, they are more likely to be satisfied with their work and remain committed to providing high-quality care (Ebrahimi et al., 2020). This includes research relating to how work environments and person-centred care can impact on dementia care (Rutten et al, 2021). A well-designed, person-centred environment is characterised by calm surroundings, familiar routines, and compassionate care and can reduce anxiety, agitation, and confusion, enhancing overall well-being (Day et al., 2000; Fleming and Purandare, 2010). Conversely, a stressful or poorly structured environment, such as one with high noise levels, frequent staff turnover, or task-focused care, can lead to anxiety and other behavioural and psychological symptoms of dementia for individuals with dementia (Calkins, 2018; Yang et al, 2019). This highlights the need for supportive, well-resourced acute care settings that prioritise both staff and the specific needs of people living with dementia (Rutten et al., 2021).

Despite the identified importance of training, emotional support, practical resources, and organisational support, challenges remain in fully addressing the needs of nurses working in dementia care. Henshall et al. (2020) highlight that limited resources, inadequate staffing, and competing priorities can hinder the implementation of effective support systems. In some settings, the lack of time and funding for comprehensive training programmes or emotional support services may lead to burnout and decreased quality of care.

The complexity of dementia care requires a multidimensional approach, which can be difficult to implement in busy hospital settings. Research suggests that the integration of dementia care into broader healthcare training and the promotion of collaborative working environments are key to overcoming these challenges (Gkioka et al., 2020; Mabona et al., 2022). Addressing the emotional, practical, and organisational aspects of support for nurses is needed for improving dementia care and ensuring that nurses can effectively meet the needs of patients.

Supporting nurses in dementia care is a multifaceted challenge that requires ongoing investment in training, emotional support, practical resources, and organisational infrastructure. Research underscores the need for comprehensive training programmes, effective emotional support systems, access to dementia care guidelines, and supportive organisational structures. While progress has been made, there remain significant challenges in fully addressing the needs of nurses. Continued efforts to improve these support mechanisms will be essential in ensuring that nurses can provide high-quality, compassionate care to individuals living with dementia in acute settings.

1.6: Initiatives to support the care of patients with dementia

A number of initiatives have been implemented within acute hospitals to support the care of patients with dementia, these include mental health liaison teams (MHLTs), dementia champions and dementia leads, dementia-friendly environments and the implementation of dementia care bundles. These initiatives were discussed within the policies developed since 2009 (NHS Long Term Plan, 2019; National Audit of Dementia Care in General Hospitals, 2019; Dementia-Friendly Hospital Charter, 2018; State of Care in Acute Hospitals report, CQC, 2017; The NHS Well Pathway, 2016; National Dementia Strategy, 2009; Prime Minster's Challenge on dementia 2020 (2012; 2015).

1.6.1 Nurses with expertise in dementia

The creation of roles focused on nurses with expertise or nurse who have been given teaching to expand their dementia expertise should be part of the criteria in improving dementia care in acute hospital settings. Nursing expertise in dementia care combines both clinical practice and academic knowledge, creating a foundation for innovative approaches to care (McHugh, 2010). While there is growing recognition of the importance of expertise in dementia care, the literature defining what constitutes dementia expertise remains limited. While government reports and healthcare policy documents advocate for expert involvement in dementia care, they often fall short of providing a clear and evidence-based definition of expertise (Department of Health, 2009; 2012; 2013; 2015).

Dementia specialists are generally described as nurses with an expert level of skill and knowledge, tasked with providing specialised care for people living with dementia and their families (DoH, 2013). These specialists are expected to demonstrate higher levels of competence compared to standard adult nurses, yet there is a lack of evidence that explains how clinical knowledge translates into expertise among dementia specialists. Specialist nurses such as Admiral Nurses, who are known for their advanced dementia knowledge and skills, are expected to support best practices in dementia care (Page and Hope, 2013). However, little research has been conducted to measure how the depth of this knowledge correlates with improved patient outcomes, and how expertise is developed, assessed, and maintained. These specialist roles serve as a resource for frontline nursing staff, helping them manage complex needs for patients with dementia, including behavioural and psychological symptoms and communication difficulties (DoH, 2013). Specialist nurses, like Admiral Nurses, contribute to best practices by offering tailored interventions, coordinating care, and advocating for person-centred approaches (Page and Hope, 2013). Additionally, they aim to help bridge gaps in nursing education by sharing advanced knowledge on dementia, non-pharmacological interventions, and family support.

Despite the previously mentioned gaps in understanding, the implementation of roles such as dementia leads and dementia champions within acute hospital settings has been increasingly recognised as essential in enhancing dementia care (Abbott et al, 2022; Karrer et al, 2021). These roles have emerged in response to the growing acknowledgment of the unique needs of patients with dementia in acute care environments. Dementia leads, champions and specialist nurses are seen as a supportive role for ensuring that dementia care remains a priority, and that staff are equipped to deliver high-quality, person-centred care. Research and reports such as those from the Alzheimer's Society (2016), NHS England (2019), and the Department of Health (2020) have recommended for these roles as part of efforts to improve dementia care across the UK.

Dementia champions, often frontline staff such as nurses and healthcare assistants, are specifically trained to advocate for dementia care within their teams (Gkioka et al, 2020). They raise awareness about dementia, provide educational resources, and support colleagues in delivering appropriate care. Their involvement has been associated with positive patient outcomes, including reduced distress and confusion among patients, shorter hospital stays, and fewer readmissions. The Alzheimer's Society (2016) report Fix Dementia Care: Hospitals found that hospitals with active dementia champions often reported better patient experiences and outcomes, highlighting the tangible benefits of these roles in practice (Abbott et al, 2022). Dementia leads and champions ensure that dementia is prioritised at every stage of the patient journey, from admission to discharge. They help facilitate better care coordination, ensuring that the unique needs of people with dementia are consistently met throughout their hospital stay.

Research supports the effectiveness of dementia champion and dementia lead roles in improving dementia care outcomes (Kim and Park, 2017; Goeman et al, 2016; Ramussen et al, 2023). The National Audits of Dementia Care in General Hospitals by the Royal College of Psychiatrists (2019; 2022; 2025) demonstrated that hospitals with dementia leads and champions in place are more likely to meet recommended care standards. These include providing dementia-friendly environments, ensuring staff are appropriately trained, and actively involving family carers in the care process. The audits also found that dementia leads were instrumental in identifying gaps in care and developing action plans to address deficiencies, further contributing to continuous improvement in care quality.

While these specialist roles are increasingly integral to dementia care, there remains a need for further research into the impact of nurses with dementia expertise on patient outcomes. Specifically, there is a need to examine how expertise translates into improved clinical practices and better patient experiences, as well as the mechanisms through which nurses with dementia expertise influence care within acute hospitals. Additionally, understanding the pathways through which nurses gain expertise, through training, clinical experience, and academic development, is needed to be able to advance dementia care in acute settings.

1.7: Education for healthcare professionals working in acute hospitals

Education provides a background theory and practical knowledge that can be tested and used in actual situations, building an individual's level of expertise (Dreyfus and Dreyfus, 1996). Hands-on learning is the basis of good clinical judgement, and a necessary education foundation of nursing programmes, as encourages the development of skills through experience (Benner, 2004). Most expert clinical performance can be attained from supportive and encouraging environments, where all levels of expertise learn from each other (Benner, 1984). Organisations that support enabling nursing environments develop clinical autonomy, sustainable education, increase shared experience and knowledge with multi-disciplinary teams and provide support for decision making and action (Lake and Friese, 2006).

A pivotal piece of research that provides a comprehensive overview of the dementia education and training in the UK is the scoping review by Surr et al (2017). The review mapped out existing dementia training programmes, revealing a wide range of approaches but also significant variation in content, delivery, and evaluation in England. This review highlighted the need for more robust, evidence-based training programmes, particularly in the context of acute hospitals where dementia leads and champions play a critical role. These findings align with the objectives set out in the Prime Minister's Challenge on Dementia (2015), which emphasises the importance of dementia-specific leadership within hospitals. The research shows that effective dementia education must go beyond theoretical knowledge, incorporating practical skills and promoting person-cantered care approaches.

People living with dementia represent a forty percent proportion of patients that use non-mental health acute hospital settings, until recently in the UK there are no prescribed standards for dementia education and training (Alzheimer's Society, 2009). In 2015 there was the development of the Dementia Training Standards Framework (updated in 2018) that NHS Trust's in the UK use to develop the learning outcomes associated with their training.

It is highlighted that the need for education and training for the nurses and healthcare professionals is important, there is currently no mandated requirement for accredited training.

Consequently, poor levels of knowledge about dementia in the nurses and healthcare professionals are common (RCoP, 2019). The UK government has set targets to increase the number of staff that receive dementia training due to the rising prevalence of dementia (DoH, 2013; DoH, 2015). The Dementia Training Standards Framework (Skills for Health, 2015; 2018), outlines the essential subjects and learning outcomes that health and social care staff should achieve in order to deliver an acceptable standard of dementia care (Skills for Health, 2015; 2018). The Dementia Training Standards Framework is divided into three tiers of Learning Outcomes.

Table 1: Dementia Training Standards Framework: Three Tiers (Skills for Health, 2015; 2018)

Tier 1	Refers to training that all health and social care staff should receive. LOs within this tier of training promote dementia awareness. For example porters, catering or kitchen staff should receive this training.
Tier 2	Refers to training health and social care staff in high prevalence area of patients with dementia. LOs in this tier of training sets out basic skills and knowledge relevant to any staff who have regular contact or provide direct care for people with dementia, such as registered nurses or care support staff.
Tier 3	Refers to training health and social care staff to be leaders and experts. LOs in this tier of training sets out advanced knowledge in the field of dementia care such as health and social care mangers, ward managers, dementia champions or dementia care trainers.

The Dementia Training Standards Framework (Skills for Health, 2015; 2018) is structured into fourteen subject areas, each designed to ensure that staff possess the necessary knowledge and skills to deliver high-quality, person-centred care. The framework begins with a focus on dementia awareness, which encompasses a foundational understanding of dementia, including its different types, underlying causes, and the impact it has on individuals and their families. This fundamental awareness is needed for all staff, enabling them to recognise the signs and symptoms of dementia and understand the broader implications of the condition. Following this, the framework addresses dementia identification, assessment, and diagnosis. This section highlights the importance of early detection and accurate diagnosis of dementia, detailing the processes involved in assessment and diagnosis. The role of healthcare professionals in facilitating a timely diagnosis, which is essential for accessing appropriate care and support. Another significant component is dementia risk reduction and prevention, which emphasises strategies for mitigating the risk of developing dementia. This includes understanding modifiable risk factors such as lifestyle choices, diet, exercise, and the management of co-existing health conditions. The aim is to promote practices that could potentially delay or reduce the onset of dementia. A core aspect of the framework is person-centred dementia care. This principle revolves around tailoring care to the individual's unique needs, preferences, and life history. The framework stresses the importance of respecting each person's individuality and ensuring that care is personalised and responsive to their specific circumstances.

The framework also covers communication, interaction, and behaviour. These areas deal with the complexities of communicating with individuals who have dementia, including strategies for effective interaction and managing changes in behaviour. It includes techniques for fostering positive communication and addressing challenging behaviours in a supportive manner. Health and well-being is another area that focuses on maintaining the physical and mental health of individuals with dementia by managing co-existing conditions, promoting good nutrition and hydration, and supporting overall mental well-being. This area ensures that care addresses all aspects of health to enhance the quality of life for those affected by dementia. The framework emphasises living well with dementia and promoting independence, which aims to support individuals in maintaining as much independence as possible. This includes assistance with daily living activities, fostering social engagement, and making environmental adaptations to support autonomy and well-being. Recognising the vital role of caregivers, the framework addresses supporting carers of people with dementia. This area focuses on providing carers with the necessary support, information, and resources. It highlights the challenges faced by carers and the importance of involving them in care planning and decision-making processes.

Equality, diversity, and inclusion is another key area, highlighting the need for care that respects and accommodates the diverse backgrounds of individuals with dementia. This section stresses the importance of delivering equitable care that is sensitive to cultural, religious, and personal differences. The framework also includes law, ethics, and safeguarding, which covers legal and ethical considerations in the care of individuals with dementia. It addresses issues related to consent, capacity, and safeguarding, ensuring that care is provided in a manner that respects individuals' rights and protects them from harm. In the area of end-of-life, the framework outlines principles for providing compassionate care at the end of life. It includes guidelines for palliative care, symptom management, and supporting both the individual and their family during this critical phase. Research and evidence-based practice highlights the importance of staying current with research and best practices. This area promotes the integration of evidence-based approaches into daily care to improve outcomes and enhance the quality.

Whilst providing guidance for content, the Dementia Training Standards Framework (Skills for Health, 2015; 2018) does not take account of the pedagogical considerations of training. The diversity of the dementia workforce presents unique challenges for healthcare providers. A review sought to establish the common features of high quality educational provision for the dementia care (Surr et al, 2017). The review adopted Kirkpatrick's model (1984) to conceptualise impact of training, whereby training with greater impact influences behaviour as well as knowledge. Review of dementia education with healthcare settings indicated that education and training programmes with greatest impact were tailored to the recipient staff groups and relevant to their role and experience, therefore avoiding a one fits all approach. Better education and training included active participation (such as group discussions and activities) that underpinned practice-based learning with theory (Surr et al, 2017). Effective education and training lasted at least eight hours in total, with sessions of 90 min or more, and was delivered by an experienced facilitator. It also provided opportunities to support the application of learning in practice.

Although there have been policy initiatives designed to increase dementia education and training, no registration or accreditation for dementia training exist therefore there is no assurance regarding training quality (Parveen et al, 2021). According to Surr et al (2017) and Gkioka et al (2020) highlighted the varied levels of education and method of delivery, there is a lack of evaluation on the effectiveness of the education being provided and how it maps to the guidelines outlined in the Dementia Training Standards Framework (Skills for Health, 2015;2018).

1.8: Nurses Seeking support

Nurses are key in delivering comprehensive care to patients with dementia. The demands of caring for individuals with dementia can be overwhelming, often leading to high levels of stress, emotional exhaustion, and burnout among nurses (Ye et al, 2024). These challenges necessitate robust support mechanisms to ensure that nurses can provide high-quality care while maintaining their well-being (Kang and Hur, 2021).

Seeking support refers to the proactive process of identifying, reaching out for, and utilising resources or assistance to address personal needs, challenges, or issues. This process can involve a variety of forms, including emotional, practical, medical, or social support, and may be sought from a wide range of sources (Posluns and Gall, 2020). The goal of seeking support is to gain help, guidance, and resources necessary to manage and overcome difficulties, improve well-being of patients, and achieve a better quality of life for people living with dementia.

The complexities of dementia care require nurses to employ a variety of strategies to seek support. These strategies encompass interdisciplinary collaboration, continuous education and training, peer support, administrative assistance, access to community resources, and self-care practices (Galvin et al, 2015). Nurses must be equipped with appropriate knowledge and skills to support the needs of people with dementia. Supporting people with dementia requires a range of skills since people living with dementia can experience changes in behaviour that are influenced by cognitive impairment and unmet needs (Revolta et al, 2016). Person-centred care has been widely adopted as a valued approach to supporting people with dementia (Manthorpe and Samsi, 2016; Kim and Park, 2017). High quality education and training are essential for delivering high quality dementia care, and ensuring appropriate care are used (Finnema et al, 2005). Understanding how nurses seek and utilise these support systems is important for developing interventions that enhance their ability to care for patients with dementia effectively.

1.9: Rationale for study

The rationale for this thesis study centres on the need to understand the seeking support behaviours among registered nurses caring for patients with dementia in acute hospital settings. There are several key factors that underpin the importance of this study.

Dementia care is inherently complex, requiring specialised knowledge and emotional resilience. Nurses face challenges when caring for people with dementia, including managing complex symptoms, providing compassionate care, and dealing with the emotional impact of their work. Research indicates that inadequate support can lead to burnout and reduced care quality (Rodriguez-Monforte et al, 2021). The NHS Long Term Plan (2019) highlights the necessity for improved support systems to manage the growing demands of dementia care. This plan highlights the importance of mental health resources, continuous professional development (CPD), and structured mentoring programmes. By investigating current support mechanisms and their effectiveness, this study aligns with the NHS's call for better support structures in acute hospitals (NHS England, 2019). Despite the availability of various support mechanisms, there is considerable variation in their effectiveness. Informal peer support, while valuable, is often inconsistent and may not fully address the needs of all nursing staff (Wills et al, 2018).

Effective support for nurses is closely linked to improved patient outcomes and care quality (Molina-Mula and Gallo-Estrada, 2020). The Dementia Training Standards Framework (2015; 2018) emphasises that supportive work environments enhance care delivery and patient satisfaction. This study will explore how support mechanisms influence nursing practices and patient care, aiming to identify factors that contribute to better outcomes for patients with dementia (Livingstone et al., 2020). The NICE Guidelines on Dementia (2018) and the Fix Dementia Care: Hospitals report (Alzheimer’s Society’s, 2016) called for structured support and training for dementia care. This study will explore the experiences of nurses and possibly lead to discussions that include the implementation of these recommendations in acute hospitals and how they impact on nurse support and patient care. Understanding how nurses seek support will provide valuable insights for improving practice and policy. The findings may help identify effective support mechanisms, address areas needing improvement, and guide the development of strategies to enhance nurse well-being and care quality.

In summary, this thesis study plans to explore and understand how nurses seek support when caring for patients with dementia in acute hospitals. This study aims to explore how nurses seek and utilise support, offering insights into strategies that can mitigate these challenges. This study seeks to address these gaps by exploring both formal and informal support systems, contributing to the development of more robust and evidence-based practices. By examining existing support structures and their effectiveness, the study aims to contribute to the development of more effective support systems, improve nursing practices, and ultimately enhance the quality of care for individuals with dementia.

1.10: Personal Background

I have a BSc (Hons) in Psychology with Health Science during my degree I focused my optional modules towards counselling and mental health. This sparked my interest in mental health and lead to me completing my Mental Health Nursing qualification. The theoretical perspective that I was taught during my Psychology degree has also underpinned my research understanding and the importance of evidence-based practice. The curriculum taught me research methods for data collection and data analysis including statistics. During my nurse training I worked as a healthcare assistant in several dementia specialist units, this experience highlighted my love of working with older adults and supporting people with dementia.

Once qualified as a Mental Health Nurse I worked mostly within Older Adult Mental Health Services (OPCMHTs) (only working a six-month secondment to Crisis Intervention Team). I have managed OPCMHTs, worked in primary care, with GPs and within acute hospitals. I have also worked for CCGs in reviewing and commissioning services that specialise in dementia care, including the design of a new diagnosis service working with Age UK. I have developed variety of skills from successful care planning and MDT working that has supported people living with dementia and their families to working at a commissioning level reviewing the ‘bigger picture’.

It has not always been a positive experience and there have not always been the answers or the access to services that I needed to support me to support people living with dementia. A key factor that links specifically to my thesis, and the role I was in when I started to think about doing a doctorate. At the time I was working within a large acute hospital supporting the implementation of initiatives to improve the outcomes for patients with dementia and develop education packages based in the Dementia Education Standards Framework (2016; 2018) for staff. It was within this role that I observed poor practice due to a lack of knowledge of nurses about dementia and how to implement best practice in supporting a person with dementia.

Prior to starting my doctorate I was part of a research centre at a university as a visiting research fellow. This started my journey into being part of and creating research. This led to the development and publication of literature reviews and research studies that focuses on exploring the initiatives that support people with dementia and exploring the experiences of nurses using those initiatives. Over the years my research and publications have expanded into wider areas including students and prisoners – although continuing to focus on dementia care and the lived experiences of participants. At this point, I consider myself to be a phenomenologist focusing on a type of experience just as it is found, a pure description of lived experience.

In recent years I have moved into teaching dementia care skills at undergraduate and postgraduate levels to all branches of nursing and midwifery. I have supported the development of evidence-based practice modules teaching future nurses about how to understand research and how to implement its findings into practice. I also teach students about dementia and teach them the skills to be able to provide care for people living with dementia that come into their care. However, when asking the different groups if they are interested in working in older adult care or dementia care rarely does anyone seem interested.

Chapter 2: Literature Review

This chapter will discuss how a systematic literature was undertaken to support the development of research questions for the proposed study. Systematic literature reviews are used by researchers to identify what has been previously written about the topic, explore previous identified patterns or trends, aggregating empirical findings related to a narrow research question to support evidence-based practice, enable the researcher to generate new frameworks, theories and identify areas where there are gaps in the research (Pare and Kitsiou, 2017). Systematic literature reviews may also provide theoretical foundation for the proposed study and support the justification that the findings of the proposed study contribute something new to the cumulated knowledge (Averyard et al, 2016; Levy and Ellis, 2006). The aim of completing a systematic literature review is to understand the contemporary literature through an exploration of robust peer reviewed published studies. A seven-stage framework developed by Wright et al., (2007) was used to systematically complete the literature review. This chapter will present the in-depth seven stage framework using the stages as titles to map out the chapter. The seven stages will discuss the design, findings, analysis and identified gaps in research that informed the development of the research questions for the proposed study.

The focus of the systematic literature review was to explore the phenomenon of seeking support for a clinical need, particularly in the context of nursing practice. It was decided to not specify a particular department or restrict the search of the literature solely to acute care settings, such as acute hospitals, so as to gain a broader understanding of the various methods of support systems that may have been implemented across different clinical departments. This approach was designed to allow for a comparative analysis of past and current support structures, as well as to determine whether strategies from a variety of acute care departments could potentially be applied to how nurses seek support for clinical needs or to support a patient with a specific clinical diagnosis such as dementia. By examining the range of support systems in place across various clinical domains, this review aimed to uncover whether there are transferable models or practices that nurses in acute care settings could adopt to better meet their clinical needs and effectively address the challenges they face (Surr et al., 2017; Griffiths et al., 2015). This approach aligns with a growing body of research advocating for the use of multidisciplinary support networks and flexible, context-specific solutions to meet the complex and often urgent needs of healthcare professionals (Lowe et al., 2016; Hult et al., 2023). Additionally, exploring support systems beyond a single department offers the opportunity to understand how healthcare settings, regardless of their specific focus, can design and implement support structures that enhance the overall quality of patient care while addressing the emotional, psychological, and practical needs of nurses (Gkioka et al., 2020; Ebrahimi et al., 2020).

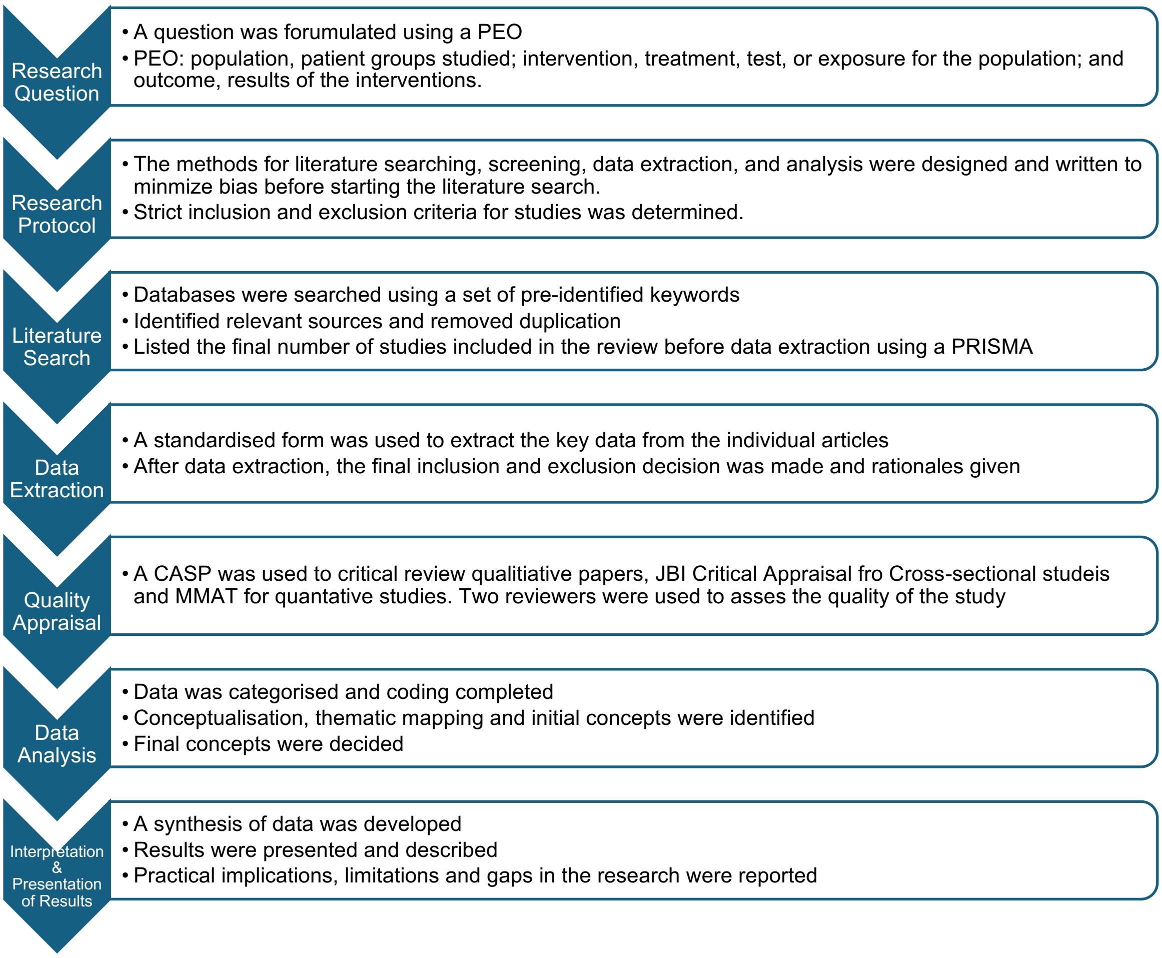
2.1: Literature Review Design

A literature review is required as part of a doctoral thesis study and is the first step in the development of a research question based on gaps in the research. There are five types of literature reviews, which include systematic review with meta-analysis; systematic review; scoping review; rapid review and traditional review. The aim of a systematic review is to identify and retrieve evidence that is relevant to a particular question or questions. A scoping review is more likely to provide an overview or map of the available evidence and possibly a precursor to a systematic review (Munn et al, 2018). Other types of literature reviews, such as rapid reviews and traditional reviews, which do not apply a systematic method may only include research selected by the authors, which may introduce bias (Janhan et al, 2016).

A systematic review is the application of scientific strategies and robust frameworks that limit bias by the systematic grouping, clinical appraisal and synthesis of all relevant studies on a specific topic (Manchikanti et al, 2009; Cook et al, 1995). A systematic review of literature uses reproducible and analytical approaches to gain information and assess the validity and applicability of the literature as a form of evidence evaluation (Shaheen et al, 2023). Systematic literature reviews are sources of evidence, which are acknowledged to be credible and the pinnacle of the hierarchy of evidence pyramid (Wright et al, 2007; Cognetti et al, 2015). The aim of this literature review was to search, appraise and synthesise research evidence. This process was completed through adherence to guidelines relating to conduct of a systematic literature review, which supported the systematic process and how to replicate the review. A systematic review has been chosen to understand the literature through robust exploration and to identify the appropriate method for the proposed study.

The systematic guidelines that were chosen for this literature review were the seven-stage framework, by Wright et al, (2007), which was utilised to enhance rigour of this systematic literature review. This framework was chosen as it provided a relatively standard form that used techniques that did not require formal training. The seven-stages of the framework include: (1) research question; (2) research protocol; (3) literature search; (4) data extraction;

(5) quality appraisal; (6) data analysis; (7) interpretation of results. Figure 4 below illustrates the application of Wright's (2007) seven-stage framework to this systematic literature review. This framework promotes the criteria for a systematic literature review as it is robust, detailed and promotes reliability.



Research Question
- A question was forumulated using a PEO
- PEO: population, patient groups studied; intervention, treatment, test, or exposure for the population; and outcome, results of the interventions.

Research Protocol
- The methods for literature searching, screening, data extraction, and analysis were designed and written to minmize bias before starting the literature search.
- Strict inclusion and exclusion criteria for studies was determined.

Literature Search
- Databases were searched using a set of pre-identified keywords
- Identified relevant sources and removed duplication
- Listed the final number of studies included in the review before data extraction using a PRISMA

Data Extraction
- A standardised form was used to extract the key data from the individual articles
- After data extraction, the final inclusion and exclusion decision was made and rationales given

Quality Appraisal
- A CASP was used to critical review qualitiative papers, JBI Critical Appraisal fro Cross-sectional studeis and MMAT for quantative studies. Two reviewers were used to asses the quality of the study

Data Analysis
- Data was categorised and coding completed
- Conceptualisation, thematic mapping and initial concepts were identified
- Final concepts were decided

Interpretation & Presentation of Results
- A synthesis of data was developed
- Results were presented and described
- Practical implications, limitations and gaps in the research were reported

Figure 4: The seven-stage framework according to Wright et al (2007)

2.2: The seven-stage framework (Wright et al, 2007)

2.3: Stage 1: Research Question

The first stage of the framework to support the literature review is to formulate a research question (Wright et al, 2007). There are several frameworks and tools that can be used to support the formulation of the research question (Bowers et al, 2011). These frameworks are used to support the breakdown of the question in relation to the relevant sub-components and map them to the concepts to be explored, this process supports the definition of the keywords and search criteria (Methley et al, 2014). These include the PICO (Population, Intervention, Comparison and Outcome), SPIDER (Sample, Phenomenon of Interest, Design, Evaluation) and Research type and PEO (Population, Exposure and Outcome). The PICO is a question format that can be used for clinical and quantitative research topics focusing on a particular population and intervention with a possible comparison that then leads to an outcome (Eriksen and Frandsen, 2018). The SPIDER is a question format that is used for qualitative or mixed method research topics as the focus is on a sample of population rather than the whole population (Methley et al, 2014).

A PEO was chosen to support the development of the literature review question to determine the research gaps and develop the research question (Munn et al, 2018). The PEO statement contains three key concepts Population, Exposure and Outcome. The population focuses on the population affected, whether this was nurses, patients or families in a specific setting. For this literature review the Population was adult registered nurses in acute hospitals. Acute hospitals have been chosen as the setting because from my own clinical background this is an area of care where the majority of the support provided to patients with dementia is from registered nurses (Abbott et al, 2022). The Exposure is the population exposed to, this might be a risk factor, for screening or to a service. For this literature review the exposure will be the nurses own clinical experience. The nurse’s own clinical experience is the focus as the background literature has identified a focus on the perspectives of patients or wider healthcare staff and not specifically nurses. As a nurse I wanted to focus on support required by my own profession, field of expertise and practice, and to fulfil the criteria for my clinical doctorate. The Outcomes could be related to experiences, attitudes or action. For this literature review the outcome will be the actions taken by nurses in seeking support. A nurse’s own action has been put as a possible outcome as the focus is on the nurse. The PEO used for this literature review, as shown in Table 1. (Bettany-Saltikov, 2016; Melnyk and Fineout-Overholt, 2019).

Table 1: PEO for the literature review

P	Population	adult registered nurses in acute hospitals
E	Exposure	for their clinical practice
O	Outcome	sought support or supporting or help or guidance or expertise

This led to the development of the systematic literature review question being "How do registered adult nurses seek support, help or guidance for their own clinical practice in an acute hospital setting?".

2.4: Stage 2: Research Protocol

The second stage of the framework was to develop a research protocol. In establishing a research protocol at this point ensures the review has structure and rigour (Wright et al, 2007). The protocol for this systematic review established and defined the research question, which supported the identification of keywords, inclusion and exclusion criteria, and the method of data extraction and data analysis. These elements will be discussed in the following sections of my thesis. The elements discussed are applied by Wright et al (2007) in defining the research protocol. A research protocol is a critical tool that researchers engage in as part of the process of completing a systematic review (Bandara and Syed, 2023). A literature review protocol is a blueprint of the complete literature review journey. Protocols are developed as part of the planning stage of a literature review. A research protocol is essential in a systematic review as it improves the quality of the review and decreases the probability of researcher bias in both data selection and analysis (Kitchenham et al, 2009). The research protocol developed for this literature review is presented below.

2.4.1: Identifying databases

The need to search multiple databases is essential, for several reasons. Firstly, the use of several databases increases the search capacity to be able to identify relevant studies. Secondly, the use of several databases reduces publication bias and prevents the restriction to sources that could change the possible outcome if included (Wright et al, 2007). Thirdly, the use of several databases promotes the ability to achieve a more comprehensive review of the literature and supports capture and re-capture of articles (Wright et al, 2007). Therefore, these processes support the rigor of the search process.

Databases provide an index to journal literature and wider publications that specifically focus on the research being completed in or about health care. CINAHL Complete will be searched as focuses on the nursing and allied health care research within north American and Europe. Medline (PubMED) will be searched as has an extensive medical, nursing and allied healthcare focus. APA PychINFO will be searched as has a psychology and psychiatry focus. These databases focus not only on the participant pool but also the phenomenon of seeking support.

The literature search will also included a search of Google Scholar and grey literature searched through Grey Open. Lastly, the references list of all included articles will be searched manually.

2.4.2: Identifying Keywords

The keywords were developed from the research question identifying the significant terms that represented the chosen topic. The chosen research question "How do registered adult nurses seek support, help or guidance for their own clinical practice in an acute hospital setting?". The process of choosing keywords includes eliminating pronouns and the consideration of verbs, as these can add context to the other keywords (Puglises et al, 2023). Boolean operators will be applied to link the search terms together supporting the appropriate increase and decrease of the search results. Through linking the terms with the word "AND" decreased results and using "OR" increased results. The Boolean operator "NOT" was not used (MacFarlane et al, 2023). Following these processes the following keywords and Boolean operators were chosen, shown in Table 2.

Table 2: Keywords

Keywords
"Nurse or nurses or nursing or nursing staff or registered nurse" **AND** *"seeking or use or practice"* **AND** *"support or help or guidance"* **OR** *"expert or expertise"* **AND** *"acute care or acute setting or acute hospital or inpatient"*

These words were chosen from my own understanding of language and the terminologies used in the background literature and were discussed with a subject expert. Using the terms nurses, nursing staff or registered nurse should include articles relating to registered and qualified nurses. The terms seeking, use or practice relate to the derivatives of finding and/or including, which relates to a registered nurse finding and/or including advice or support. The terms support, help or guidance are used to focus on the exposure being explored, additional terms of expert and expertise has been added as background literature discussed the role of experts in specialised services as a means of support. The terms acute care, acute setting, acute hospital and inpatient are used to narrow the search to acute hospital settings. These keywords will be used through preliminary searches and may be expanded or narrowed based on the search results. Subject Headings and MeSH terms will be used within the electronic database to set limiters, including English language, academic and peer reviewed journals and search date from 2000.

2.4.3: Inclusion and exclusion criteria

Inclusion and exclusion criteria were developed that reflected the context of the research question. As part of the development of a robust and systematic approach to the literature review an in-depth and clear structure was used to develop the inclusion and exclusion criteria. Ten elements were used to guide the specific areas that needed to be considered. These included: date, exposure of interest, geographic location of study, language, participants, peer review, reported outcomes, setting, study design and type of publication (Patino and Ferreira, 2018). Table 3 provides the definitions of these elements. Only studies which met the inclusion criteria were included.

Table 3: Ten elements of the inclusion and exclusion criteria

Element	Description	Inclusion Criteria	Exclusion Criteria
Date	The periods of time that the review will cover	Jan 2000 – July 2024	Any prior to December 1999
Exposure of interest	The specific phenomena that is being explored	Seeking support Seeking knowledge or expertise	Seeking support for promotion Seeking support for a grievance or staff related issue
Geographic location of study	Targeting the same population of interest	Worldwide acute hospital settings	No limitations
Language	The language that the article is written in	English	Published in any language other than English
Participants	The restriction to specific participants based on the	Adult nurses	Other healthcare professionals including doctors, midwives, newly qualified

	population being explored		preceptor nurses and HCAs Child nurses, learning disability nurses, mental health nurses Obstetrics, paediatrics and other child- related departments
Peer Review	Deciding whether peer reviewed literature, non-peer reviewed literature, reports and guidelines highlighting what will be included in the review	Peer reviewed academic journals	
Reported Outcomes	The inclusion of a study may depend on whether particular outcomes of interest have been reported and in an appropriate, consistent manner	Clinical need Patient illness or presentation Own wellbeing	Research involving staffing, retention or safety Support given to patients by nurses
Settings	The restriction to specific settings based on the population being explored	Acute hospitals	Mental health settings Primary care setting including GPs Long-term care or nursing homes

Study Design	Whether studies will be excluded by their design	No limitations	
Type of publication	The types of studies included such as primary research, literature reviews or dissertations.	Primary research	Editorials, opinion or discussion papers, dissertations, case studies, reviews of the literature

The publication dates for the review were chosen as a balance between being contemporary whilst also comparing the dates of when dementia initiatives were included in mainstream guidance. The participants, exposure of interest and reported outcomes relate to the key areas highlighted within the PEO. Only studies published in English were included, as this is my primary language and concepts regarding dementia can be misunderstood in translation. Included articles reported primary research that have had been peer reviewed. Editorials, opinion pieces or discussions papers, were included if they met the criteria. Literature reviews or dissertations were reviewed and included if the criteria are meet. There were no limitations on geographic location and study design.

To ensure rigour and provide structure for reporting of the systematic review the inclusion and exclusion criteria will be applied to the articles following the Preferred Reporting Items of Systematic Reviews and Meta-Analyses (PRISMA) to format the literature search results. The PRISMA statement consists of a 27-item checklist and four-phase flow diagram that was completed at different stages when identifying the potential papers (Page et al, 2021). There are four main stages: identification, screening, eligibility and inclusion. These stages supported the identification of potential papers, screening by titles and abstract, applying the inclusion criteria and concluding with the final inclusion. The aim of the PRISMA statement is to promote transparency and allow for the rigour to report a systematic literature review. PRISMA is a tool that is promoted by academic journals as a guideline for literature reviews. In nursing the use of the PRISMA serves as a guideline and method of enhancing the quality of evidence (Moher et al, 2009).

2.4.4: Data extraction

Following the search and final selection of the studies, which were included in the literature review, the next step was to read the full text of each article and extract the relevant data using the framework by Wright et al (2007). The format of the data extraction table included the following elements, author, year, country, aim, study design, population, intervention, control, outcome and comments. The data extraction table in this review was used to gather and compile the data from eligible publications and support the organisation of the information to enable synthesising the studies and explore possible conclusions and narrative synthesis (Schmidt et al, 2021). The purpose of data extraction is to be able to accurately summarise the include studies in an appropriate format that promotes the narrative synthesis. The process also allows for information to be obtained objectively whilst assessing the risk of bias within the studies.

2.4.5: Critical appraisal

Critical appraisal will be completed by the application of standardised critical appraisal tools, to understand the methodological rigour and quality of the included articles. This process will be completed by the researcher and an independent colleague. The critical appraisal tools will include the Critical Appraisal Skills Programme (CASP) qualitative studies checklist (CASP, 2018), Joanna Briggs Institute Checklist for Analytical Cross-Sectional Studies (Moola et al, 2017) and the Mixed Methods Appraisal Tool (MMAT) (Hong et al, 2018). The critical appraisal tools will be applied according to the methodology of the included articles. Following the completion of the appropriate tools by the researcher and their independent colleague the assessments will be compared, and any differences will be discussed and required actions taken.

2.4.6: Data analysis

The chosen method of data synthesis will be narrative synthesis analysis, this involves the development of synthesisation of the data found within the included studies, rather than organising the data chronologically or by methodological sequence (Sutton, 2016). Due to the wide scope of the literature review question including the interventions and outcome measures, a narrative synthesis will be completed. A narrative synthesis addresses the four processes described by the Economic and Social Research Council (ESRC) Methods Programme (Popay et al, 2008). The first stage will be to identify and explore the elements of how nurse seek support, this will then support the second stag, which is the development of the concepts exploring the practical elements of when, how and who provides support. This then will be followed by the third stage, which is identifying patterns across the studies and any possible relationships between the data. Lastly, the four stage will be the generalisability of the results will be explored in the interpretation of the results.

2.4.7: Interpretation of Results

The findings of the narrative synthesis will then be interpretated to enable the creation of conclusions based on the evidence found within the systematic literature review. This section will discuss the strengths and weaknesses of the included studies. This section will also identify gaps in the contemporary literature.

2.5: Stage 3: Literature Search

The previous section has presented a overview of the research protocol for this literature review. The next stage in the framework was then commenced, beginning with the systematic search of published literature.

2.5.1: Databases

As discussed in the research protocol, the following databases were searched: CINAHL complete, MEDLINE (PubMED) and APA PsychINFO.

2.5.2: Keywords

The keywords used in the primarily search to answer the question “How do registered adult nurses seek support, help or guidance for their own clinical practice in an acute hospital setting?” were (nurse or nurses or nursing or nursing staff or registered nurse) AND (seeking or use or practice) AND (support or help or guidance) OR (expert or expertise) AND (acute care or acute setting or acute hospital or inpatient).

2.5.3: Search

A search of the literature was undertaken following the chosen framework (Wright et al, 2007). The keywords were applied to each database search, with the inclusion of recognised Boolean operators of AND/OR. Limiters were used within EBSECO that were reflective of the inclusion criteria. These were the search date range (01012000 to 16072024), English language and peer review academic papers. The search was then completed across the databases individually and through gradually adding the search terms. This was done to check that the search terms used collated the expected articles. Table 4 shows the recorded hits as they developed and the findings of duplications.

Table 4: Recorded hits per database

	APA PsycInfo	MEDLINE	CINAHL Complete
ST1: nurse or nurses or nursing or nursing staff or registered nurse AND seeking or use or practice	33, 254	38, 754	2, 046
ST2: nurse or nurses or nursing or nursing staff or registered nurse AND seeking or use or practice AND support or help or guidance	10, 764	11, 553	536
ST3: nurse or nurses or nursing or nursing staff or registered nurse AND seeking or use or practice AND support or help or guidance OR expert or expertise	59, 411	52, 518	837
ST4: nurse or nurses or nursing or nursing staff or registered nurse AND seeking or use or practice AND support or help or guidance OR expert or expertise AND acute care or acute setting or acute hospital or inpatient	11, 451	12, 744	656
Duplicates	987	1, 495	70
Totals per database	10, 464	11, 249	586

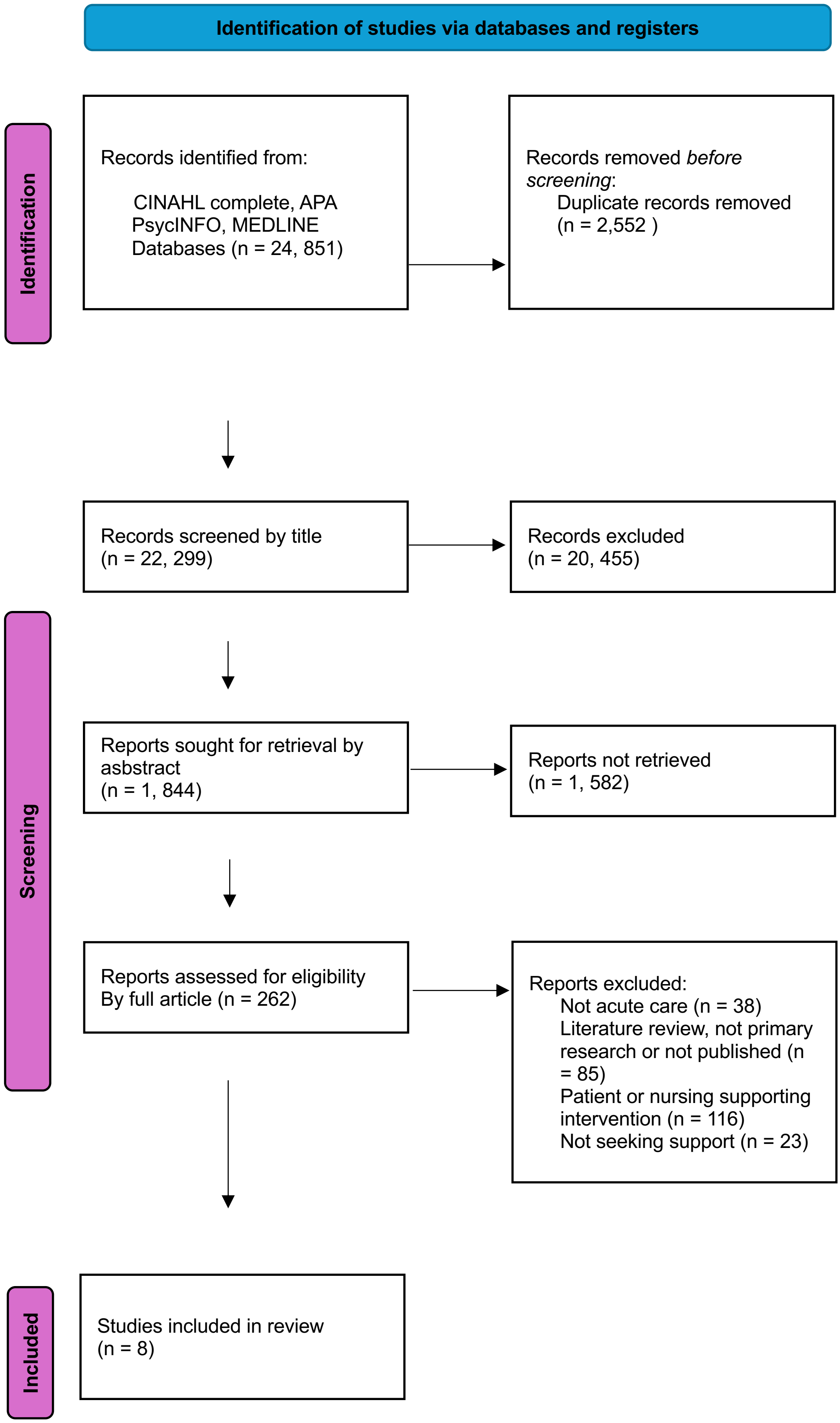
The inclusion and exclusion criteria, as described in the research protocol, was implemented to narrow down the appropriate literature. The PRISMA process was followed to ensure rigour and show transparency in how the included articles are found. Following the use of the keywords to search CINAHL complete, APA PsychINFO and MEDLINE a total of 24, 851 articles were found, following the removal of duplicates a total number of 22, 299. Google Scholar, Grey Literature and the manual searching of references lists did not produce any articles that met the criteria.

These articles were then reviewed by title only using the inclusion and exclusion as a specific guide to identify the articles for abstract review. Reviewing by title allowed for a large reduction of articles that did not meet the inclusion and exclusion criteria, most commonly articles were excluded as the focus was not on the nurse role within an acute setting or support related to a patient intervention or the definition of support did not relate to the nurse.

Following title review 1,844 articles remained. These articles were reviewed through reading the abstract, again applying the inclusion and exclusion criteria to identify articles for the full paper review. At this point literature reviews were identified and the reference lists were reviewed for suitable articles by title, 12 articles were identified and added for review by abstract. This process identified 262 for full paper review.

Full papers were reviewed applying the inclusion and exclusion criteria and the reasons for exclusion were detailed. All 262 papers were gathered most were easy to find, however 14 were sent to the library request system. The papers were excluded for four main reasons. The first reason was due to the focus of the article, such as literature reviews, editorials and opinion or discussion papers, which did not include primary research. Five dissertations were identified and were considered not to meet the inclusion criteria. The second reason was the involvement of participants outside of acute care or nurses in acute care. The third reason was a focus on patient care interventions or interventions relating to the nurse providing care rather than seeking support. The fourth reason was the intervention did not focus on the act of nurses seeking support. The PRISMA is found below in Figure 5.

Figure 5: PRISMA adapted from Page et al (2021)



2.6: Stage 4: Data extraction

The data extraction process was completed following the framework of Wright et al (2007). The data was extracted through reading each paper, identifying the first author, year and country; the aims of the research study; study design including participant population; data collection and analysis; the study's findings and the discussion. On the completion of the data extraction table an independent colleague checked the table and the included articles for accuracy and to ensure robust extraction. The completed data extraction table can be found in Table 5 below.

Table 5: Data Extraction Table

First **Author** **Year** **Country**	**Aim**	**Study Design** **Data collection** **Data analysis** **Population**	**Findings**	**Discussion**
Cronin 2001 Ireland	To understand how nurses working on a burns unit reflect on their experiences and deal with their emotions.	Hermeneutic phenomenology Interviews Content analysis Qualitative Registered nurses working on a burn's unity (n=5)	Themes explored how nurses reflected and dealt with their experiences: 1.The nurse, who brings their own expertise, personality characteristics, such as confidence, control and hardiness 2.Support, from an informal network amongst colleagues, friends, but avoidance of counsellors who are provided to support them 2.Rationale, the provision of justification and procedures	When nurses required support, they were left to find this support themselves. However, avoided the provision of formal support and relied on colleagues and friends, which was not always considered as 'healthy'.
Hofmann 2009 USA	An exploration of help seekers' perceptions of potential help	Quantitative Survey Multi-level model analysis	Multi-level model analysis:	There is a need for help providers to be perceived as possessing a high degree of expertise, and an interactive

	providers, and predictors of interpersonal perceptions of help provider job. experience and work roles.	Nurses (n=146)	Model 1 - help provider’s perceptions significantly predicted being consulted by others (trust: .47, p 01; expertise: .34, p 01; access: .18, p 01). Model 2 - two-way interaction - expertise-by-access interaction reached statistical significance Model 3 - three-way expertise-by-accessibility-by-trust interaction was significant (.12, p 01; R2 change 05, p 01).	relationship is required between trust and accessibility to support nurses in seeking help.
Bundz 2016 Australia	To explore the influences on help seeking by community nurses for pressure injury management in patients with a spinal cord injury.	Exploratory quantitative Survey Quantitative Descriptive statistics Factor analysis Registered nurses (n=50)	Aspects attributed to nurse consultants, which influenced nurses to seek support from them: -most important factors: proximity and personality -least important factor: knowledge Aspects of scenarios, which influenced nurses to seek further support: -unsuccessful trial and error -the patient wants a second opinion -the patient is refusing visits -a Stage 4 wound -wound deterioration	The reasons nurses sought help for the treatment of a pressure injury varied and was influenced by a range of factors including those related to the nurse consultant, clinical presentation, and nurse’s individual characteristics. Identifying the need for the nurse consultant to consider all these aspects to support nurses.

			-equipment as the cause of the problem -no medical involvement. However, older nurses and those with more experience were more likely to seek help	
Currey 2006 Australia	To describe critical care nurses' perceptions of their responsibility for the nursing management of cardiac patients in the initial two-hour. postoperative period	Qualitative Interviews Observations Framework analysis Critical care nurses (n=38)	Six themes were identified: 1.Feeling daunted – such as feelings of anxiety, fear, or nervousness 2.Being challenged - in the sense this activity was stimulating, exciting and positive 4.Anaesthetists' handover - was the framework for their haemodynamic decision-making 5.Settling in procedures - such as establishing haemodynamic monitoring 6.Collegial assistance - no formal processes in place, but one or more nursing colleagues provided support	Nurses were daunted or challenged and stimulated while making decisions and handover from anaesthetists, settling in procedures and collegial assistance were perceived as major influences on decision-making.
Huijten 2021	To explore hospital nurses' perceived support needs when	Cross-sectional Survey	The most frequently endorsed support needs:	Nurses across different specialities working in a hospital identified similar

Netherlands	providing palliative care for persons with dementia and to identify.	Cronbach's alpha for reliability Chi-square test Registered nurses (n= 235)	-communicating with persons with severe dementia (58.3%) -appointing a permanent contact person in the care for persons with dementia (53.6%) -dealing with family disagreement in end-of-life care (53.2%) -recognising and dealing with challenging behaviours (52.3%). -involving persons with dementia in end-of-life decision making (46.4%) Significant differences between ward types: -contributing to meaningful activities for persons with dementia (X2[2] = 8.565, p = 0.014) -involving families in the entire care process (X2[2] = 6.399, p = 0.041). Preferred forms of support: -classroom education" (49.8%)	support needs when providing palliative care for patients with dementia and providing support to family members.

			-joint case discussions" (46.0%)	
Irvine 2024 New Zealand	To provide evidence to support nurses affected by workplace aggression and violence.	Mixed Methods exploratory sequential design Interviews Inductive thematic analysis Survey Categorisation and frequency ED registered nurses (n=315)	Four key themes summarised coping with aggression and violence: 1.Minimising exacerbating factors (mental health, lack of understanding of zero tolerance in practice, and wait times) 2.Support before violence (education including restraint, self-defence, de-escalation, legalities and duty of care) 3.Support during violence (use of huddles and having experienced nurses on each shift, security staff and police) 4. Support after violence (debriefing, incident reporting and a sense of 'toughness')	Nurses working in an emergency department require preparation for violent and aggressive incidents through training, and ongoing support during and following these complex incidents, and the impact on nurses physical and mental wellbeing.
Marshall 2011 Australia	To explore the preferred sources of information intensive care	An instrumental case study design	Preferred sources of information included: -people, useful and most accessible in the clinical setting	Accessibility of information within this study, was clearly linked to nurse's responsibility for direct

	nurses used and the perceptions of the accessibility and usefulness for making decisions in clinically uncertain situations in enteral feeding in critical care	Think aloud process Q-methodology Focus groups Inductive analysis Intensive care unit registered nurses (n= 29)	-text and electronic information sources were time consuming due to access limitations People more frequently approached had: -higher levels of expertise -clinical relevance -perceived specific expertise Q Factor analysis identified: -56 information items available, 15 were ranked ≥ +2, including: -human sources of information (n=10) -electronic-based information (n=3) -text-based information (n=2)	patient care, who placed importance on the proximity of senior colleagues with expertise, who were frequently in the clinician area.
Peterson 2010 USA	An exploration of resources nurses used when coping	Qualitative Interviews Grounded theory	Internal factors -nurses were comforted by evaluating the death of a patient as part of life	Communication is essential to support nurses to cope with the death of a patient, these supportive conversations may be other

	with the death of a patient.	Nursing students and registered nurses (n=15)	-nurses relied on professional distance, by keeping their emotions separate from their treatment of the patient External factors -nurses sought support, such as comfort, advice, and assurance from peers, including other nurses and other healthcare professionals -some nurses sough support from religion -nurses also identified families and even the patients themselves were a source of comfort and support	colleagues, or with family members or even the patient themselves, prior to their death.

2.7: Stage 5: Quality Appraisal

Critical appraisal of four studies was completed through the application of the Critical Appraisal Skills Programme (CASP) for qualitative studies checklist (CASP, 2018). Of these four studies, all studies presented a clear statement of aims, applied an appropriate methodology, data collection and recruitment strategy, as well as a sufficiently rigorous analysis and a clear statement of findings (Cronin et al, 2001; Currey et al, 2006; Peterson et al, 2010; Marshall et al, 2011). The relationship between the researcher and the participants was not identified in three studies (Cronin et al, 2001; Peterson et al, 2010; Marshall et al, 2011). Finally, two studies, did not explicitly explore ethical considerations (Cronin et al, 2001; Currey et al, 2006), although it is acknowledged due to the date of one publication, the need to state ethical approval and explore ethical considerations may not have been a requirement (Cronin et al, 2001). The second study presented results for a larger study, which was referenced in their methods section, and therefore ethical approval and considerations was not directly reported (Currey et al, 2006). For further comments refer to Table 6.

Table 6: CASP Critical Appraisal Checklist for qualitative studies; (CASP, 2018)

	Cronin 2001	Currey 2006	Peterson 2010	Marshall 2011
1.Was there a clear statement of the aims of the research?	NO	YES	YES	YES
2.Is a qualitative methodology appropriate?	YES	YES	YES	YES
3.Was the research design appropriate to address the aims of the research?	YES	YES	YES	YES
4.Was the recruitment strategy	YES	YES	YES	YES

appropriate to the aims of the research?				
5. Was the data collected in a way that addressed the research issue?	YES	YES	YES	YES
6. Has the relationship between researcher and participants been adequately considered?	CAN'T TELL	YES	CAN'T TELL	CAN'T TELL
7. Have ethical issues been taken into consideration?	CAN'T TELL	CAN'T TELL	YES	YES
8. Was the data analysis sufficiently rigorous?	YES	YES	YES	YES
9. Is there a clear statement of findings?	YES	YES	YES	YES
10. How valuable is the research?	YES	YES	YES	YES
Comments	This paper was published in 2001, and does not include ethical	This paper is part of a larger study, which elements have already been published, and	A robust study qualitative study, lacking the reporting of one element. A survey with the	A qualitative study, which also applied Q-methodology, again a robust qualitative

	approval, or the relationship of the researcher and the participants, although this might be due to less rigor in reporting of studies in 2001	reference included, therefore direct mention of ethical approval was not included within this paper. Otherwise, this is a robust study with all elements considered.	inclusion of two validated questionnaires was reported with results, but unsure how this related to the qualitative approach and results of this study.	study, lacking the reporting of one element. The analysis is factor analysis as well as the appropriate inductive analysis of the qualitative data.

Critical appraisal of three studies was completed through the application of the Joanna Briggs Institute's (JBI) Critical Appraisal Checklist for Cross-Sectional Studies (Moola, 2017). All studies provided clear inclusion criteria, description of participants, setting, and the exposure involved. Exposure included clinical practice and the experience and education of the nurses, and these were considered in the application of appropriate analysis (Hofmann et al, 2009; Huijten et al, 2021; Bundz et al, 2016). However, within two studies the outcomes were measured through a questionnaire explicitly designed for the study, and in both studies the validity and reliability of this approach was not discussed (Hofmann et al, 2009; Bundz et al, 2016). Only Huijten et al, (2021) applied previous validated and reliable questionnaires. For further comments refer to Table 7.

Table 7: JBI Critical Appraisal Checklist for Cross-Sectional Studies; (Moola et al, 2017)

	Hofmann 2009	Huijten 2021	Bundz 2016
1.Were the criteria for inclusion in the sample clearly defined?	YES	YES	YES

2. Were the study subjects and the setting described in detail?	YES	YES	YES
3. Was the exposure measured in a valid and reliable way?	YES	YES	YES
4. Were objective, standard criteria used for measurement of the condition?	YES	YES	YES
5.Were confounding factors identified?	YES	YES	YES
6.Were strategies to deal with confounding factors stated?	NO	YES	YES
7.Were the outcomes measured in a valid and reliable way?	YES	YES	YES
8.Was appropriate statistical analysis used?	YES	YES	YES
Comments	A robust approach, although the design of identifying groups of nurses working together to rate who they would seek help from was unique, and a self-rated Likert scale was applied, which	Previously validated measures were used. Confounding variables identified in this study included, age, nurses who worked within different specialities, and nurse's different levels of education.	A robust approach, accounting for all elements of a cross-section study, although the survey was created by the authors with no presentation of validity or reliability, perhaps due to

	does have limitations.		the nature of the survey.

Critical appraisal for one study (Irvine, 2024) was completed through the application of the Mixed Methods Critical Appraisal Tool (Hong et al., 2018). This study clearly identified the research question and the rationale for mixed methods approach (Irvine, 2024). The qualitative element of this study was an appropriate approach to under the research question, data was collected to allow an in-depth analysis and interpretation, demonstrated by the presentation of direct quotes in the findings (Irvine, 2024). The quantitative element of this study was a cross-sectional survey, however, the authors did not include information on how or if the sample was representative of the population, if the responses were complete, and if confounding variables were considered (Irvine, 2024). Finally, the data and results from both the quantitative and qualitative elements of this study were integrated, but divergencies and inconsistences were not explored (Irvine, 2024). For further comments refer to Table 8.

Table 8: Mixed Methods Critical Appraisal Tool (MMAT); (Hong et al, 2018)

Category of study design and questions	Irvine 2024
Screening questions	
S1. Are there clear research questions?	YES
S2. Does the collected data allow to address the research question?	YES
Qualitative	
1.1 Is the qualitative approach appropriate to answer the research question?	YES
1.2 Are the qualitative data collection methods adequate to address the research question?	YES
1.3 Are the findings adequately derived from the data?	YES
1.4 Is the interpretation of the results sufficiently substantiated by data?	YES

1.5 Is there coherence between the qualitative data sources, collection, analysis, and interpretation?	YES
Quantitative non-randomized	
3.1 Are the participants representative of the target population?	CAN'T TELL
3.2 Are measurements appropriate regarding both the outcome and intervention (or exposure)?	YES
3.3 Are there complete outcome data?	CAN'T TELL
3.4 Are the confounders accounted for in the design and analysis?	CAN'T TELL
3.5 During the study period, is the intervention administered (or exposure occurred) as intended?	YES
Mixed methods	
5.1 Is there an adequate rationale for using a mixed methods design to address the research question?	YES
5.2 Are the different components of the study effectively integrated to answer the research question?	YES
5.3 Are the outputs of the integration of qualitative and quantitative components adequately interpreted?	YES
5.4 Are divergences and inconsistencies between quantitative and qualitative results adequately addressed?	CAN'T TELL
5.5 Do the different components of the study adhere to the quality criteria of each tradition of the methods involved?	CAN'T TELL
Comments	No information was provided in this paper on the nurses who responded to

	the survey, therefore it is unclear if these nurses were representative of ED nurses. However, both elements of this mixed methods study were integrated to develop the findings.

All studies were included within the systematic review, some of the elements identified within the critical appraisals of these studies will be discussed when interpreting the results and discussion for this review.

2.8: Stage 6: Data Analysis

2.8.1: Overview of included studies

On completion of the application of the inclusion and exclusion criteria eight studies were included within the systematic review, of which four applied a qualitative approach (Cronin et al, 2001; Currey et al, 2006; Peterson et al, 2010; Marshall et al, 2011), three a cross-sectional approach (Hofmann et al, 2009; Huijten et al, 2021; Bundz et al, 2016), and one a mixed methods approach (Irvine, 2024). Three studies were conducted in Australia (Bundz et al, 2016; Currey et al, 2006; Marshal et al, 2011), two in the United States of America (Hofman et al, 2009; Peterson et al, 2010), one in Ireland (Cronin et al, 2011) one in the Netherlands (Huijten et al, 2021), and one in New Zealand (Irvine et al, 2024). The number of participants in each study ranged significantly due to the methods of each study, participants within qualitative studies ranged from 5 to 38, with a total of 87 participants, the quantitative and mixed methods studies ranged from 50 to 315, with a total of 746 participants. Overall, the number of participants within the studies and this systematic literature review is 833 nurses.

Each study focused on exploring how nurses sought support for different elements of clinical practice. The element of clinical practice ranged significantly across studies and included nurses seeking support who worked on a burn’s unit (Cronin et al, 2001), nurses who worked with spinal cord injuries and sought support for pressure injury management (Bundz et al, 2016), nurses who sought support to care for cardiac patients in the first two hours following surgery (Currey et al, 2006), nurses who sought support to provide palliative care for patients with dementia (Huijten et al, 2021), nurses working in an emergency department who sought support following an incident of violence and aggression (Irvine et al, 2024), nurses who sought support to aid clinical decision making in ICU (Marshall et al, 2011), nurse who sought support coping with the death of a patient (Peterson et al, 2010), and one paper explored how nurses in general sought support (Hofman et al, 2009).

2.8.2: Development of Data Analysis

The articles were analysed following the completion of critical appraisal. A narrative synthesis was used as the chosen method of analysis (Barnett-Page and Thomas, 2009). A narrative synthesis allows a flexible and practical synthesis of diverse literature (Sukhera, 2022). The first stage of ESRC involved the identification and exploration of the components of support which was given to a registered nurse, this supported the second stage of development of the practical elements of the how, what and where support was found. The third stage included the identification of patterns within the data across the included studies and relationships in the data. However, due to the different focus of support given to nurses the identification of patterns and relationships in the data was necessarily descriptive. Finally, the fourth stage of the generalisability of the results will be explored within the interpretation of results.

Three concepts focusing on support were identified using the narrative synthesis analysis as supported by ESRC. These were (1) the need for peer support; (2) the need for emotional support; (3) unmet needs and competing tasks. Table 9 highlights where each concept was identified in the included articles.

Table 9: Mapping concepts across the included articles

	Concept 1: the need for peer support	Concept 2: the need for emotional support	Concept 3: unmet needs and competing tasks
Bundz et al (2016)	X		
Hofmann et al (2009)	X		
Cronin (2001)	X	X	X
Huijten et al (2021)		X	X
Irvine et al (2024)		X	X
Peterson et al (2010)	X	X	X

Marshall et al (2011)	X	X	
Currey et al 2006	X		

2.8.3: Concept 1: The need for peer support

The literature review findings found that nurses experience a variety of clinical scenarios, due to the complexity of providing holistic care. At times these clinical scenarios can lead the nurse to seek further support from their peers. This may include other healthcare professionals, senior nursing staff or peers. In acute hospital settings, nurses often seek support from experts and peers through conversations, groups, or discussions in informal settings.

Bundz et al, (2016) illustrated in spinal cord injury management, nurses would turn to wound care consultants to manage intricate wound care needs that surpass their own nursing knowledge. Currey et al, (2006) also discussed how the handover of anaesthetists guided nurse's immediate patient management decisions. Nurses would actively seek the support of medical colleagues as a method of ensuring the correct care intervention and management of the patients care needs were implemented. Marshall et al, (2011) also showed a higher factor Q-sort value for nurses to seek advice from either a registrar (2) and medical officer (2). Q-sort values involve the participants ranking statements according to a specific criterion that they are given (Ratchford et al, 2023).

Nurses would also seek support from nursing peers including colleagues or peers, team leaders and clinical nurse specialist (Peterson et al, 2010; Marshall et al, 2011; Hoffman et al, 2011). Marshall et al (2011) reported higher factor Q-sort values relating to nurses seeking support from clinical nurse specialists (5), team leaders (4), clinical nurse educators (3) and unit managers (3). However, other specialist roles including clinical nurse consultant (1), staff specialist (0) and research nurse (-1) had lower factor Q-sort values than other nurses and medical colleagues.

Peer support sometimes included senior co-workers, the most common peer was from colleagues in similar roles (Peterson et al, 2010). Hoffman et al (2009) also acknowledged nurses sought support from their peers and explored the qualities and characteristics nurses identified as important in their peers, which enabled them to approach their peer for support.

Important qualities and characteristics included identifying their peer as an expert, accessible, and trustworthy or all three elements. Currey et al (2006) found that nurses would seek peers they considered to be experts and Peterson et al (2010) and Bundz et al (2016) found peers who were considered to be experts were the nurses with the most years of experience.

Peterson et al (2010) also highlighted nurses sought out the support from their peers when coping with the death of a patient:

> *"It was easy to talk to my coworkers as many of us were experiencing the same things."* (p. 436)

The support given by peers was not necessarily related to a clinical intervention but was sought to provide assurance or comfort (Peterson et al, 2010; Cronin, 2001; Currey et al, 2006). Nurses identified seeking support from their peers, on a very informal basis, such as during coffee breaks, to support their needs to explore their experiences and emotions from working on an acute burn's unit (Cronin, 2001). Nurses also discussed seeking support during talks with work colleagues outside of the burn's unit. However, this approach was suggested by the nurses as being an unhealthy form of support (Cronin, 2001).

Nurses also sought support from different forms of religious resources such as pastors, chaplain or a member of the clergy (Peterson et al, 2010). Peterson et al (2010) was the only study that discussed the use of external peers as a method of support. The majority nurses identified a preference for seeking support from a person, when requiring support to make a clinical decision (Marshall et al, 2011). However, Cronin (2001) did discuss support being non-human and nurses seeking support to manage emotions in private either through physical exercise or watching TV with coffee. Marshall et al (2011) also discussed the use of other non-human resources including patient notes (Q-sort value: 4), Intranet (Q-sort value: 3) and intensive care unit homepage (Q-sort value: 2) as the top factor Q-sort values. Nurses believed that these resources were less accessible, and nurses would often print the information or struggle to find the specific information that supported them with the answer.

This concept identified how nurses recognise their own limitations and actively seek support from peers, who they deem to have expertise and experience. In addition to peers having experience, they also needed to be deemed as trustworthy and accessible to the nurse. The support sought in the majority of cases related to decision making about a clinical intervention. However, nurses also sought support for comfort and assurance.

2.8.4: Concept 2: The need for emotional support

Nurses sought support from peers in decision making and for emotional needs, to develop a support system for being a nurse and to manage their well-being. Effective emotional support can include access to counselling services, peer support groups, and institutional mechanisms for stress relief, which are essential for maintaining nurse well-being and preventing burnout. Support mechanisms and resources play a vital role in helping nurses navigate daily clinical challenges and crisis.

Nurses sought support to enable them to cope with the emotional impact of caring for a patient with severe burns or a patient who was dying, and this coping strategy was essential to enable them to understand and work through their emotions (Cronin et al, 2001; Peterson et al, 2010). A strong informal network among nurses provided the time for nurses to discuss the emotional impact on themselves, due to their experiences of working within a burns unit, and made reference to the burns unit as "*a type of family*" (Cronin et al, 2001). This was echoed by the nurses in palliative care:

> *"I think that there is a bond among nurses when they've worked together for a while, because you deal with so much suffering and death, stress, and that kind of thing that it's really therapeutic to be able to speak amongst each other.*" *(Peterson et al, 2010; p. 436)*

Nurses working within emergency departments (ED) also identified the need to cope with the emotional impact of being involved or witnessing aggression and violence from a patient or family members. Nurses within ED discussed the feelings of self-blame and needing to be "*tough*" to then continue with their shift. Although, nurses did not always seek support for emotional support and expressed struggling to manage:

> *"The one that affected me the most… I actually just got into my car and just burst into tears, and I don't do that, I don't cry." (Irvine et al, 2014; p. 99).*

Nurses tended not to seek emotional support from their organisation (4.25%) or professional emotional support (1.7%) and preferred to seek support through previous education (49.8%) and joint case discussion (46%). The emotional support needs identified by nurses also related to difficulties communicating with the patient, and disagreements between family members (Huijten et al, 2021).

Currey et al (2006) discussed nurses seeking support for assurance. Inexperienced nurses preferred to seek support from experienced colleagues when completing a clinical task as a method of increasing their confidence. This was echoed within palliative care, where nurses sought support from senior co-workers as they "*would have a lot of experience in that area. They'd have a lot of advice.*" (Peterson et al, 2010).

Sometimes nurses did not seek support from peers but from religious beliefs (Peterson et al, 2010). Nurses stated that their belief in heaven helped them cope and understand the death of patient and speaking to a pastor, chaplain or member of the clergy as a method of comfort when coping with a death of a patient. Nurses made comment that discussing the death of a patient with someone that is outside of nursing, was often helpful. Although this was mainly relating to clergy, the discussion did expand to the families and friends of the person that died (Peterson et al, 2010).

This concept explores emotional support and how nurses access a combination of structured support systems and informal networks to address their emotional needs. The use of informal networks and the development of a "*famil*y" support system presents both benefits to nurses but also highlights concerns regarding boundaries. The concept shows that nurses need support for their own emotions whether following the death of a patient or being part of a violent situation, supporting a nurse's well-being is needed so that they can provide care to others.

2.8.5: Concept 3: Unmet needs and competing tasks

This concept explores the unmet needs of nurses and how these are compounded by competing tasks. The unmet needs of nurses are time to express and cope with their own emotions, education in managing emotions and having no support on how to seek support from both people and resources. Nurses felt they were compelled to focus on the needs of their patients rather than their own well-being. Nurses identified finding time within busy environments was the rationale to being unable to seek the support.

Nurses identified they did not have enough time during their shifts to be able to seek the support they required, whether this was following a different clinical scenario, a situation of violence or a patient death (Cronin, 2001; Irvine et al, 2024; Hujjten et al, 2021). Nurses highlighted the ED was a busy environment that prevented debriefing as a method of support (Irvine et al, 2024). Most nurses (96%) within the study by Irvine et al. (2024) stated seeking support for aggression and violence in the ED took a lot of their time and impacted on their ability to care for other patients. A similar concern of a lack of time was highlighted by many nurses (66.4%) within Hujjten et al. (2021) study, as nurses identified time was needed to provide personal care and support to patients with dementia rather than seeking support. Marshall et al, (2011) highlighted there was a perceived lack of time to seek support from both literature and Trust online resources and therefore seeking out a colleague was a priority instead, as discussed here:

> *"If I can find the result from someone more simply because it is sort of effective time management, staff is the best option in my mind for that." (Marshall et al, 2011; p. 230).*

Nurses also discussed they did not have enough time to express their emotions, which they believed lead some nurses to *"some dealing with their emotions inadequately"* (p. 346; Cronin, 2001). Nurses discussed how there was no education that focused on death or difficult clinical situations and how to manage their emotions (Peterson et al, 2010; Cronin, 2001). Nurses highlighted most of their training in how to cope would come from their own experience or from the support of their peers. This advice would include *"specific directions about behaviours such as crying in front of a patient's family"* (Peterson et al, 2010; p. 437).

Seeking support was often put off or thought not appropriate as prevented nurses from caring for their patients (Irvine et al, 2024; Huijten et al, 2021). Nurses (75%) expressed a need for emotional support through debriefing following incidents, nurses feared seeking support, as believed this was seen as a weaknesses and inability to do their role (Irvine et al, 2024). Nurses (36.2%) stated providing care was the priority, which prevented them from seeking support regarding palliative dementia care (Huijten et al, 2021).

Several papers highlighted nurses are on their own in terms of finding support (Cronin, 2001; Irvine et al, 2024; Peterson et al, 2010; Huijten et al, 2021). Nurses specifically stated:

> *"We are very much left to find our own support… there is no time for any support. You know, formally, on a shift." (Cronin, 2001; p. 346).*

Informal support structures and networks with colleagues built from experienced nurses working together for long period of time were identified as the only significant method of seeking support, however newly qualified nurses experienced a period of no support (Cronin, 2001).

Additionally, nurses reported when they sought support from literature, they found this process very daunting and did not have the expertise needed to locate and critique the research literature (Marshall et al, 2011). Nurses identified that although a person was a preferred source of support, when struggling to use different sources of electronic information they would locate information, sometimes without validity or accuracy, using search engines.

> *"I'm a bit naughty, I would just probably put it into a search engine and see what websites come up." (Marshall et al, 2011; p. 231).*

This concept identified several process and pathways that nurses seek to solve the problem of needing support. A prominent factor was time, time to seek support as support was not seen as a priority, the priority was always the needs of patients. The need for a nurse to ask for support for their own emotions was deemed to identify a nurse who was not capable of completing their role. The element of self was discussed several times across papers – "*I would be weak*" or "*I need to find my own support*", there was an emotional "*weight*" that nurses would struggle to address. When seeking support nurses would develop their own support networks of other nurses rather than any electronic resource. Although when electronic resources were used the validity of the resource was questionable. Understanding these unmet needs is essential for fostering a more supportive and sustainable environment for nurses, ultimately benefiting health care systems.

2.9: Stage 7: Discussion

The systematic literature review has illuminated several aspects of how registered nurses seek support, help, guidance, and expertise in their clinical practice, particularly in acute hospital settings. The findings have highlighted nurses frequently sought support from peers they are deemed as experts, and sought emotional support due to role, death of a patient or complex clinical scenario, nurses also experienced a lack of time to express and cope with their own emotions and had no support on how to seek support from both people and resources (Bundz et al., 2016; Cronin, 2001; Hofmann et al., 2009; Irvine et al., 2024; Peterson et al., 2010; Huijten et al, 2021; Marshall et al, 2011). The findings of the systematic literature review will now be discussed within the wider published literature.

2.9.1: Concept 1: The need for peer support

Acute care refers to the short-term, intense treatment provided to patients with severe or life-threatening conditions, often in settings such as emergency departments (EDs), intensive care units (ICUs), and specialised wards (Hirshon et al, 2013). The rapid pace of these environments demand nurses have a broad and deep knowledge base. However, even experienced nurses may encounter cases that challenge their expertise, particularly when patients present with highly complex or rare conditions (Benner, 2008). In such instances, nurses must seek specialised expertise from senior nurses, clinical nurse specialists, or consultants in specific fields like cardiology, neurology, or critical care (Peterson et al, 2010; Marshall et al, 2011; Hofmann et al, 2009). The reliance on specialised expertise highlights the collaborative nature of acute care, where interdisciplinary teamwork is essential for managing the multifaceted needs of critically ill patients (Bendowska and Baum, 2023).

Nurses would also seek support from nurses they felt had expertise by experience. (Hofmann et al, 2009; Currey et al, 2006; Peterson et al, 2010; Bundz et al, 2016). Seeking expertise from peers in nursing is a aspect of professional development and improving patient care outcomes. Peer consultations and collaboration allow nurses to share knowledge, troubleshoot complex clinical situations, and refine their decision-making skills. Peer support enhances learning by fostering a collaborative environment where nurses can draw on each other’s experiences and expertise (Busari et al, 2017). This practice not only boosts individual competency but also contributes to overall team efficiency and patient safety (Rosen et al, 2019). Peer mentoring has been associated with increased job satisfaction and reduced burnout, as nurses feel more supported and confident in their roles (Galanis et al, 2023).

The relationship between nurse education, experience, and clinical expertise, emphasising how these factors interact within the hospital environment has been explored (McHugh and Lake, 2011). This work stressed the need to understand how nurse expertise develops, especially considering ongoing debates about the respective roles of formal education and practical experience in shaping clinical competencies (McHugh and Lake, 2011). Nurse education, particularly through the development of degree qualified nurses positively impacts on clinical expertise and patient outcomes. Practical experiences are also considered to be important as it refines skills and supports decision-making. McHugh and Lake (2011) argue that both education and experience are essential, with education providing theoretical knowledge and experience allowing for its application. The research of McHugh and Lake (2011) indicates nurses with both higher education and more experience are linked to improved patient outcomes and indicates why these particular nurses may be sought by other nurses for support.

Expertise in nursing is not just clinical knowledge and skills but also hinges on accessibility and the trust nurses place on their peers (Hoffman et al, 2009). This perspective aligns with research suggesting that trust and interpersonal relationships are critical in healthcare environments, as trust between colleagues significantly improves teamwork and communication, leading to better decision-making in patient care (O'Leary et al, 2012). Effective peer consultations rely not only on a colleague's clinical expertise but also on the strength of professional relationships, as trust also fosters open communication (Busari et al, 2017).

Accessibility is key to peer learning, with nurses more likely to seek advice from colleagues they can easily approach and whom they perceive as trustworthy (Rafii et al, 2021). This aligns with Hofmann et al. (2009) findings, as nurses were more inclined to consult peers who are readily available and reliable, even if they possess comparable levels of expertise. Consequently, trust and accessibility were not only complementary to clinical expertise but are essential factors that influence collaborative learning and decision-making in nursing. While clinical expertise remains a cornerstone of nursing practice, its effectiveness is often mediated by the relational dynamics between nurses. Building trust and ensuring accessibility enhances the willingness to seek and share expertise (Hofmann et al, 2009).

Nurses seeking support for both clinical interaction and emotional assurance is well-supported by the literature found. Peterson et al (2010), Cronin (2001), and Currey et al (2006) highlighted how nurses rely on their colleagues not only for clinical advice but also for emotional support. This dual form of support plays a crucial role in maintaining both professional competence and personal well-being. Multifaceted support needs have been identified as nurses frequently sought support from peers for clinical decision-making and for reassurance during difficult cases, reinforcing their confidence (Johansen and O'Brien, 2016). The ability to provide and receive reassurance contributes to a positive workplace culture and enhances team cohesion, which is essential for effective patient care (Mabona et al, 2022). The research literature consistently supports the idea that nurses seek both clinical support and emotional assurance from their peers.

The overarching message that nurses prefer to seek support from individuals rather than relying on literature or other resources is supported by multiple studies. Marshall et al. (2011), Cronin (2001), Currey et al. (2006), and Bundz et al. (2016) all highlighted nurses valued the interpersonal aspects of support, indicating that direct communication with a trusted colleague is often more effective and comforting than seeking information solely from written sources.

Nurses have also identified the need and preference for real-time, person-to-person interactions for problem-solving in clinical situations (Papathanasiou et al, 2014). These interactions not only provide immediate feedback but also create a sense of reassurance, as nurses often face high-pressure scenarios that demand quick and confident decision-making (Akyirem et al, 2022). The human element of support contributes to a collaborative work environment that fosters trust and teamwork, which are essential in healthcare settings.

One key reason nurses preferred seeking support from peers, rather than electronic resources, was the immediacy of response. In high-pressure clinical environments, situations can change rapidly, requiring quick decisions. Benner et al (2008) emphasises that immediate access to knowledgeable colleagues allows nurses to navigate complex clinical scenarios effectively. Real-time communication enables nurses to ask questions, clarify doubts, and receive guidance tailored to their specific circumstances. This immediacy is often lacking in written resources, which may require time for review or interpretation before application.

2.9.2: Concept 2: The need for emotional support

Emotional support from peers helps nurses manage stress and prevent burnout, especially in high-pressure environments like ICUs and ED (Simms et al, 2023). The importance of emotional support is highlighted by Billeter-Koponen and Fredén (2005), who argue that nurses experience a significant emotional burden, and peer support is for coping with the emotional demands of their role. The findings of this review highlighted nurses sought emotional support as a coping strategy for managing their own emotions (Cronin, 2001; Perterson et al, 2010). This aligns with studies by Oomms et al (2022), which show that emotional support from colleagues helps mitigate the effects of stress and moral distress, improving overall job satisfaction and resilience in the nursing profession.

Cronin (2001) and Peterson et al, (2010) highlight how casual interactions, such as discussions during coffee breaks or socialising outside of work, serve as opportunities for nurses to share experiences and cope with the emotional demands of their profession. These informal networks facilitate peer support, allowing nurses to engage in candid conversations about their caseloads and the challenges they face in a non-threatening environment (Pereira et al, 2021).

Informal interactions between nurses have also been identified to help reduce stress and burnout by providing a space for nurses to express their feelings and receive validation from colleagues who understand their experiences (Williams et al, 2022). These exchanges not only foster alliances but also enhance resilience by reinforcing a sense of belonging and community within the workplace. Informal networks can also enhance professional development, as casual discussions among peers often lead to the sharing of knowledge and best practices that may not be captured in formal training or protocols (Ben Natan et al, 2015). This peer learning is essential, as it allows nurses to gain insights from each other’s experiences, thereby improving their clinical skills and decision-making abilities.

The significance of informal networks emphasises that emotional support gained through casual interactions can contribute to job satisfaction as well as comfort (Winslow et al, 2019). When nurses feel supported by their colleagues, they are more likely to remain engaged in their roles and less likely to experience feelings of isolation or disconnection. While informal networks are beneficial, they should not be seen as a substitute for structured support systems provided within healthcare organisations.

The concept of a “*family*” type emotional support structure among nurses shows the significance of strong interpersonal relationships in the nursing profession (Cronin, 2001; Peterson et al, 2010). This informal support system, likened to a family, reflects the close-knit nature of nursing teams, where emotional bonds provide emotional support. Family-like support system can enhance emotional resilience and reduce feelings of isolation in the workplace, as strong interpersonal relationships among nurses promote emotional well-being (McAllister and Brien, 2019). Nurses who perceive their colleagues as part of a supportive family are more likely to engage in open communication, share concerns, and seek assistance, leading to better coping strategies during stressful periods (Thapa et al, 2022). There is the potential for emotional exhaustion to occur when the boundaries between personal and professional relationships blur (Kristrofferson, 2019). Nurses may find it difficult to separate their emotional ties from workplace responsibilities, which can lead to stress.

Within areas such as the ED, nurses highlighted feelings of self-blame and the need to be “*tough*” following violent or aggressive situations (Irvine et al, 2014). Nurses in these settings often internalise feelings of self-blame after such encounters. Workplace violence against healthcare workers, particularly in emergency settings, is not only common but also leaves a psychological toll on nurses, who may feel they should have handled the situation differently, even when the aggression was beyond their control (Kafle et al, 2022). This self-blame can lead to emotional exhaustion, reduced confidence, and long-term psychological stress.

The perception of needing to be "*tough*" is another common response among nurses in these high-pressure environments. Violence or aggression often leads nurses to adopt a stoic facade, as they may feel pressured to demonstrate emotional toughness in front of colleagues and patients. Nurses, particularly in acute care settings like the ED, often suppress emotional responses to maintain professionalism, which can contribute to feelings of isolation and reduce the likelihood of seeking support (Han et al, 2023). The overemphasis on toughness can also lead to an unhealthy suppression of emotions (Waugh and Sali, 2023). This emotional suppression often results in nurses feeling unsupported or unprepared to deal with the psychological consequences of violent or aggressive encounters, which can negatively impact their mental health and well-being, and contribute to burnout and compassion fatigue (Collier et al, 2024).

Nurses also sought emotional support outside of their nursing peers, including individuals within religious communities such as clergy, for emotional guidance, particularly in coping with grief, trauma, and stress (Peterson et al, 2010). The role of religion and spirituality as a form of emotional support in nursing is well-documented, many nurses draw on their personal faith or spiritual beliefs to cope with the demands of their profession (Hu et al, 2019). Nurses often turn to religious figures not only for personal spiritual guidance but also for emotional reassurance in their professional lives (Rachel et al, 2019). Religious leaders may provide a non-judgmental, empathetic ear, offering a form of counselling that is different from peer support, which might focus more on the technical or professional aspects of nursing. This spiritual support allows nurses to process their emotions in a broader, existential context, helping them to make sense of the emotional burdens they carry.

While seeking support from religious figures can be beneficial, not all nurses may find this avenue accessible or appropriate, depending on their personal beliefs. For some, support from peers may be a more suitable option. Vachon (2016) suggests that structured psychological support, such as counselling, can be equally effective in helping nurses process their emotions in a non-religious context.

One of the key challenges is the inadequate support systems available to nurses when attempting to seek emotional support. There are very few structured formal system arranged by NHS Trusts, leaving nurses to seeking informal support and develop their own support systems. Nurses participating in the studies included in this literature review sought emotional support from colleagues and peers but also from other sources, such as religion.

2.9.3: Concept 3: The unmet need and competing tasks

Nurses identified a lack of time during their shifts to be able to seek the support they required, whether this was following a different clinical scenario, a situation of violence or a patient death (Cronin, 2001; Irvine et al, 2024; Hujjten et al, 2021). The lack of time during shifts to seek support required was a common challenge in acute healthcare, Cronin (2001), Irvine et al. (2024), and Hujjten et al. (2021) found time constraints and workload pressures often prevented nurses from seeking emotional and peer support they needed. A lack of time for emotional processing or debriefing can have serious implications for both nurses' well-being.

The fast-paced and demanding nature of nursing, especially in acute care settings, such as ED, often leaves nurses with little time to reflect on or discuss emotional and stressful events (Williams et al, 2022). Nurses frequently work through emotionally distressing events, such as patient deaths or violent scenarios, without opportunities to process their feelings due to the continuous demands of patient care (Montgomery et al, 2015). This can lead to emotional suppression, which, over time, contributes to burnout, compassion fatigue, and reduced job satisfaction.

The inability to seek timely support can also affect clinical decision-making. Nurses who are unable to debrief or seek guidance after difficult situations may experience ongoing stress, which can impair cognitive function and hinder their ability to provide high-quality care (Kim and Chang, 2022). Nurses prioritise the needs of their patients over managing their own emotions, as found by Irvine et al (2024) and Hujjten et al (2021), and frequently suppress their emotional responses to maintain a high standard of patient care, often at the expense of their own well-being. Without opportunities to discuss challenging cases or violent scenarios, nurses may internalise feelings of self-blame or inadequacy, exacerbating stress and mental fatigue.

An element of nurses' prioritising patient needs over personal emotional distress has been described as an obligation to ensure the immediate needs of patients our met (Maben and Bridges, 2020). This phenomenon of emotional suppression is related to "*emotional labour*," a term coined by Hochschild (2003), which refers to the process by which professionals, especially those in caregiving roles, manage their own emotions to meet the expectations of their role. For nurses, this includes projecting a calm, empathetic demeanour even in the face of personal stress or trauma. Emotional labour is both a source of professional pride and personal strain for nurses, as it allows them to maintain the high level of care expected in their roles but can lead to emotional exhaustion over time (Kinman and Leggetter, 2016). The impact of neglecting includes burnout among nurses, higher turnover rates, increased absenteeism, and lower job performance, all of which affect patient outcomes (Kelly et al, 2021).

Nurses were often left to seek support on their own, Peterson et al. (2010) and Cronin (2001), highlighted a gap in organisational support structures within healthcare settings. This lack of formalised support leaves nurses to rely on informal networks or personal coping mechanisms to manage the emotional toll of their work, which can be insufficient, particularly in high-stress environments. When formal support systems, such as debriefing sessions, peer support, or counselling are absent, nurses are often left to process their emotions alone, which increases the risk of burnout and emotional exhaustion (Abram and Jacobowitz, 2021).

Healthcare organisations that provide structured emotional support systems have seen improvements in nurse well-being and retention. Hospitals with formal support programmes, such as regular debriefing sessions, peer support groups, and access to mental health resources, create a healthier work environment where nurses feel supported and less isolated (Sovold et al, 2021; Browne and Tie, 2024). Such programmes not only help nurses process their emotions but also signal that the organisation values their well-being, which can reduce burnout and improve job satisfaction (Kelly et al, 2021)

Electronic resources to access support were not used effectively by nurses, who instead turned to web search engines for support due to a lack of skills and expertise (Fossum et al, 2022). This reflects a broader issue in the integration of technology in healthcare (Marshall et al, 2011), which suggests while electronic resources, such as clinical databases, are available, they are underutilised as nurses lack the necessary training or confidence to access and use these tools effectively.

One of the key challenges is the digital divide in healthcare, where healthcare workers, including nurses, may not have the necessary digital literacy to use advanced electronic resources efficiently or may only be have limited access to outdated NHS systems. Many nurses feel inadequately prepared to navigate electronic health information systems and databases, often defaulting to more familiar, less specialised tools like general web search engines (Salameh et al, 2019). While search engines like Google can provide quick information, they lack the accuracy, reliability, and clinical relevance of professional databases such as PubMed or CINAHL, potentially leading to misinformation or inappropriate care decisions.

2.10: Literature Review Conclusion

The findings of the literature review have highlighted that in nursing the need for peer support is paramount. The complexities and high stress demands of acute healthcare settings often require nurses to seek help not just for clinical expertise, but also for emotional reassurance. Peer support is a key element in fostering collaboration, improving decision-making, and enhancing patient safety. Nurses frequently rely on colleagues with whom they share trust and mutual respect, seeking out peers who have either formal education or significant experience (Hoffman et al., 2009; McHugh and Lake, 2011). This trust-based dynamic reinforces the collaborative nature of nursing, where nurses benefit from each other's strengths and insights to handle complex patient care scenarios.

The importance of interpersonal relationships in providing peer support extends beyond clinical guidance. Nurses turn to their peers for emotional sustenance, particularly after challenging experiences like patient deaths or violent scenarios. Emotional resilience is supported by informal conversations during breaks or outside work, which offer a safe space for nurses to process the emotional toll of their job (Cronin, 2001; Peterson et al., 2010). This informal network often takes on a family-like structure, where emotional bonds among colleagues become a critical support system. Informal interactions help nurses mitigate stress, prevent burnout, and promote a sense of belonging within the workplace (McAllister and Brien, 2019). While these relationships are essential for emotional well-being, the informal nature of such support can sometimes blur boundaries between professional and personal lives, potentially leading to emotional strain (Kristrofferson, 2019).

Despite the importance of peer support, time constraints in acute clinical settings often hinder nurses from accessing the support required. The fast-paced nature of acute care settings leaves little time for emotional processing or peer consultation, especially after distressing events like patient deaths or episodes of violence (Cronin, 2001; Irvine et al., 2024). As a result, nurses frequently suppress their emotions and prioritise patient care, a phenomenon linked to "*emotional labour*". This suppression may provide a short-term solution to maintaining professionalism but can contribute to long-term emotional exhaustion and burnout (Kinman and Leggetter, 2016).

Compounding this issue is the lack of formal support systems in many healthcare settings. Nurses are often left to seek emotional and clinical support on their own, relying heavily on informal networks or personal coping mechanisms. While some hospitals offer structured debriefing sessions or counselling, these resources are not universally available, leaving gaps in the support infrastructure (Abram and Jacobowitz, 2021). The absence of adequate support systems can lead to feelings of isolation among nurses, further exacerbating stress and burnout.

Additionally, the underutilisation of electronic resources by nurses reflects broader issues related to digital literacy in healthcare. Although electronic databases and clinical resources are available, many nurses lack the skills or confidence to navigate them effectively. As a result, they often default to using general web search engines for clinical support, which may not provide the most reliable or specialised information (Marshall et al., 2011; Salameh et al., 2019). Nurses express a significant preference to speak to another person, rather than use an electronic resource.

In conclusion, the need for emotional support in nursing in acute care settings, has been found within the findings of this literature review. Nurses depend on trusted colleagues for both clinical advice and emotional reassurance, creating a collaborative and emotionally supportive work environment. Challenges such as time constraints, inadequate formal support systems, and underutilised electronic resources continue to hinder nurses' ability to fully access the support they need.

2.11: Strengths and Limitations of the studies

The literature review searched multiple databases including grey literature in OpenGrey to enable the capture of all articles that met the criteria of the literature review. The screening process, that included the screening of title, abstract and full paper, was screened by me and an independent colleague as a method of ensure rigour. The whole systematic literature review was completed following a robust framework (Wright et al, 2017) and included a detailed research proposal. The literature review question and key terms were broad to capture the phenomenon of support within the literature, which is a strength of this review. The limitation of the literature review was that only articles that were included were in English, although a strength in the inclusion of different healthcare systems across studies. The critical appraisal of each study needs to be considered when interpretating the results and conclusions.

2.12: Gaps in the research

The literature review aimed to answer how nurses seek support for a clinical need in an acute hospital. This led to some articles exploring nurses seeking support and identifying areas where they required support. Every article had data collected in an acute care setting, several articles did not have a specific clinical need or scenario but focused on the nurses' individual emotional needs. Only one article out of seven focused within the area of dementia. No article discussed how the nurse's definition of expertise was linked to organisational support systems.

2.13: Rationale for proposed study

The literature review focused on registered nurses seeking support for a clinical need the findings show that nurses seek support from another healthcare professional, which they deem as an expert, frequently nurses found that this person was not available at the time they needed support, or there was not a person with the expertise they required.

The articles in this literature review identified nurses sought emotional support, but rarely did nurses seek support for a clinical scenario. Understanding how nurses access emotional support and develop coping mechanisms is essential for developing strategies to mitigate burnout and enhance resilience. Effective support mechanisms are for nurses working with patients with dementia. The literature review suggests that both formal and informal support systems, such as debriefing sessions, peer support, and access to resources, play a crucial role in helping nurses manage their responsibilities and maintain high standards of care (Bundz et al., 2016; Cronin, 2001; Hofmann et al., 2009; Irvine et al., 2024; Peterson et al., 2010).

The article (Huijten et al, 2021), which focused on nurses identifying their support needs when caring for patients with dementia in a palliative care setting, rather than their experiences of seeking support to care for patients with dementia. Accurate and timely information is critical for decision-making in dementia care. Nurses rely on evidence-based guidelines and expert opinions to guide their practice (Adams et al., 2016; Elman et al., 2019). Investigating how nurses seek and utilise information in dementia care can highlight areas for improving access to and quality of information resources.

All articles in the literature review (n=7) focused on the nursing experiences and used a phenomenological approach (Bundz et al., 2016; Cronin, 2001; Hofmann et al., 2009; Irvine et al., 2024; Peterson et al., 2010; Huijten et al, 2021; Marshall et al, 2011). No articles in the literature review research focused on the experiences of registered nurses' of seeking support for caring for a patient with dementia in an acute non-mental health setting.

Therefore, there is an identified need for research that explores the experiences of nurses using both formal and informal support systems to seek support when providing care to patients. From exploring the background literature in dementia and completing a literature review that looked at nurses seeking support for a clinical need, coupled with my clinical background in the area of dementia care, I have decided to focus on how nurses seek support to care for a patient with dementia.

The majority of the articles found in the literature review were from the perspective and experiences of nurses. My previous research has explored the description of lived experiences, however at doctorate level the proposed study should expand from pure description and focus on how to interpret a type of experience by relating it to a relevant feature of context. Hermeneutic phenomenology sees that our understanding is embedded in the phenomenon and derived from past and current experiences (Smythe and Spence, 2012).

2.14: Research Aim

The findings of the literature review and my clinical expertise in dementia care informed the development of my research aim and questions. The study aims to explore the experiences of registered nurses who have sought support about caring for a patient with dementia in an acute non-mental health setting.

2.15: Research Questions

This study will address the gaps identified in the literature review by asking the following questions:

RQ1: What is the lived experience of registered nurses and dementia specialist nurses seeking support in caring for patients with dementia in a non-mental health acute hospital setting?

RQ2: What types of support are accessed by registered nurses and dementia specialist nurses to care for people living with dementia?

RQ3: What challenges do registered nurses and dementia specialist nurses experience in implementing or not implementing the support provided

Chapter 3: Methodology and Methods

3.1: Introduction

The purpose of this chapter is to introduce and justify the research methodology for this qualitative hermeneutic phenomenological study based specifically on the theories of Husserl and Heidegger. This chapter is divided into three sections, the first section commences with a reflective account of the researcher's ontological stance and continues with an overview of phenomenology and an exploration of the contribution of philosophers to the continued development of phenomenological studies, including Husserl and Heidegger. The second section of the chapter will focus on the methods of this study, including recruitment, participants, data collection and data analysis. The third and final section will focus on the credibility, transferability, dependability, and confirmability of qualitative research, and an in-depth discussion of ethical considerations.

The methodology applied within this study will be discussed in depth, commencing with a history of the development of phenomenology and the relevant philosophers. The application of a qualitative hermeneutic phenomenological study was chosen as a qualitative study addresses the questions and is reflective of an individual person's world view and expands further than the description of experiences used in phenomenology (Neubauer, 2019). The application of this methodology to explain a phenomenon relies on the perception of a person's experience in a given situation (Neubauer et al, 2019). A quantitative approach is appropriate when a researcher seeks to understand relationships between variables (Creswell, 2022). However, compared with quantitative approach's this study's phenomenological approach has the potential to support a deeper understanding through an interpretive process of how registered nurses' lived experience (Nowell et al, 2017).

3.2: The Researcher

This section explores my own views as the researcher and explores my ontological stance to answer the question "what is the nature of reality?". Ontology is the philosophical study of the meanings of a social world. Researchers need to assume the world they investigate is populated by human beings who have their own thoughts, interpretations, and meanings (Crotty, 2003; Guba and Lincoln, 1989). The truth is not 'out there' as reality is constructed by each individual. Thus, every perspective of reality has a peculiar individual interpretation in relation to their perceived reality. The hermeneutic phenomenological methodology applied in this study looked to support an in-depth understanding of a human phenomenon through analysis and interpretation of meaning participants ascribe to event. My ontological position is informed by the view that "no one reality exist but many realities exist" as individuals ascribe their own interpretation and meaning to the phenomenon (Bradshaw et al, 2017, p. 2). The aim of ontology is to find answers to the questions "how we know the nature of knowledge? what constitutes knowledge, or where knowledge comes from?". Through the use of hermeneutic phenomenology, it is considered that knowledge is interpreted by the researcher based on the accounts given by the research participants, and knowledge can then be generated through shared language and dialogue with the research participants (Padilla, 2008).

Novice researchers can find it challenging to justify their philosophical underpinnings, especially when stating the differences and similarities between paradigms (Panya and Nyarwath, 2022). A high level of certainty and confidence are required to report and defend the philosophical foundation of any research (Corry et al, 2019). The process of reading and understanding how different theorists have articulated their choices, philosophical underpinnings, epistemology, ontology, methodology, and methods can create confusion, because a range of terminologies are used interchangeably (Decuir-Gunby and Schutz, 2017; Bradshaw et al, 2017). Pinxten (2015; pg. 7) states that "the literature on worldviews leaves one with a feeling of uneasiness". Therefore, to reduce the confusion and identify terminology accordingly, for this study I decided to describe and justify the rationale of using hermeneutic (interpretive) phenomenology as a worldview, and how this paradigm informs this qualitative study.

3.3: Phenomenology

The concepts of phenomenology can be defined as the study of structures of experience, or consciousness (Smith, 2013). Phenomenology is the study of "phenomena", which includes the appearances of things, or things as they appear in our experience, or the ways we experience things, thus the meanings things have in our experience (Smith and Thomasson, 2005). This approach aims to gain a full and deep understanding of the experience as conveyed by the person living the experience. In contrast to narrative research which focuses on a single person and the collection of stories, which are used to construct a narrative of the individuals experience and the meanings they attribute, phenomenology describes the lived experience of several individuals (Creswell, 2007). Phenomenology assumes that people make sense of their lived experience according to its personal significance to them and implies that experiential, practical and instinctive understanding is more meaningful than abstract, theoretical knowledge (Standing, 2009). The significance of this approach in this study allowed the participants to provide their experiences of seeking support when caring for people living with dementia in acute hospitals. Phenomenology focuses not on what appears, but on how it appears (Lewis and Staehler, 2010).

The main goal of phenomenological research is obtaining complex, in-depth descriptions of human experience as lived in the context of time, space, and relationships (Finlay, 2009). The world of lived experience is defined as what people experience before it has been labelled or conceptualised by themselves or wider society (Laverty, 2003). The research data from the phenomenological research should contain detailed, narrative accounts by the participants regarding their experience regarding the phenomenon being studied (Lopez and Willis, 2004). Phenomenology does not produce empirical or theoretical observations or accounts but rather offers accounts of experienced space, time, body, and human relation as we live them (Neubauer, 2019). Therefore, this research does not aim to build a theory, but to understand a phenomenon. The researcher must try to understand the experience and the world in which the experience occurred as described by the participant. This study embraced the understanding of the participant's world and their experiences as obtained through one-to-one interviews.

3.4: Phenomenology and Nursing Research

Phenomenological research is particularly important when exploring nursing as a phenomena, as nursing is both an art and a science, which involves human responses to actual and potential health problems (Jasmine, 2009; Vega and Hayes, 2019). Science helps to explain the work of a nurse, whilst art works towards the skills of a nurse in communicating, connecting and providing compassion. It is both of these elements that make a nurse. The lived world of nursing phenomena includes the specialised knowledge and practice of nursing, contextual realities and concerns of the patients for whom nurses provide care (Lopez and Willis, 2004). Nursing research covers many areas of both patient care, interventions and nurses experiences. Phenomenology provides a means to investigate an experience from the beginning investigative stages to the later stages when specific areas of inquiry are followed to elicit additional detail and further knowledge (Jarvis, 1987). Various qualitative research methods are available, each designed for specific types of inquiry. In nursing research, common methods include grounded theory, phenomenology, ethnography, and qualitative description. The choice of method depends on the research question, as each approach has unique assumptions and goals. For example, grounded theory is typically used to explore the process of a phenomenon's occurrence, whereas phenomenology focuses on understanding the meaning or lived experience of that phenomenon. This research study, however, has taken a hermeneutical approach. Heidegger provides a very specific definition of phenomenology; stating that hermeneutical phenomenology comes from research that is based on the meaning of 'Being' as a fundamental ontology (Heidegger, 1988; Horrigan-Kelly et al, 2016). Phenomenology is focused on lived experiences and hermeneutics is an phenomenological approach where researchers provide an interpretation of an individual's interpretation of their lived experience (Neubauer, 2019). Hermeneutics is the study of interpretation of language, whether written or spoken and the analysis of this understanding (George, 2021). The next section will provide a background of the history of phenomenology and the development of different phenomenological approaches.

3.5: Phenomenological Approaches

There are a number of phenomenological approaches, these include but are not limited to descriptive phenomenology, interpretative phenomenology, and hermeneutic phenomenology. The origins of phenomenology can be traced back to Husserl, he is regarded as "the fountainhead of phenomenology in the twentieth century" (Vandeburg 1997, p11). Edmund Husserl (1859-1938) "sought to develop a new philosophical method which would lend absolute certainty to a disintegrating civilization" (Eagleton, 1983, p.54). Husserl rejected the belief that objects in the external world exist independently and the information about objects is reliable. Husserl argued people can be certain about how things appear in, or present themselves to, their consciousness (Eagleton, 1983; Fouche, 1993). However, to arrive at certainty, anything outside immediate experience must be ignored, and in this way the external world is reduced to the contents of personal consciousness. Realities are thus treated as pure 'phenomena'. Husserl named his philosophical method 'phenomenology' the science of pure 'phenomena' (Eagleton, 1983, p.55). Husserl emphasised the study of consciousness and the structures of experience. Within hermeneutic phenomenology this structure views interpretation as a dialogical process between the researcher and the participant when striving for a collaborative understanding (Neubauer, 2019). This approach acknowledges that the researcher's background, experiences, and perspectives can influence the interpretation. Researchers employing hermeneutic phenomenology aim to suspend their own preconceptions and biases. Husserl developed the method of bracketing or "epoche," which involves setting aside preconceptions to approach phenomena with a fresh perspective (Moustakas, 1994, p85). Understanding your individual pre-conceptions allows researchers to approach the data with an open mind, avoiding undue influence from their own beliefs or assumptions. Husserl stated those who used phenomenology as a research method must put aside their own experience, pre- conceptions, and theoretical leanings, a reduction practice known as bracketing (Dorfler and Stierand, 2020). Heidegger emphasises that our understanding of the world is always shaped by pre-conceptions, which influence how we interpret experiences and phenomena. He argues that these pre-conceptions are not just biases to be removed but are an essential part of human existence, guiding our interpretation of being (Heidegger, 1962).

A student of Husserl, Martin Heidegger (1889 – 1976), introduced the concept of ‘Dasein’ or ‘Being there’ and the dialogue between a person and their world. Heidegger and Husserl respectively explored the ‘lived-world’ and ‘Lebenswelt’ in terms of an average existence in an ordinary world (Schwandt, 1997). While Husserl was interested in the nature of knowledge (an epistemological focus), Heidegger was interested in the nature of being and temporality (an ontological focus) (Reiners, 2012). With this focus on human experience and how it is lived, hermeneutic phenomenology moved away from Husserl’s focus on acts of attending, perceiving, recalling and thinking about the world and on human beings as knowers of phenomenon (Laverty, 2003). Heidegger emphasised the idea that understanding is rooted in our existence in a particular historical and cultural context (Wheeler, 2020). Heidegger highlighted the importance of context and how our experiences are shaped by our cultural, historical, and linguistic background. Heidegger identified the importance of context and how our experiences are also shaped by our linguistic background (Wheeler, 2011; Horrigan-Kelly et al, 2016). The iterative process of interpretation was developed by Heidegger who introduced the concept of the Hermeneutic Circle, which emphasised the fusion of horizons between the interpreter and the text (Tomkins and Eatough, 2017). The Hermeneutic Circle demonstrates understanding is an iterative process. The iterative process involves moving back and forth between parts of the text whilst maintaining an understanding of the whole of the text, and the recognition a deeper understanding of individual experiences contributes to a broader comprehension of the overall phenomenon (Heidegger, 1988). The sections below will explore

Husserl's descriptive phenomenology, Heidegger's hermeneutic phenomenology and interpretative phenomenology.

3.6: Descriptive Phenomenology

Descriptive phenomenology is primarily derived from the work of Husserl with his primary question being: 'What do we know as persons?' Husserl focused on describing human experience as understood and described from the perspective of those who have had the lived experiences and were able to describe their experiences (Polit and Beck, 2008; Ironside, 2005). Among Husserl's assumptions was human experience possesses value and qualifies to be an object of scientific study (Lopez and Willis, 2004). Husserl's assumptions are called 'universal essences' or 'eidetic structures'. These terms refer to common aspects among those who have lived the same experience and as such, need to be generalised in order to contribute to the science (Lopez and Willis, 2004).

Husserl identified four steps in descriptive phenomenology: bracketing, intuiting, analysing, and describing (Polit and Beck, 2008). Intuiting involves remaining open to the meanings attributed to the phenomenon by those who have experienced it (Polit and Beck, 2008). By using this process, the phenomenon can be approached in a fresh and new manner (Finlay, 2009). Analysing focuses on identifying and extracting significant statements linked to the possible phenomena and reflections by those interviewed, categorizing them, and evaluating them for their contribution to the understanding of the studied phenomenon. Researchers perform the last step of describing by simply describing their conclusions which were drawn from their data analysis. Descriptive phenomenology was not considered an appropriate approach for this study due to the researcher's experience and knowledge on the provision of support and training for nurses caring for patients with dementia in a non-mental health acute hospitals. The pre-conceptions of the researcher need to be highlighted; however this may occur at different times during the study as the nature of the individual's experiences may highlight pre-conceptions and possible bias the researcher may not be aware of. Husserl assumed that true understanding of a phenomenon was obtained only when bracketing was performed. As part of using the hermeneutic methodology the researcher must 'bracket' pre-conceptions. If this process is not followed and they fail to appropriately 'bracket out' experiences, pre-conceptions, and theoretical learnings, they will fail to see the phenomenon by its true qualities and aspects (Ramsook, 2018). This led to exploration of the work of Heidegger.

3.7: Interpretive Phenomenology

Interpretive phenomenology derives from the philosophy of Heidegger and strives to understand the meaning of being in the world (Ironside, 2005). The primary question of this approach is “What is Being?” The importance of interpreting and answering this question has to be understanding over merely describing human experience (Polit and Beck, 2008). An essential concept of interpretive inquiry is situated freedom, which means individuals are free to make choices, but their freedom is not absolute, it is circumscribed by the specific conditions of their daily lives (Lopez and Willis, 2004). The concept of situated freedom guides the focus to describing the meanings of the individuals’ being-in-the-world and how these meanings influence the choices they make (Lopez and Willis, 2004). Within this study situated freedom may influence registered nurses from seeking support outside of the nursing profession. Nurses may be influenced by their previous decisions and choices in how they describe or disclose their experiences relating to the research questions of this study.

Another concept of Heidegger’s is that interpretative phenomenology relates to the researcher’s knowledge contributing to the study and the findings. This results in a blend of meanings articulated by both participant and researcher within the focus of the study (Lopez and Willis, 2004). Heidegger asserted the researcher’s knowledge is valuable in guiding the study to specific areas of inquiry in order to produce useful knowledge of that specific phenomenon or lived experience. Without this knowledge influencing the direction of the interview, pertinent information may not be obtained.

3.8: Hermeneutic Phenomenology

Hermeneutics is the theory and practice of interpretation developed through the work of Heidegger, which involves interpreting the transcriptions of one-to-one interviews to isolate common themes, thereby gaining understanding, and meaning of the phenomenon (Sloan and Bowe, 2014). This term focuses on entering another person’s world to discover the possibilities and understandings found from their perspective (Polit and Beck, 2008). Hermeneutics is the broader philosophical theory of interpretation, focusing on understanding texts, actions, or events within their historical and cultural contexts (Heidegger, 1988). In contrast, interpretative approaches, such as interpretative phenomenological analysis are more specific, concentrating on how individuals make sense of their personal experiences in relation to their life world (Smith, Flowers, and Larkin, 2009).

According to Spielgelberg (1982) hermeneutics is a “process and method for bringing out and making manifest what is normally hidden in human experience and human relations” (p. 72). Within this study and through analysing the transcriptions of one-to-one interviews, was possible to uncover common themes as shared by the participants to gain new knowledge about living through a particular phenomena or life experience.

Hermeneutic phenomenology relies on both interpretation and description of the lived experience. Hermeneutic phenomenology is a descriptive (phenomenological) methodology because it is attentive to how things appear, it lets ‘things’ speak for themselves. It is also an interpretive (hermeneutic) methodology due to the understanding there are no such things as uninterpreted phenomena (Boess et al, 2004). Interpretation occurs at two levels, the person recalling the phenomenon will interpret their experience through language and their narrative (Ricoeur, 1976). Once a narrative is transcribed into text, further interpretation occurs through a circle analysis by the researcher known as the hermeneutic circle (Heidegger, 1988). The hermeneutic circle refers to a person’s understanding of a text as a whole is based on their understanding of each individual part, as well as their understanding of how each individual part refers to the whole text (Tomkins and Eatough, 2017). The hermeneutic circle encourages a person to try to understand what is being read in the context of a cultural, historical, and literary context, along with a person’s own personal context. This process involves moving from parts of the experience (words, sentences, and paragraphs of the text), to the whole of the experience (the complete paragraph or text), and back and forth again and again to increase the depth and level of understanding from within the text (Laverty, 2003).

The interpretation of lived experiences can be achieved through the analysis of narratives from one-to-one interviews and the development of themes, discourses, narratives, moments, or incidents. The development of codes and themes have become prevalent in phenomenological research and are the basic building block of interpretive research, as evidenced by thematic analysis techniques (Braun and Clarke, 2006; Howitt and Cramer, 2008; Fereday et al, 2006). The process of hermeneutics allows and encourages reflection on the theme and the outcome of the analysis of the phenomenon under study. Hermeneutics raises the question of how we might shape and structure our interpretations in terms of values, textures, relations or indeed by dimensions of hermeneutic circling, such as presences and absences. The participants describe their lived experiences, their accounts are then analysed while noting pre-conceptions but continuing to utilise on the researcher's own lived experiences and comes to an understanding of the phenomena within the context of their own world. The process of understanding each circle through multiple cycles results in a full and deep understanding of the phenomena.

As a acolyte of Husserl, Heidegger developed the theory people are not able to completely 'bracket out' their own experience, pre-conceptions, and theoretical leanings (Wheeler, 2011). The rejection of 'bracketing' and the inclusion of context is essential to the epistemological underpinnings of Heideggerian hermeneutics (Heidegger, 1970). This is because Heidegger believed that it is only through an individual's placement in the world that correct interpretation occurs. A person's history or background includes what a culture provides a person from birth and is handed down, which includes ways of presenting and understanding the world. Heidegger rejected the concept of 'bracketing' and theorised an individual could never be free of their background, rather researchers gain enhanced understanding and meaning of a phenomenon when contextualizing it in their own life experiences (Wheeler, 2011).

The use of historical experiences and context is something that cannot be reduced or 'bracketed' to reach a better or more accurate state of understanding of another individual's lived experience, rather it contributes to the depth of understanding (Neubauer, 2019). Heidegger applied the term 'lifeworld' to demonstrate an individual's reality is always influenced by their surrounding world and cannot be separated from this world (Leng, 2022). As such, all experience is interpreted within the social, cultural, and historical context of the phenomenon, investigating the relationships, interactions, physical experiences, and social experiences. According to Heidegger, to think consciousness can experience itself in the absence of the world is false (Lewis and Staehler, 2010). Consciousness is considered not to be the right word for human existence and experience of the world. For Heidegger, the task of philosophy is to investigate the meaning of "*Being*" (Heidegger, 1985). This essence of "*Being*" or "*Dasein"* refers to an individual 'Being-in-the-world' through experiencing the day to day of living (Wheeler, 2011). The arrival at the meaning of an experience or "*Being*" is influenced by the researcher's background and experiences. This transaction between me, my background and context, and interpretation of being is ongoing and connected throughout the research process of this study, this promotes the fully transparency of the study. This connection has been documented since developing the method, collecting data and into data analysis. Hermeneutics has faced criticism for its potential to foster subjectivity in interpretation, as researchers' personal biases may influence how texts or phenomena are understood. This subjectivity raises concerns about relativism, where all interpretations are seen as equally valid, making it difficult to establish objective or shared meanings (Warnke, 2016). Additionally, it is argued that hermeneutic approaches may lack generalisability, as they focus on context-specific understanding rather than producing findings that can be widely applied (Leung, 2015).

3.9: Justification of Methodological Approach

Heideggerian hermeneutic phenomenology provided the framework for exploring the lived experiences of nurses seeking support while caring for patients in an acute hospital setting. Given that the research question is concerned with understanding nurses' experiences in depth, this methodology facilitated an exploration that moves beyond surface-level descriptions and instead uncovers the fundamental structures of meaning embedded in their daily practice. Heidegger's emphasis on Dasein, the human way of being-in-the-world, acknowledges that nurses' experiences of seeking support are not isolated events but are situated within a broader existential and relational context (Heidegger, 1927/1962). This aligns with the notion that human experience cannot be fully understood apart from the social, cultural, and historical structures in which it unfolds (Laverty, 2003).

By adopting a hermeneutic phenomenological lens, this study recognises that meaning emerged through interpretation rather than simple description (Benner, 1994). Within nursing research, this interpretive process has been widely acknowledged as significant for understanding how nurses navigate the complexities of practice (Crist and Tanner, 2003; Smythe et al., 2008). Heidegger's ontological perspective provides a way of engaging with nurses' experiences in a manner that acknowledges both their factual reality and their existential depth, addressing how they make sense of support-seeking within the constraints and possibilities of their working environment.

This methodological choice is not only epistemologically coherent with the research aims but also offers a means of generating rich, interpretive insights that challenge traditional empirical approaches to studying nurses' experiences. The use of hermeneutic phenomenology allows for an understanding of nurses' struggles as they navigate institutional and relational dynamics in seeking support (Todres and Galvin, 2010). By engaging in an iterative process of interpretation and reflection, this study seeks to reveal the deeper, varied dimensions of support-seeking in acute hospital settings, thus contributing both to phenomenological inquiry and to the wider discourse on nursing practice (Dreyfus, 1990; Mackey, 2005).

3.10: Reflexivity

I am an experienced mental health nurse, who has worked in acute non-mental health hospitals, supporting, and providing education for healthcare professionals caring for and working with patients with dementia. I have also worked and managed within a Community Mental Health Teams and supported the commissioning of dementia services. Therefore, I am aware of dementia services for both those living with dementia and their family members, as well as support services for healthcare professionals across community (primary care) and acute healthcare settings (secondary care). Through both roles I have supported people with dementia, their family members and healthcare professionals, signposting relevant services within primary and secondary care. Therefore, hermeneutic phenomenology supports the ontological stance based on their experience, as described. I acknowledge my own knowledge gained through working in and providing dementia care services, which has supported the development of the research question and a focus on possibly important elements of the phenomena. The experiences gained during these roles has led to the development of personal views on the provision of dementia care services and how these can and are accessed by people with dementia, their family members and healthcare professionals. However, for this research study, even though these experiences and knowledge have influenced the development of this research study, these pre-conceptions will be identified as they occur. The application of the hermeneutic circle is therefore essential, to support the analysis the data and understand 'what is being' read in the context of a cultural and historical element of nursing in an acute non-mental health hospital.

3.11: Methods

The previous section discussed the justification for the application of the methodology of hermeneutic phenomenology. In this section the research methods applied to support the hermeneutic phenomenological design of this study will be discussed. The following information is provided relating to study participants, sample size, sampling, inclusion and exclusion criteria, recruitment, informed consent, and data collection. Followed by an exploration of the processes of memoing, journal reflection, data management, data analysis, and the 6-step framework of reflexive thematic analysis (Braun and Clarke, 2022).

3.12: Study Participants

The participants were registered nurses working in any acute non-mental health hospital in England within one of the below four specialities:

- emergency departments (ED)
    - The emergency department (ED) is a medical department focusing on emergency medicine, the acute care of patients; who attend either by their own means or by ambulance or calling 999. People attending ED do not have appointments and are treated for a variety of illnesses and injuries. ED may also be used as a place of safety (Wiler et al, 2010).
- older adult wards
    - Older adult wards are medical wards that provide ongoing assessment and treatment for adults over the age of 60. The patients may or may not have dementia. The wards does not specialise in dementia but does have a higher prevalence of patients with dementia (BGS, 2023).
- oncology wards or departments or centres
    - Oncology is a specialised branch of medicine that focuses on the diagnosis and treatment of cancer. There can be different types of wards, departments or centres based on the type of cancer and treatment or therapy (National Cancer Institute, 2023).
- dementia specialist nurses or teams or mental health liaison teams
    - Dementia specialist services provide support to people with dementia and healthcare professionals in different healthcare settings. These services may include supporting the person with dementia and their families with different aspects of life and healthcare needs that may require further support. Roles within the team may include specialist nurses or nurse consultants. Mental health liaison teams are teams that provide support relating to any type of mental health illness, this may include dementia (NHS England, 2023).

These specific departments have been included due to the variation of the prevalence of patients with dementia attending these specific departments. Patients with dementia are more likely to be admitted to an ED due to medical emergencies, such as dehydration, or infections, although are admitted less often for cancer (Bickel et al, 2018; Zafeiridi et al, 2014). Studies have shown over 40% of older people admitted via ED have significant cognitive impairment and older people with dementia have poorer outcomes following an emergency admission to hospital (Sampson et al, 2009; Bradshaw et al, 2013; Reeves et al, 2023). Prevalence data has shown dementia is the most common diagnosis in older adult wards with 51.1% of admitted patients having the diagnosis (Timmons et al, 2015; WHO, 2023). People with dementia are likely to have another long-term condition, as 1 in 13 people over the age of 75 have both cancer and dementia (Surr et al, 2020).

3.13: Sample size

The rationale for the sample size relates both to the aim and methodological approach of the study. A hermeneutic phenomenological study continues to collect data, until no new experiences or meanings attached from experiences are identified (Saunders et al, 2018). Creswell et al. (1985) discusses that five to twenty-five interviews are ideal in order to full explore a phenomenon. Within hermeneutic phenomenology data saturation is not discussed as it is the essence of experiences that are explored rather than the differences of individual's experiences (Laverty, 2003). Through my clinical experience of "*Being*" within the world of dementia care I have an awareness of the lifeworld of my participants. This knowledge allows for an understanding of the experiences of nurses working in dementia and therefore I feel I am able to identify the participants numbers being appropriate to show the sought support phenomena. After consideration I opted to have at least two participants from each specialism (ED, older adult wards, oncology) and then have two participants from a variety of dementia specialist services (Admiral Nurses, dementia nurse consultants and dementia specialist nurses) to engage in one-to-one interviews.

3.14: Sampling

The sampling technique was convenience sampling, with the inclusion of snowball sampling. Convenience sampling is a type of non-probability sampling that involves the sample being drawn from a part of the population that is close to hand (Lavrakas, 2008). In research snowballing is most commonly defined as a method whereby a participant gives the researcher another potential participant, this method of sampling links to hermeneutics. (Patton, 1990; Atkinson and Flint, 2001; Cohen and Arieli, 2011). The sample may include different characteristics, such as gender, age, experience, and banding that may influence their experience, in this instance a diverse group of participants creates a broad understanding and answer the research question. Other sampling techniques such as stratified sampling, were not appropriate for this study, due to the recruitment process. Stratified sampling includes the stratification of a population, for example the division of the population of registered nurses working in ED in acute non-mental health hospitals in England, into homogeneous subgroups. Then a random sample from each homogeneous subgroup, to ensure representation from each subgroup (Bornstein et al, 2013). Stratified sampling is not appropriate for qualitative approaches, as this method of sampling focuses on the major variations, such as above average, below average, or average rather than being used to identify a community (Patton, 2002).

3.15: Inclusion and Exclusion Criteria

The inclusion and exclusion criteria will be developed and implemented to ensure that participants have relevant experiences that they can share and discuss their lived experience of seeking help to care for a patient with dementia and disclosing situations with specific areas of uncertainty or need to find further support or were experts in dementia supporting healthcare professionals to care for people with dementia (refer to Table 10). The inclusion criteria included registered adult nurses on the Nursing and Midwifery Council (NMC) Register, who were working within one of the four identified specialities. Participants were required to be in a substantive role for longer than six months, which was essential to ensure they were fully inducted into their roles and had both expertise in their speciality and the experience of supporting a patient with dementia. All potential participants were able to speak and understand English as they were currently working in an acute non-mental health hospital in England providing care to patients in English and documenting care and interventions in English. The level of English required by the regulatory body of nursing, the Nursing and Midwifery Council (2023) was deemed sufficient for involvement in the proposed study. Sex or age were neither inclusion nor exclusion criteria as the role of a nurse includes anyone over the age of twenty, following the completion of their nursing qualification to become a registered nurse. Dementia specialist nurses working within a dementia specialist team or mental health liaison team were also included, meeting the above criteria.

The exclusion criteria included registered adult nurses who completed bank or agency shifts within one of the four identified specialities or had been in post for less than five months. Registered nurses new to the organisation and possibly still completing induction or probationary processes, were deemed not to have sufficient experience or knowledge of where to seek help as being a new member of staff. Registered nurses working through agency have been excluded as they may not be aware of all the systems and pathways of support available. Further exclusion criteria were registered nurses who worked in operational or non-patient facing roles and would have no need to seek help to care for patients with dementia or provide support for healthcare professionals to care for people with dementia. Specialist teams that did not focus on dementia and dementia related diseases were not included because the study focuses on seeking support relating to dementia.

Table 10: Inclusion and exclusion criteria

Inclusion criteria	Exclusion criteria
Qualified nurses registered with the Nursing Midwifery Council	Registered Nursing Associates, Health Care Assistants and other health care professionals
Working in an acute non-mental health hospital in England in one of the following specialities: ED Older Adult Ward Oncology Or Dementia Specialist or Nurse	Registered nurses working in an acute non-mental health hospital in England, in a speciality other than the four described, such as orthopaedics or surgery, or were in a non-patient facing role
Permanent member of staff for longer than six months	Working bank or agency shifts, or in post for less than six months

3.16: Recruitment and Consent

Social media (Twitter) was identified for recruitment for this study, due to the lasting impact of COVID-19 on acute healthcare services, and this approach has been identified as efficient, inexpensive and supports a high participant response rate (Herbell et al. 2018). Even prior to COVID-19 recruitment for health-related research through Twitter had become more common and the impact of retweets identified. The process of retweets is unique to twitter, for example, O'Connor et al. (2014), posted 359 original study-related tweets, which led to 529 participants completing an online survey, due to the retweets reaching a large audience. Participants were identified through social media posts, so called tweets, on the platform Twitter (since the completion of recruitment, Twitter has been re-named X, but Twitter will be applied throughout this thesis). Twitter was chosen as the social media platform for this study as the primary purposes is to connect the users and allow them to share thoughts with their followers and others using tweets. Many healthcare professionals as well as professional bodies and charities use this platform to disseminate best practice and research.

Once the study-related posts or tweets were posted, further communication occurred through discussion tweets, DMs (direct messages), and re-tweets. Once the study-related tweets had been posted (Appendix 3), potential participants were prompted to get in touch either by DM or email, if they were interested in participating in the study. Once a potential participant made contact, they gave their email address which the study-related document was sent too, which included a participant information sheet (Appendix 1) and consent form (Appendix 2).

This approach ensured the confidentiality of staff who voluntarily contacted with an interest to participate. This is because, the researcher is the only person with access to the Twitter account (QI_Dementia) and email (mor1@stir.ac.uk) given to prospective participants. An emphasis was put in place on the voluntary nature of participation, and if they do or do not participate this will not impact on their role. All potential participants were informed they will not be asked to disclose the name of their employing Trust. The only information required was that they worked for an acute non-mental health NHS trust, and within one of the four specialities identified. Each participant had the opportunity to discuss the study further and decide if they still wished to participate, the emphasis was on with the participant to contact the researcher and discuss the study in more depth. Recruitment started in November 2022 and ended in July 2023, during this period prospective participants made contact (n=20), some went on to have interviews (n=11) and others either stopped making contact (n=6), cancelled or felt the study was not appropriate to them and their role (n=3). Figure 6 shows the flow chart of how participants were recruited.

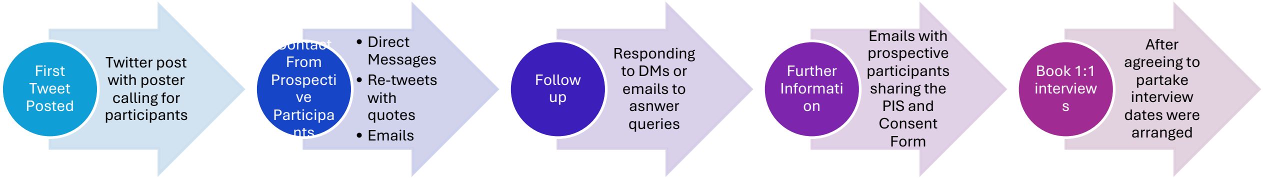


Figure 6: Recruitment flow chart

All participants received a participant information sheet and a consent form through email and were invited to introductory discussions, prior to the online interview. Each participant had a one-to-one opportunity to ask any further questions, prior to being invited to an MS Teams online interview. Participants were asked to sign a consent form prior to the interview and send this electronically to the researcher. Participants were also asked to verbally consent to participating in the study prior to commencing a one-to-one interview with audio recording.

At the start of the one-to-one interview the participant was asked if their choice of location was in an environment that was comfortable and quiet, they were unlikely to be disturbed and they and were happy to talk. This was important to allow the participant to feel comfortable and in an environment that would not breech the confidentiality of any patients or NHS Trust discussed (Wolgemuth et al, 2015). The researcher conducted all one-to-one interviews in their home office in a quiet environment that was separate from the rest of the household to maintain confidentiality.

All participants were informed that the study was voluntary, and they could withdraw at any time during the process, up to eight weeks post their interview, without giving any reason. Each participant was given a unique code on their consent form which links to the anonymised transcripts (Denzin and Lincoln, 1998). The central excel spreadsheet was only accessible by the researcher, contained the personal contact details also has the linked unique codes attached to each participant. In accordance with the General Data Protection Regulation (2018) all data collected during the study was handled and stored confidentiality and securely. The purpose of GDPR is to impose a uniform level of data protection when data is being processed, which ensures organisations and researchers understand the priorities when it comes to personal data security and protection. Any personal data including contact details and name are stored on an encrypted excel file within the University of Stirling One Drive, which is password protected and accessible only by the researcher. The transcripts were anonymised and kept separate from the personal data of the participants. Supervisors had access to anonymised transcripts and data excepts from memos during supervision sessions. Personal data was stored for six months following data collection and anonymised data will then be destroyed within ten years, as per the University of Stirling's guidelines.

Participants were informed that participating in this research study did not benefit them, directly sharing their experiences both positive and negative could develop the understanding of how nurses seek support to care for people with dementia. The participants who consented to take part in the study contacted me using my university email address. The only details of the participants the researcher collected was their name, job role or title, department of employment, as well as a contact email to arrange the interview. All details were kept securely on the University of Stirling OneDrive and only known to the researcher. Personal and identifying information was removed from the transcripts and destroyed when the data analysis was completed. All participants details were anonymised by using pseudonyms (Harry Potter Characters).

The confidentiality of the registered nurses working for any NHS Foundation Trust was considered in the design of this research. The initial introduction of the study occurred through social media posts. Participants were then given access to the Participant Information Sheet and Consent Form to read to be able to understand the study requirements. If at any time during the interview they mentioned any identifiable factors, such as ward names or places, these were anonymised in the transcripts. Personal or work contact information (email address or twitter handle) of the registered nurses who were interested in participating in the study were collected to arrange a one-to-one interview using MS Teams platform at time that was convenient for them. Contact information, whether personal or work is the only identifiable information that was collected.

Discussion of a sensitive topic, such as experiences with patients with dementia, has the potential to cause distress to the participant. Participants need to feel comfortable to share their perspectives, therefore it is essential that the researcher understands the nuances of the topic and be able to engage with participants to ensure the proposed research has meaning and value (Pinto et al, 2022). As a mental health nurse, who has worked in acute hospitals and dementia specialist services I am aware of terminology used in practice and also able to offer debrief following the interviews, if needed. Participants were reminded that they can end the interview at any time by informing the researcher they wished to pause or end the interview, without providing a reason. If a participant wanted to stop or have a break the recording was paused and a discussion on how the participant would like to continue occurred. If the participant felt they needed further support, this was discussed the participant information sheet included relevant signposts.

The participants were reminded at the beginning of each one-to-one interview that participation and information provided is confidential unless any information disclosed raises concern for the safety of staff or patients. In this case the information will be discussed further with the individuals concerned and in accordance with NMC Code of Conduct (NMC, 2015) confidentiality may be breached. In the event of any concerns for the safety of staff or patients this will be reported to the University of Stirling and the NMC, if appropriate. At the beginning of the one-to-one interview the participant was informed that during the interview they should not identify specific patients or Trusts, but if they did this would be anonymised in the transcripts.

3.17: Data Collection

The method of semi-structured, in-depth interviews was applied. This method of data collection was suitable for individuals and based on an interview guide, which provides a schematic presentation of questions relating to the topic the researcher wishes to explore (DiCicco-Bloom and Crabtree, 2006). The interview structure can be seen in Appendix 4. In hermeneutic phenomenological research, semi-structured interviews encapsulate the research question and how the person's previous experiences and interpersonal concerns shape the participants abilities or needs to seek support (Oerther, 2021). Semi-structured interviews are particularly valuable in hermeneutic studies as this method supports an in-depth exploration of participants' experiences, enabling a richer understanding of their lived realities (Frechette et al, 2020). Semi-structured interviews provide a flexible framework that allows both the researcher and participant to engage in a meaningful dialogue. This flexibility enables the exploration of unexpected or unanticipated aspects of the participants' experiences. This approach also provides room for participants to elaborate, provide context and express their experiences in their own words and on their own terms (DeJonckheere and Vaughn, 2019).

Semi-structured interviews align with the hermeneutic approach, as the emphasises is on interpretation and understanding of meaning. This method allows for the exploration of participants' subjective interpretations of their experiences. This approach also allows participants to provide contextual information that supports a comprehensive understanding and acknowledges the importance of context in shaping meaning (Frechette et al, 2020). As this approach facilitates the exploration and interpretation of the meanings and experiences of participants within their specific contexts. This methodological choice supports the central tenets of understanding and interpretation that are fundamental to hermeneutic studies.

One-to-one interviews were chosen as to give participants the opportunity to speak freely and develop a trustworthy acquisition of interview data, as the hermeneutic phenomenological approach requires a feeling of trust between the researcher and the participant (Vandermause and Flemming, 2011). The hermeneutic interview shares characteristics with interviews forms that are more interpretive than reductionist in nature, this method will underpin how the researcher acts within the interview (Lauterbach, 2018; Vandermause and Fleming, 2011).

During the interview, the researcher must encourage participants to discuss their experiences in their own words and in their own way without being constrained by categories or classifications imposed by the researcher (Austin and Sutton, 2014). Interviews should be conversational with a relaxed tone, working from the interview schedule that has been carefully prepared ahead of time, which contains detailed and specific list of items that concern relevant topics to answer the research questions (Magnusson and Marecek, 2015). Throughout the process of data collection, the semi-structure interview schedule was adhered to and applied to through the one-to-one interviews, sometimes with different prompt questions, to ensure a comparability between the one-to-one interview data.

The interview schedule (Appendix 4) began with open-ended questions, which explored both registered nurses' experiences of seeking support to care for a patient with dementia, and registered nurses in dementia specialist teams or services discussing their experiences of giving support and how they seek it themselves. The interview schedule was followed, which included the use of prompting questions, with the intent to gather data with more depth on support including barriers and facilitators (Hoffding and Martiny, 2015). The interview schedule ends with open-ended questions, framed to invite more depth regarding seeking support to enable best practice in dementia care. Although there is a schedule for the interviews, this is to ensure that all interviewees are asked the same main questions, the line of enquiry may change based on the experiences of the registered nurses to ensure a full interpretation of the described experiences can be done.

One-to-one interviews were conducted using MS Teams. MS Teams was used as, at the time, it was the preferred method of online communication, as other platforms such as Zoom had security issues, which would prevent ethical approval being granted (NHS England, 2023). However, as MS Teams was part of the Microsoft 365 package it was deemed that most participants would have access both at home and at work, as it is a free platform. The use of MS Teams to conduct interviews supported the inclusion of participants who lived in any region in England, but also supported a face-to-face discussion although through a computer screen, which enabled a relaxed conversation between the researcher and participant, and for the research to gain extra data through emotions shown through face and body language. The use of MS Teams was considered to provide more data than telephone interviews and was more inclusive than face-to-face interviews. The one-to-one interviews were audio recorded electronically, with consent, and then transcribed verbatim, as per the first stages of thematic analysis (Braun and Clarke, 2020). All audio recordings were completed on an external Olympus encrypted Dictaphone, no recordings were completed using MS Teams due to factors, which could breech anonymity such as an onscreen username or email. Notes (Memoing) were also taken during and after each interview, to support the researcher to complete the process of reflection.

Data was collected through eleven one-to-one interviews with registered nurses working across acute non-mental health NHS hospitals in England. Participants included two nurses from ED, two nurses from Oncology wards, thwo nurses from Older Adult wards, two Admiral Nurses, two dementia nurse consultants one dementia specialist nurse. The interviews lasted between thirteen and forty-two minutes. Hermeneutic phenomenology bases itself on the understanding of "*dasein*", the "*being*" of the researcher and the participants (Frechette et al, 2020). I used an interview schedule guide to plan my open- ended questions (appendix 4). The interview schedule guide was used as a guide to maintaining an open conversation with prompt questions were also included to guide the researcher and prompt the participant. This method of open questions prompted participants to reflect on their experiences of seeking support, to deeply engage with the participants, the researcher adopted active listening (Dibley et al, 2020). The essence of existence and lived experience, as defined by Heidegger in hermeneutics, is based on the interpretation, language and understanding creating the '*Being*' (Horrigan-Kelly et al, 2016).

Following the completion of an interview, the recordings were uploaded on to the University of Stirling OneDrive ready to be transcribed. The data was then deleted from the dictaphone.

Once all interviews were completed the transcribing process was started. Each interview was individually transcribed verbatim by the researcher, and any identifiable factors were removed.

3.18: Memoing

Following each transcription, additional reflections were added to memos. This involved the reading and re-reading of the data and starting to make memos bout any analytic ideas or insights relating to both the individual transcripts and the data set as a whole. Within hermeneutic phenomenology the use of memos and journal notes are part of interview data (Crowther et al, 2017). Memoing throughout the research process allows for the recording of descriptions, thoughts and reflections of the researcher (Bingham, 2023). The researcher recorded a journal of memos throughout the data collection process which also included personal reflections about the interviews and the data gathering process. The researcher also recorded memos thoughout the analysis process, which included thoughts during the familiarisation stage as well as working ideas for codes and themes during those stages. Theses memoes were used by the researcher as a method of recording both pre-conceptions to reduce bias, but also to highlight and remind the researcher of key elements that may become relevant at the point of discussion.

3.19: Journal of Reflection

Heidegger (1962) discusses the concept that understanding, and interpretation can be influenced by an individual's 'historicality' or lived experience when exploring a particular phenomenon. Heidegger (1962) also maintained that these pre-conceptions are imperative to the process of understanding. Therefore, as part of the analysis process the researcher used a journal of reflection to be able to record their pre-conceptions both prior to the study but also more significantly the ones that occurred during the interviews and as part of the reflection after them.

3.20: Data Analysis

Data was analysed by applying thematic analysis as described by Braun and Clarke (2006) applied through the lens of hermeneutic phenomenology, as thematic analysis is the approach of analysing data and not the theoretical approach of this study. By the application of thematic analysis through the lens of hermeneutic phenomenology researchers can ensure a more comprehensive and rigorous exploration of the data. Thematic analysis can be used to explore the lived experiences of individuals and attempt to seek understanding of any hidden meanings (Braun and Clarke, 2014).

There are many ways to approach thematic analysis (Alhojailan, 2012; Boyatzis,1998; Javadi and Zarea, 2016). However, this variety means there is also some confusion about the nature of thematic analysis, including how it is distinct from a qualitative content analysis (Vaismoradi et al, 2013). Thematic analysis is the process of identifying patterns or themes within qualitative data. Braun and Clarke (2006) suggest that it is the first qualitative method that should be learned as '..it provides core skills that will be useful for conducting many other kinds of analysis' (p.78). A further advantage is that it is a method rather than a methodology (Braun and Clarke 2006; Clarke and Braun, 2013). This means that, unlike many qualitative methodologies, the analysis is not tied to a particular epistemological or theoretical perspective therefore allowing a structured analysis method to be used within a hermeneutic perspective.

Thematic analysis is a qualitative research method that can be used in conjunction with hermeneutic phenomenology to enhance the understanding of complex human experiences (Sundler et al, 2019). Thematic analysis complements hermeneutic phenomenology by providing a structured framework for identifying and analysing patterns or themes within the data (Nowell et al, 2017; Sundler et al, 2019; Fereday and Muir-Cochrane, 2006). The identification of themes helps to organize and make sense of the rich, qualitative data gathered through the phenomenological inquiry. Hermeneutic phenomenology often deals with intricate and nuanced experiences. Thematic analysis offers a systematic way to break down and categorize these experiences, making them more manageable for interpretation and understanding. Thematic analysis allows researchers to delve deeper into specific themes that are identified from the data, supporting a more detailed and nuanced understanding of particular aspects of the phenomenon under study (Jowsey et al, 2021; Nowell et al, 2017). Thematic analysis adds a layer of systematic coding and analysis, which can help validate and refine interpretations derived from the hermeneutic phenomenological approach (Finlay, 2021). This structured framework, can also allow for a degree of flexibility in interpretation. This balance is particularly valuable in hermeneutic phenomenology, which values openness, and flexibility in understanding subjective experiences. Thematic analysis can enrich the interpretations derived from hermeneutic phenomenology by providing a systematic way to identify recurring patterns and connections in the data (Nowell et al, 2017). Hermeneutic phenomenology empowers the influence of the researcher's perspective in interpreting data.

Thematic analysis can serve as a form of triangulation, helping to address potential biases and providing an additional perspective on the data (King, 2004). Using this method in this study will support the examination of the perspectives of each participant, highlighting both similarities and differences, as well as generating unanticipated insights.

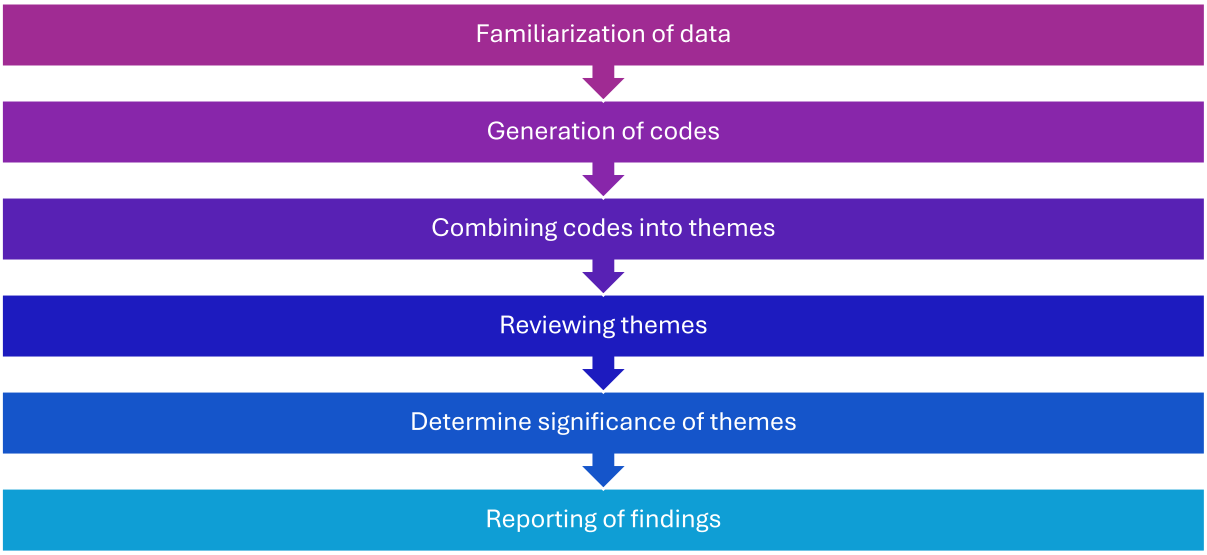
Thematic analysis supports the iterative process of the hermeneutic circle, allowing for an ongoing refinement and deepening of the analysis. Themes identified through thematic analysis can be revisited and further explored in light of the hermeneutic phenomenological insights. Overall, the application of thematic analysis to qualitative data derived from a hermeneutic phenomenological study leads to a more comprehensive and nuanced exploration of complex human experiences, allowing researchers to uncover deeper insights and generate robust interpretations.

3.21: The 6-StageFramework of Reflexive Thematic Analysis

The application of thematic analysis was informed by Braun and Clarke's (2006) 6-stage framework. Thematic analysis focuses on examining themes or patterns within the data, leading to a rich description of the data and theoretically driven interpretation of meaning (Daly et al, 1997). Thematic analysis was chosen due to its ability to be flexible (Braun and Clarke, 2006). Thematic analysis is compatible with phenomenology as it focuses on the participants' subjective experiences and sense-making (Guest et al, 2012; Dapkus, 1985). Analysis of hermeneutic phenomenological derived data requires researchers to understand the philosophical tenets, therefore enabling the researcher to preserve possibilities of interpretation. In doing so, methods of thematic analysis can uncover and present the structure of the meaning of lived experience (Ho et al, 2017). Interviews in this study were transcribed, as this allowed the process of immersion in the data and therefore begin the process of analysis through reflection (Lester et al, 2020).

The 6-stage coding framework for thematic analysis will is used to identify themes and patterns in the data (Braun and Clarke, 2006), see Figure 7 below:

Figure 7: The 6-stage of thematic analysis



3.21.1: Familiarisation of the data

This stage is repetitive in nature, the researcher read and re-read each transcript, immersing in individual participants experiences the data set as a whole to the point where the researcher could recall the experiences of all the participants. Braun and Clarke (2022) describe familiarisation occurring over three aspects. The first aspect focuses on the development of a deep and intimate knowledge of the dataset through the reading and re-reading of the data. Braun and Clarke (2022) state:

"You want to get to the point where, if suddenly your data got stolen, you'd be able to describe the broad content fairly well, even if precise detail was gone" (Pg43).

The process of transcribing each individual interview verbatim within this study, supported a good understanding and commenced familiarisation in the individual and full data set. The process supported listening to the participants knowledge, understanding and descriptions of their experiences of caring for people living with dementia. All interviews were listened to twice - firstly to support transcription, secondly to check the transcript. After all interviews were transcribed, re-read and the researcher was immersed in the data, familiarisation with the data occurred. This process involved read and re-reading the individual interviews to a point the researcher could recall information from the interviews, which supported further thoughts and reactions to the data.

The second aspect involved questioning the data and my own response to the data to facilitate critical engagement with it, this included asking questions such as “why might I be reacting to the data in this way?” “What ideas does my interpretation rely on?” “What different ways could I make sense of the data?” (Braun and Clarke, 2022). This second aspect led to having to interrogating myself as I started - and continued – engaging with reflective thematic analysis. In doing this, I became familiar with the content of the individual interview and full dataset, through a process of immersion. At this point I chose to move on to into a more immersive thought process and start to think critically focusing on the three research questions. I read the transcripts again with these questions in mind.

The third aspect involved noting ideas around the data that has developed through familiarisation and immersion within each individual interview. This involved making brief, but systematic overall familiarisation notes related to the whole dataset, capturing my ideas regarding potential patterning of meaning, and questions I had (Byrne, 2022). The point of the overall dataset familiarisation note-making was to take the time to reflect on my responses to the dataset as a whole, rather than just individual data items, this allowed to commence coding with an already-engaged, critically questioning mindset (Byrne, 2022; Brauna and Clarke, 2023). Lastly, I started to build memos. These included some of the comments or answers for the critical engagement questions, defined by Braun and Clarke (2023) but also these notes included a journal of reflection, questions, memos or comments based on the data. These notes referred to the content of the interview and reactions and responses of both me and the participants. After I had completed this task for each interview, I compiled an overall statement - starting with an overview about my thoughts and acknowledging my previous knowledge, then a combination of comments, quotes and idea formulation, as part of the reflexivity process.

3.21.2: Generating initial codes

Once the researcher was familiar with the entire dataset, the data was analysed creating semantic and latent codes. The process of generating semantic codes involves a descriptive analysis of the data, focusing on accurately representing the content as conveyed by the respondent. In contrast, latent coding delves deeper, seeking to uncover underlying meanings, assumptions, ideas, or ideologies that may influence or inform the semantic or descriptive content of the data (Byrne, 2022). Reflecting on the completion of the analysis of the transcript of the first interview, it became apparent that data from non-dementia specialist departments would benefit from being analysed separately to the dementia specialist departments. This was because the codes were contradicting, which caused the individual essence of the data to be confusing and unclear. The differences between the positives and challenges experiences of seeking help for caring for people with dementia and providing support for those caring for people with dementia, were fundamentally different. Nurses working in dementia specialist departments did not focus on the positives and negatives on how they sought support, but on providing support for others, which was their main concern. Therefore, following discussion with my supervisors it was decided to separate the data analysis into two parts. The first part, A: to include ED registered nurses, oncology nurses and older adult ward nurses. The second part, B: to include Admiral Nurses, dementia nurse consultants and dementia specialist nurses.

Following the separation of the dataset, Part A generated 147 codes and Part B generated 131 codes. The initial coding required the reading of each transcript line by line and assigning codes accordingly to the data that had meaning that was potentially relevant to the research question (Braun and Clarke, 2022). An inductive approach was used allowing the data to drive the analysis, this allows the data to represent the voices of the individual participants experiences. There is no coding framework within reflexive thematic analysis leading the analysis to be open and organic (Braun and Clarke, 2022; Byrne, 2021). Braun and Clarke, (2022) define semantic themes as being:

"...within the explicit or surface meanings of the data and the analyst is not looking for anything beyond what a participant has said or what has been written" (p.84).

Analysis in this stage moves beyond describing what is said to focus on interpreting and explaining participants experiences. In contrast, the latent level explores beyond what has been said and this is defined as when the researcher:

"...starts to identify or examine the underlying ideas, assumptions, and conceptualisations – and ideologies - that are theorised as shaping or informing the semantic content of the data" (p.84).

3.21.3: Coding record

The process of the development of codes was documented with a clear audit trail to support the credibility of the codes. These processes included written records, such as reflections and any thoughts on how each code was developed, but also the use of an excel spreadsheet, which comprised of a list of all the codes, an example of the data linked to the code and any thoughts or decisions about how the code was developed. NVivo was not used in any of this process as after completing the training about the programme it did not appear to improve the process that the researcher has previously used. An example is shown below (Table 11):

Table 11: Example of code recording

Code Label	Data Linked to Code	Thoughts or Decisions
C49: Need to know the person with dementia	*"And this lady she used to she she used to get into a right state and she she'd be saying things like I want; I want the red pillar box; I want the red pillar box.* *I remember it clear as day now and I'll be going, I don't know what this is and I was getting frustrated and she was getting frustrated. But the dementia nurse knew her and knew she wanted this red box that had her glasses in"*	In order to be able to understand what a patient with dementia needs, you need to know about them. This suggests that registered nurses can get frustrated not knowing what to do or how to provide what the person with dementia needs

3.21.4: Merging of codes

When all codes had been identified, the process of merging the codes was the next stage. This process developed as some of the codes had similar meanings, which could be merged into one, code this action reduced the overall total of codes generated across both data sets. The merging of codes supported further in-depth understanding of the data and moved away from reporting the content of the data to understanding the data within the context of dementia care and the lived experience of participants. For example, the code 'role modelling' was identified in the data from Dementia Specialist Services to empower nurses, this was created following the merging of two previous codes as the key experience in the data was not specific to just Admiral Nurses or BPSD as a care need (Table 12).

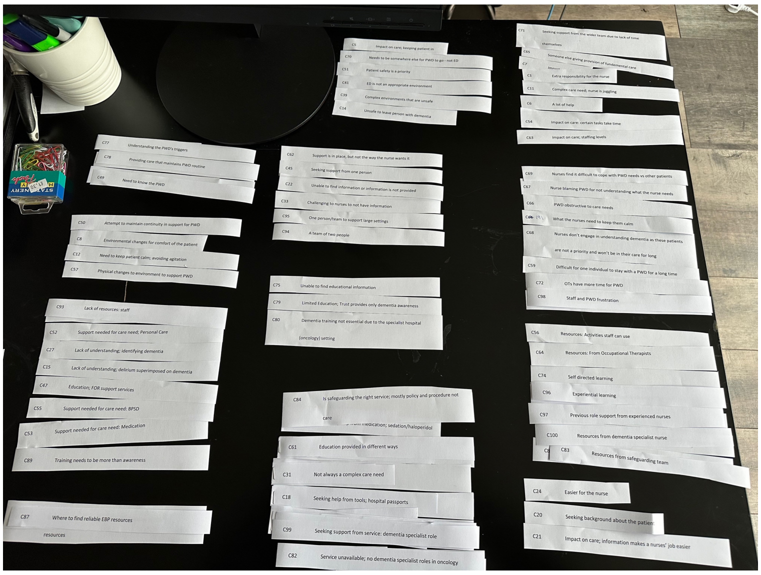
Table 12: Example of codes merging

Code Labels	Data Linked to Code	Thoughts or Decisions
C214: Role modelling used by Dementia Specialist Services to empower nurses From the codes below: 'Admiral Nurses empowers nurses through them role modelling how to respond to BPSD' 'Dementia Specialist Services use role modelling to support nurses'	*"if they need support with complex and behaviours that challenge particularly and I can support them with that, it's more like role modelling and supporting them to care for the person with dementia as opposed to me coming in and and doing the work like solely if that makes sense. So yeah, it's empowering other people"*	Role modelling was a technique that was used by most dementia specialist services, not just the Admiral Nurses. It was also a technique that was used for more than BPSD – hence the merge to include the wider connotations.

3.21.5: Generating themes

Reflexive thematic analysis, as described by Braun and Clarke (2022), directs the researcher in a useful manner rather than being prescriptive in the development of generating initial themes. My approach, to help me organise the codes and work towards developing themes was a practical and visual approach, this was done by printing all the codes and having them displayed in front of me. Once all the codes were printed onto A4 paper, and cut each code out, so I could start manually grouping codes, which had common meanings (Figure 8). This approach enabled me to have an overview of several groups of codes, and the opportunity to move codes from group to group to identify how and where each code would or would not fit within a group of codes. This approach provided me with both an understanding of each code, each group, and each initial theme, whilst providing me a broader overview of the data set I was working on, as I completed this separately for my two data sets, A and B. This overview allowed me to be able to search for patterns and possible sub-themes and themes.

Figure 8: Grouping codes into potential themes

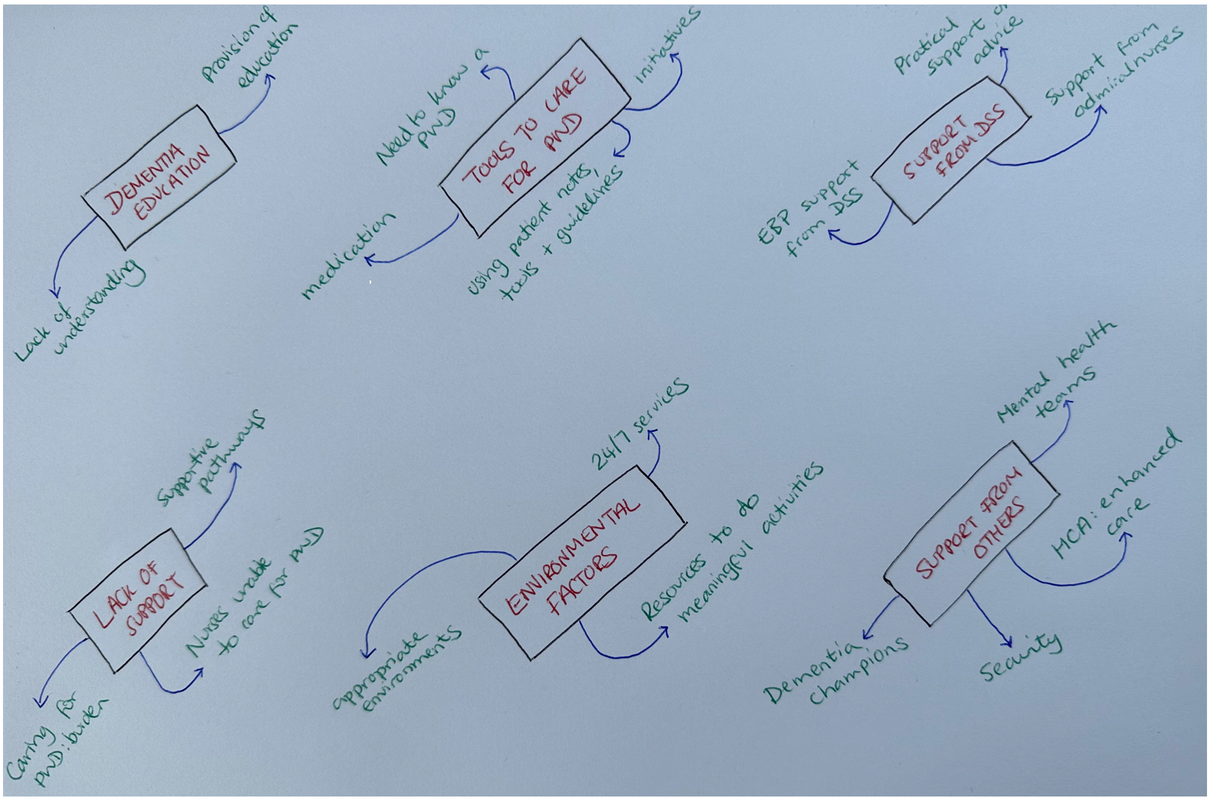


3.21.6: Reviewing potential themes

The next stage involved reviewing and refining the themes and sub-themes of the dataset. Firstly, this process involved reading the data linked to each code within the potential themes and sub-themes to be able to identify whether they form a coherent pattern that represented the overall narrative of the dataset (Braun and Clarke, 2022).

At this early-stage review there was a need to move codes around to give further clarity to the sub-themes and the development of the themes. The first potential themes were reduced from six to four, which provided a clearer direction and description of each theme, with less overlap across themes. There was a reduction of sub-themes, and some codes were no longer included as they were either merged with other codes or did not concur with the story of the sub-themes or themes. The thematic mapping was used to demonstrate the changes made in theme development (Thematic map 1). The themes are within boxes to highlight the working titles and the sub-themes are linked to the themes through one way arrows, as a rough guide.

Thematic Map 1: Development of potential themes

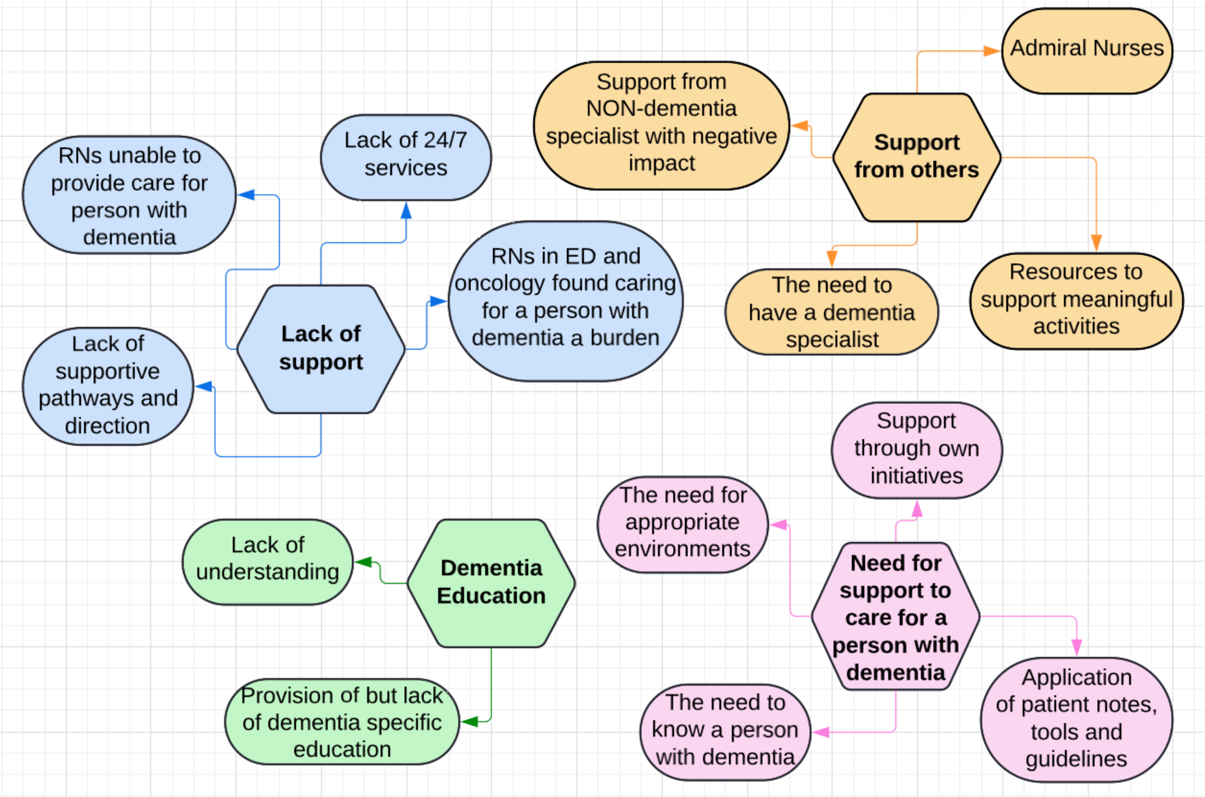


The process was then repeated, again and again until no further changes were identified, and then potential themes and sub-themes were reviewed in relation to the research questions (Braun and Clarke, 2022). As part of this process, I reviewed the themes and critically analysed how they answered the research questions and which themes linked to which research question. The theme ‘need for support to care for a person with dementia’ answered the first research question, the experiences of nurses in seeking support to care for a person with dementia. The themes ‘support from others’ and ‘dementia education’ answers the second research question, as they linked to types of support registered nurses accessed. The theme ‘lack of support’ answers the third research question and identified the challenges that registered nurses’ experience in obtaining support.

3.21.7: Defining and naming themes

The next phase was the development of the final thematic map (Thematic map 2). Each theme, linked with the sub-themes is identified using singular colours so as to clearly identify them to the researcher. Following the definition of the themes for each dataset (Part A and Part B), I wrote a comprehensive analysis for each theme. This was completed using data linked to the individual codes that created the sub-themes and themes and provided a detailed narrative (Braun and Clark, 2022). The findings of this analysis process are written in chapter 4.

Thematic Map 2: Developed themes



3.21.8: Producing the report

Themes should be displayed in a manner that is clear and understandable to wider readers. I have chosen to use a thematic map to display the themes, as seen in Thematic Map 2. This method shows the overall themes clearly displayed and the linked sub-themes. In producing a report of the findings, the most representative narratives from the datasets are used alongside analytic narrative that presents more than description and show the argument that links to the research question (Braun and Clarke, 2022).

3.22: Ethical Approval

Approval was obtained from the NHS, Invasive or Clinical Research Committee (NICRS) Ethics Committee (No 19/20 - 063) and then the NHS Health Research Authority (HRA) before the recruitment of participants into this study. The research protocol was submitted for consideration, comment, guidance, and approval to the concerned research ethics committee prior to the commencement of the study as part of the University of Stirling's processes.

The study was conducted in accordance with the recommendations for research on human subjects adopted by the 18th World Medical Assembly, Helsinki, 1964 and later revisions and will adhere to Good Clinical Practice (GCP) and the NHS Research Governance Framework to Health and Social Care (Last updated on 6 Sep 2023).

Due to the COVID-19 pandemic an amendment was submitted to the Ethical Review Board (NICRS) which requested the study recruitment to occur through social media and the conducting one-to-one interviews via MS Teams. The amendment to the research protocol was approved (November 2022). The original pre-pandemic research protocol involved recruiting from three NHS Trusts and arranging face to face focus groups of registered nurses from four specialisms (ED, Oncology wards, Older Adult wards and Dementia Specialist Services). However, due to the withdrawal of all research in NHS Trusts, unless it was COVID-19 specific research, this approach was no longer possible. Therefore, an amendment was submitted relating to recruitment and data collection, which reflected changes both within the healthcare system and society, relating to how staff interact with patients and colleagues, and visitation policies within NHS Trusts. Due to the changes in recruitment from NHS Trust sites to social media NHS HRA approval was no longer required.

3.23: Rigour

This section will commence with an exploration of the elements of trustworthiness, including trustworthiness, dependability, conformality, credibility, transferability, and how each element has informed the development of this study.

3.23.1: Trustworthiness

Lincoln and Guba (1985) noted that credibility, transferability, dependability, and confirmability are necessary in establishing trustworthiness. One of the ways to ensure credibility and transferability is to ensure that those interviewed have the experience to discuss the phenomenon and meet the inclusion criteria (Lincoln and Guba, 1985). When conducting data analysis, the researcher becomes the instrument for analysis, making judgments about coding, theming, decontextualising, and recontextualising the data (Starks and Trinidad, 2007).

Each qualitative research approach has specific techniques for conducting, documenting, and evaluating data analysis processes, but it is the individual researcher's responsibility to assure rigor and trustworthiness. Qualitative researchers can demonstrate how data analysis has been conducted through recording, systematising, and disclosing the methods of analysis with enough detail to enable the reader to determine whether the process is credible (Attride-Stiring, 2001; Cote and Turgeon, 2005; Ryan et al, 2007). The research must be accessible to aid trustworthiness (Yin, 2011). While the anonymised transcripts for this research will be stored as per the University of Stirling's Regulations. Each element of trustworthiness will be discussed below with reference to the current research, both the approach and design, but also within the analysis of data and reporting of findings.

3.23.2: Credibility

Guba and Lincoln (1989) claimed the credibility of a study is determined when coresearchers or readers are confronted with the experience, they can recognise it. Credibility addresses the "fit" between respondents' views and the researcher's representation of them (Tobin and Begley, 2004). Lincoln and Guba (1985) recommended peer debriefing to provide an external check on the research process, which may therefore increase credibility, as well as examining referential adequacy to check preliminary findings and interpretations against the raw data (Lincoln and Guba, 1985). I discussed their interpretation and identification of codes and then the development of themes with my supervisors. The development of the study was continuously discussed and reviewed through the structure of the clinical doctorate programme with lecturers, peers and allocated supervisors. This process continued through all six stages of thematic analysis and commenced with the provision of two transcripts to both supervisors as an example of the data. This process ensured the themes are a true interpretation and reflection created from the data. The identification of my pre-conceptions through reflection were key in developing the interpretation.

3.23.3: Transferability

Transferability refers to the generalisability of inquiry (Tobin and Begley, 2004). Transferability according to Lincoln and Guba (1985) is the generalisability of data. To what extent can findings be transferred to other settings or a group? This study uses a hermeneutic phenomenological approach, therefore the aim was not to generalise the findings but to provide deep description of the phenomenon of seeking support to care for people with dementia from the nurse's perspective. The findings need to be understood and situated within the parameters of the research but may inform how nurses sought support to care for patients with dementia in acute non-mental health hospitals.

3.23.4: Dependability

To achieve dependability, researchers should ensure that the research process is logical, traceable, and clearly documented (Tobin and Begley, 2004; Johnson et al, 2020). When readers are able to examine the research process, they are better able to judge the dependability of the research (Lincoln and Guba, 1985; Mays and Pope, 2000). One way that a research study may demonstrate dependability is for its process to be audited (Koch, 1994; Johnson et al, 2020). As a doctorate student the project maybe audited. Therefore, the processes followed in recruitment, data collection and data analysis are detailed in this chapter and reflect all actions taken. In addition, during the development and implementation of this research all discussions with the researcher and supervisors were clearly recorded, developing a clear electronic paper trail.

3.23.5: Confirmability

Confirmability is concerned with establishing the researcher's interpretations and findings are clearly derived from the data, requiring the researcher to demonstrate how conclusions and interpretations have been reached (Tobin and Begley, 2004). According to Guba and Lincoln (1989), confirmability is established when credibility, transferability, and dependability are all achieved. Koch (1994) recommended researchers include markers such as the reasons for theoretical, methodological, and analytical choices throughout the entire study, so that others can understand how and why decisions were made. One way to establish confirmability is to ensure researcher bias has not occurred, and the data has been interpreted in an unbiased way. The process adopted by the researcher was to transcribe the interviews and manually code the text, alongside concurrent discussions with their supervisor to ensure a deep understanding of the content of each interview and individual participant's intent. The application of hermeneutic phenomenology accepts all human understanding is informed and guided by the interpreter's inherent biases and prejudices shaped by their personal experiences and prevailing cultural attitudes of their socioeconomic demographic (Metselaar et al, 2016). I had a set of clear rules and several controls to help ensure following of the rules took place. This included the use of a reflective journal and memoing to highlight pre-conceptions.

3.24: Chapter Three Conclusion

This chapter has outlined the research methodology and methods used to answer the research questions and presenting the justification for the use of hermeneutic phenomenology. A hermeneutic phenomenological approach was explored and discussed, demonstrating that it was the most appropriate approach for this research study. This approach was used to develop an understanding of the lived experience of registered nurses seeking support in caring for patients with dementia in non-mental health acute hospital settings. Following a review and critique of the methodology, the methods applied was detailed including the procedure, study participants, data collection, and interview questions outlined the specifics of how the study was conducted and who participated in the study.

Chapter 4: Findings

4.1: Introduction

This chapter presents the findings of an exploration of the lived experience of registered nurses seeking support in caring for patients with dementia in non-mental health acute hospital settings, what types of support were accessed, and challenges experienced in implementing or not implementing guidance provided. The findings are split into two parts: Part A, commences with an overview of the demographic details of the non-dementia specialist registered nurse participants, followed by the identified themes (n=3) and subthemes (n=9) from the data analysis of their interviews. The three themes were 1. need for an appropriate infrastructure to care for a patient with dementia, 2. need for support from others and 3. lack of support. In the second section; Part B, commences with an overview of the demographic details of dementia specialist registered nurse participants, followed by the identified themes (n=4) and subthemes (n=10) from the data analysis of their interview. The four themes were 1. dementia specialist services (DSS) providing support; 2. DSS seeking support; 3. the infrastructure of DSS; and 4. nurses lacking understanding of dementia and willingness to engage with DSS.

4.2: Part A Dataset from non-dementia specialist registered nurses

4.3: Participant characteristics

Registered nurses from non-dementia specialist services (n=6) participated in this study. The participant pseudonyms and characteristics are shown in Table 13 and 14. Participant pseudonyms were chosen as Harry Potter characters, as the use of people's names can help the reading of the data seem more human and individual (Saunders et al, 2015). All the participants were registered nurses working in non-mental health acute settings within specifically chosen wards or teams, which included emergency departments (ED), oncology and older adult wards. The tables 13 and 14 below highlights the specific roles, grade bands, and years of experience, which varied across participants. Participants, of all who were registered nurses, will now be referred to a 'nurses' to support the presentation of the findings. The letters ED (emergency department), O (oncology) and OA (older adult ward) were used to identify the departments from where participants were from.

Table 13: Participant pseudonyms

Participant pseudonyms
06604 – Ginny – ED 13605 – Molly – ED 31503 – Arthur – O 19607 – Fred – O 22608 – George – OA 19710 – Ron - OA

Table 14: Characteristics of the participants

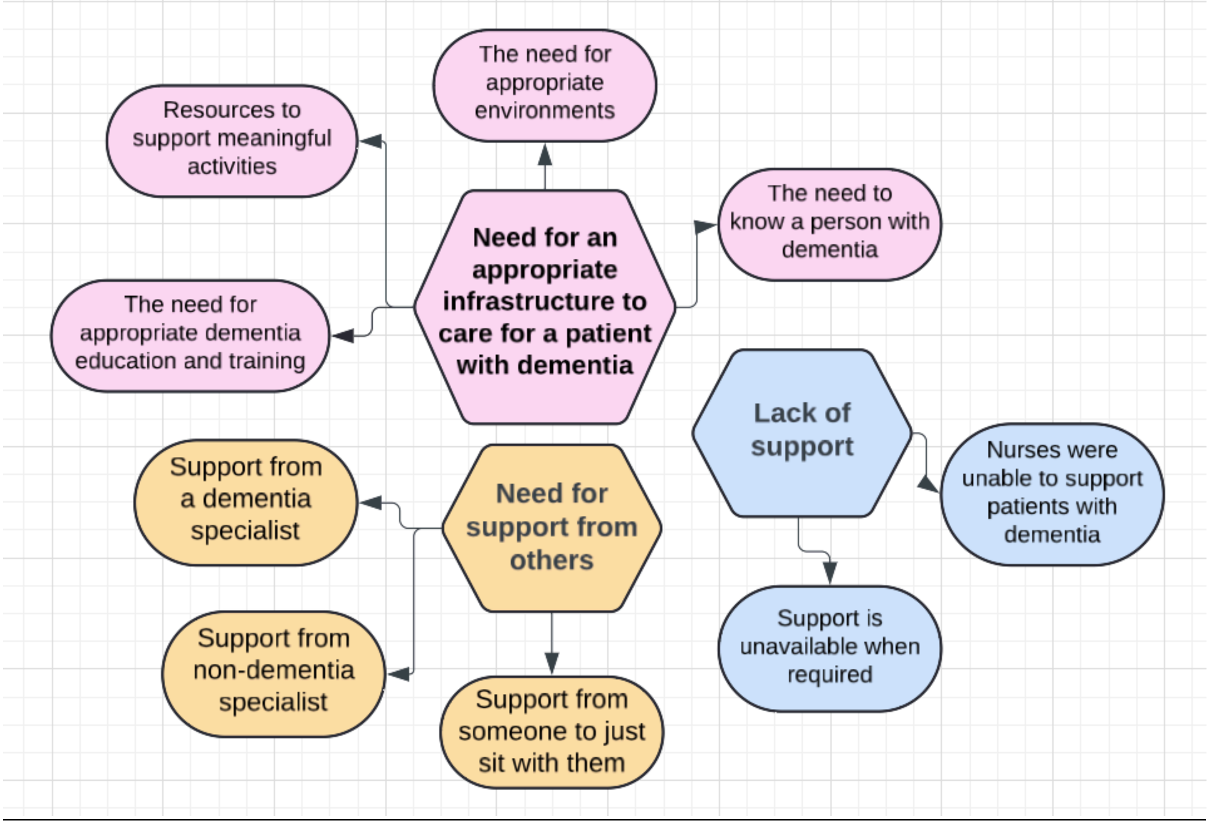
Sex	**Number of participants**
Female	5
Male	1
Nurse Grade Band	**Number of participants**
6	4
7	2
Years of registered nurse experience	**Number of participants**
Less than 5	0
6 - 20	4
21 - 30	2
More than 30	0
Department	**Number of participants**
Emergency Department	2
Oncology	2
Older Adults Ward	2
Role	**Number of participants**
Nurse	2
Sister	1
Ward Manager	2
Nurse Consultant	1

All the non-mental health acute hospitals were in large cities and were within NHS Hospital Trusts with multiple hospitals sites. All EDs were classified as major accident and emergency departments, with one specialised and equipped with a helicopter trauma centre. The oncology departments were within major acute settings; one setting was a specialist cancer centre and one setting was a non-mental health acute hospital. The oncology departments were staffed with specialist cancer nurses of different nurse grade bands. The older adult wards were large county-wide hospitals. The older adult wards did not specialise in dementia care but were general medical wards.

4.4: Overview of the findings

The themes discussed in this section explore how non-dementia specific nurses seek support when caring for a person living with dementia. The themes are shown in Thematic Map 3 and include the **need for an appropriate infrastructure to care for a patient with dementia**; **need for support from others**; and **lack of support**.

Thematic Map 3 - Theme Diagram



The first theme, **need for an appropriate infrastructure**, explores the experiences of nurses in gathering information to enable them to care for a person with dementia. There are four subthemes that support this theme, these subthemes show the different ways by which the nurse participants feel supported or seek the answers to be able to provide care for the person with dementia. The first subtheme identified was the *need to know a person with dementia*, this subtheme explored the nurses' experiences of knowing information about the person with dementia including how to gather that information and how this impacted the nurse's ability to implement care. The second subtheme, *the need for appropriate environments*, focused on the nurses' experience of how environmental factors can improve and hinder the provision of care for a person with dementia. The third subtheme, *resources to support meaningful activities*, nurses discuss the use of different methods of implementing engaging activities to support them in caring for a person with dementia. The fourth subtheme, *the need for appropriate dementia education and training*, acknowledges the learning provision available across the acute hospitals and highlights the nurse's perception of the versatility of what is being provided. This theme shows the routes taken by nurses to find the appropriate information that they find supportive in being able to provide the right care to a person with dementia that enters their department.

The second theme, **need for support from others**, explores the nurses' positive and negative experiences of gaining support and direction from other services, departments and activities, whilst also highlighting aspects where services are either non-existent or do not work the way the nurse requires them to. There are three subthemes that underpin this theme. The first subtheme, *support from non-dementia specialist*, explores the impact on people with dementia when nurses seek support from services that are not specialised in caring for a person with dementia. The second subtheme, *support from a dementia specialist*, accumulates the perceived needs of the nurses in caring for a person with dementia that they perceive could be resolved if a specialist in dementia was available to them. The last subtheme, *support from someone to just sit with them*, discusses how nurses in the emergency department and oncology want an individual to keep a patient with dementia company.

The last theme, **lack of support**, explores the nurses having an overwhelming perception of missing factors, whether within the services themselves or the lack of direction to find support themselves when caring for a person with dementia. There are two subthemes that support this theme, these subthemes explore the complications and difficulties that nurses experience in searching for support to care for a person with dementia. The first subtheme, *support is unavailable when required*, discusses the nurses experience in not being able to access a supportive service at the time of day or day of the week that they need the support. The second subtheme, *nurses were unable to support patients with dementia*, this subtheme relates to the nurses' expressed feelings of inadequacy in being able to meet the care needs of a person with dementia due to supportive factors. This theme highlights the overwhelming negative experiences of nurses' being unsupported, both by services and processes leading them to provide inadequate care of people with dementia.

These themes and subthemes are based on the experiences and perceptions of nurses seeking support when caring for a person with dementia. The themes and subthemes are discussed in this chapter and are evidenced using verbatim quotations taking from the transcript interview scripts. The contribution of the dataset to the development of the themes is presented in Table 15 below, which shows the non-dementia specialist nurses who shared similar views or different views as interpreted by the researcher. Hermeneutic phenomenological method gives a voice to the experiences of each participant.

Table 15: The identification of the themes and subthemes from the individual interviews of registered nurses

Participant No and specialism	06604 Ginny (ED)*	13605 Molly (ED)	31503 Arthur (O)**	19607 Fred (O)	22608 George (OA)***	19710 Ron (OA)
Need for an appropriate infrastructure to care for a person with dementia						
The need to know a person with dementia	x	x	x	x	x	x
The need for appropriate environments	x	x			x	x
Resources to support meaningful activities	x	x	x	x	x	x
The need for appropriate dementia education	x	x		x	x	x
Support from others						

Support from non-dementia specialist	x	x	x	x		
Support from a dementia specialist	x	x	x	x	x	x
Support from someone to just sit with them	x	x		x	x	
Lack of support	x	x	x	x	x	
Support is unavailable when required	x	x	x	x		
Nurses were unable to support patients with dementia	x	x	x	x	x	x

(ED) - RN from Emergency Department*
*(O)** - RN from Oncology*
*(OA)*** - RN from Older Adult Wards*

The next section discusses the thematic findings from the interviews with non-dementia specialist nurses working in the emergency department, oncology, and older adult wards where nurses were asked to response to five main open-ended questions that link directly to the research questions:

Can you tell me about a time that you sought support to care for a patient with dementia?
Where are the main areas of caring for a patient with dementia did you go to seek support about?
Can you tell me about a time when you have not sought support, as you have used support you received previously, or has this not occurred?
Can you tell me about any barriers that you have experienced when seeking support?
Can you tell me what helped you seeking support?

4.5: Theme 1: Need for an appropriate infrastructure to care for a patient with dementia

All participants (the nurses in the study) acknowledged the need for an appropriate infrastructure to support them to care for patients with dementia. The nurses identified important elements of an infrastructure to support their care for patients with dementia, which were required to address four overarching needs: *the need to know the patient, the need for an appropriate environment, the need for resources to support meaningful activities*, and finally *the need for appropriate education and training*. Each of which will be discussed in detail below.

4.5.1: Subtheme: 1a. The need to know a patient with dementia

The nurses discussed the dominance of knowing a patient to provide supportive and appropriate care and acknowledged how this was essential when caring for a patient with dementia. Nurses identified that obtaining information from patients with dementia through conversation was both difficult and time-consuming, and require the nurses to involve family members. The information required to support the appropriate care of a patient with dementia included an understanding of triggers, fundamental needs, communication, and background medical and social history, for example, Ginny expressed the dominance of understanding the fundamental care needs of a patient with dementia to develop an appropriate care plan:

> *"Basic things basic care needs. Like what they like to eat, what they like to drink, so they have thickened fluids and things about them, what sort of things they did in their previous job. Is there anything that they might enjoy?"* (Ginny/ ED)

The participants explored the difficulties in obtaining information directly from patients with dementia, which was attributed to their ill health and impact on their cognitive abilities, including their word finding and speech. An element required to address these difficulties was time, and the need to spend time with the patient with dementia, to engage with them and learn how to communicate with them. However, Molly identified time was an issue, and nurses did not have the time to engage in this manner:

> *"I think it's more about spending time, having someone that can spend time with the individual and giving them what they need. Finding out what they need as well, I suppose."* (Molly /ED)

Nurses working on older adult wards and in emergency departments, discussed an initiative of hospital passports, which provided individualised information about the patient with dementia. Hospital passports are individual documents that records an individual health needs, as well as other useful information like their interests, likes, dislikes, how they communicate and any reasonable adjustments that they might need. These documents are completed on the first admission to hospital or by their family and accompany the patient on admissions to hospital or when attending other medical appointments. Nurses found this initiative supported the care of patients with dementia, the documents were not always available and nurses were not always aware of the initiatives, as Ginny noted:

> *"Sometimes they (patients with dementia) have a hospital passport. That's just been brought in that it started off being for learning difficulties patients but has actually been used for patients with dementia or patients that have had strokes that can't communicate."* (Ginny/ ED)

> *"I think the passports were definitely just about being giving information we require to care for them (patients with dementia), but other nurses need to know that the information is there would also be better."* (Ginny/ ED)

The participants still acknowledged the lack of time impacted on their communication with patients with dementia. Poor communication through the inability to convey information between nurses and patients with dementia, left participants feeling frustrated as they are not able to meet the needs of a patient with dementia, and the patient with dementia becoming agitated as their needs were not met, as Arthur explained:

> *"This lady she used to get into a right state and she she'd be saying things like I want; I want the red pillar box; I want the red pillar box. I remember it clear as day now and I'll be going, I don't know what this is and I was getting frustrated and she was getting frustrated." (Arthur /O)*

All nurses tried to support patients with dementia becoming agitated due to unmet care needs by obtaining information from their family. Nurses believed family members could provide important information on the usual behaviours and cognitive abilities of the patient with dementia and how these have been impacted by their current illness. The experience and understanding of family was valued by nurses, especially in understanding if the behaviour of a patient with dementia may escalate, as Fred explained:

> *"Learning from like their families next to kin about sort of ways their, what their behaviours are like and and if whether they may escalate at anytime."* (Fred/ O)

Lastly, nurses recognised the need to sometimes step back and understand how to communicate with a patient with dementia, as their preconceptions and a lack of knowledge of the patient impacted on their expectations of the ability of the patient to communicate their needs, as George explained:

> *"As a qualified nurse, we sometimes step back and watch the "specialist care team" interact with the patient and actually the patient can interact at a higher level than we first thought, if they get them engaged, all of a sudden, they are talking more coherently, they're telling them what their needs are…"* (George/OA)

4.5.2: Sub-theme: 1b. The need for an appropriate environment

A further aspect of the infrastructure necessary to support nurses to care for patients with dementia, which was discussed by nurses who worked on older adult wards and within emergency departments, was the need for an environment that supported the needs of a patient with dementia. Nurses working in these two specialities identified the need for quiet spaces for patients with dementia.

Nurses working on older adult wards and within emergency departments discussed the busy and complex nature of an acute hospital setting. Nurses working on older adult wards commented on how the ward becomes busy and noisy during the day, which had the potential to cause concern and unsettle patients with dementia. Therefore, nurses identified the need to have a quiet space or spaces off the main ward to support patients with dementia to remain calm. Nurses working on older adult wards identified the use of a quiet room, as George explained:

> *"When the consultants and all the doctors and physios are on the ward, it is exceptionally busy and noisy. So that's the time when it's really good if the "specialist care team" can come and take people with dementia off to the quiet room or off to the other ward quiet room so they're not disturbed by the 'absolute hubub' that goes on an acute older person ward."* (George/ OA)

The two nurse participants working within an emergency department also discussed the hectic environment of their department, and the need for a quiet space for patients with dementia. However, within emergency departments moving a patient with dementia to a quiet space was not always possible, especially if they were acutely unwell. The nurses highlighted that a lack of an appropriate environment to care for patients with dementia left them scared and frightened, as Molly explained:

> *"But from our point of view, it's about having somewhere appropriate that you can care for them (patient with dementia) I mean, sometimes you just haven't, sometimes they have to go into RESUS and you know, they're in RESUS because they're poorly, but they're not poorly enough whereby they've have a reduced consciousness. So, they still know what's going on and they're scared and frightened."* (Molly/ ED)

Nurses working in emergency departments also acknowledged other aspects of the environment, which from their perspective also impacted on the safety of patients with dementia. Although, risks about safety were discussed regarding patients with dementia and those with significant mental health issues, the ED nurse did not identify the differences of potential risks between someone with dementia or someone with a severe mental health issue, or though recognised this as an issue, as Ginny described:

> *"The struggles we have in the department, such as the layout, the doors, the exits, the, the ligature risks, the stuff that affects dementia patients as well as mental health patients, I think, having a specialist to try to encourage us into talking about dementia separately rather than just mental health problems as a general, I think that'll be really good."* (Ginny/ ED)

The focus of nurses working in emergency departments was ensuring the safety of the patient with dementia by keeping them calm and come to no harm in a busy and unfamiliar environment, as Molly discussed:

> *"In the emergency department, it's more about patient safety and about keeping the patient safe because the emergency department isn't a calming environment."* (Molly/ ED)

4.5.3: Sub-theme: 1c. Resources to support meaningful activities

Another important infrastructure nurses working on older adult wards and within emergency departments recognised was the need to have activities to both support and occupy the patient with dementia. Nurses interviewed working on older people wards tended to discuss resources that provided meaningful activities for patients with dementia, whereas those working in emergency departments focused on the need to occupy the patient with dementia to keep them calm. As George, who worked on an older adult ward and Ginny, who worked in ED, explored:

> *"We (nurses) use the term meaningful activities and we've had someone that comes in once a month from the local museum, who brings in objects to get older people, not only with cognitive impairment or dementia, but around a table handling objects. And what are these and what era do you think these came from? And talking and engaging with the object."* (George/ OA)

> *"Trying to keep them calm and not injured because obviously they were in a complete alien and busy environment for them"* (Ginny/ ED)

The dominance of meaningful activities was further explored by George, and the supportive impact of these activities on patients with dementia. This was in reference to meaningful activities that supported patients with dementia to feel involved and engaged in a social situation. However, the acute non-mental health hospital where George worked has also implemented a 'specialist care team' who came to the wards and supported the provision of meaningful activities:

> *"I generally do believe that the "specialist care team" support rehabilitation of the patient because they do activities, like non-baked cooking, social dining, so they improve the nutrition of the patient, so there's lots of things that they do that just naturally engages the patients and so they're more socially interactive and within that process, and they appear to be recovering quicker."* (George/ OA)

One nurse working in the emergency department also discussed the support provided by an occupational therapist, who had created a room, with activities and resources within the

Emergency Assessment Unit (EAU). However, this was not a resource the staff within the emergency department used even though they were aware of the room and all the resources available within the room, as Molly discussed:

> *"Occupational therapists have organised some resources on EAU there's a whole, there's a room with lots of stuff, it's really lovely, lots of resources in you can either borrow or the patient can use, not so much us (in emergency department), we don't tend to take our patients around there, but when they're on EAU, they can go into the room and then spend as much time as they like in there."* (Molly/ED)

The resources identified within the room in EAU, were not fully described by Molly, but the activities that were mentioned would not be classified as a meaningful activity, and some resources would be viewed as controversial. Although nurses working in emergency departments acknowledged a small budget to support activities, this was used to buy a radio, which suggests that NICE guidelines (2018) and wider research on meaningful activities was not consulted prior to purchasing the radio, as Molly described:

> *"They'll be a (therapy) doll in there. There were all sorts of different bits in there that could keep somebody occupied and calm."* (Molly/ED)

> *"We (emergency department) do seem to have a budget to do small things like patient the room and buy, you know, a radio and you know, various things. I wouldn't like to say that we a lot of money, but we certainly seem to have some available to help."* (Molly/ED)

The use of a therapy doll and radio for patients with dementia in the emergency department is in contrast with the description of the evidence-based activities that are provided for patients with dementia in older adult wards, as discussed by Ron:

> *"I've just recently come out of one of the bays where we've got sort of activity books and things we've got a water mat with the fish inside it and there's like a soft book that's got clips and activity bits in it to do."* (Ron/OA)

4.5.4: Sub-theme: 1d. The need for appropriate dementia education and training

The last element of the infrastructure to support nurses to care for patients with dementia was discussed by all nurses and focused on the provision and accessibility of appropriate dementia education and training. Nurses discussed the dominance of dementia education and training, but acknowledged in some specialities, such as oncology, this was not seen as a priority. As Arthur suggested, nurses only attended dementia education and training, if they had experienced caring for a patient with dementia:

> *"The attendance at teaching sessions very much depends on and varies from ward to ward, and whether you've got or had challenging dementia patients, because if you had, you'd find that you got half the ward going to the teaching session. If you hadn't, then they wouldn't bother"* (Arthur/O)

The two nurse participants working on oncology wards highlighted that even when they did attend dementia education and training, they felt it did not provide the practical and informative answers to their questions. Nurses working on oncology wards were seeking answers to what may trigger a patient with dementia to become unsettled or agitated, rather than focusing on the need for a person-centred approach, as Fred explained:

> *"But there was still no direct education on like this is the way these patients can behave, the sort of potential triggers or anything like that"* (Fred/O)

One nurse acknowledged there was not any specific training on dementia in their NHS Trust prior to the implementation of both Tier 1 and Tier 2 training as recommended in the Dementia Training Framework (DoH, 2016) by Admiral Nurses, who came eighteen months ago. Ron identified the need and supportive nature of this training for both nurses and all staff within the Trust:

> *"They (Admiral Nurses) put on regular training for the whole trust. They've put on a Tier 2 dementia training day, which we didn't use to have. So, there is quite a lot of training, tier one for all the staff to do, which is definitely a help as it is training that we didn't use to have. There was no formal training on dementia."* (Ron/OA)

Nurses working in an oncology wards or the emergency department identified different elements of dementia training and education, which were found to be impactful. They identified that an online version of Tier 1 was part of the mandatory training and discussed varied elements of face-to-face training that could constitute as part of Tier 2 training. The two participants remembered these elements of training, even a year later, which involved either simulation and the inclusion of senses or role play experiences, as Molly described:

> *"There's some sort of quiz, um, and then she (dementia lead) does some sort of sensory input. I don't know what the word is but she'll, she'll ask us to do things, something around either being touched without consent when you've got your eyes shut, for example, or a loud noise anyway, so it's always quite impactful"* (Molly/ED)

How the learning from these sessions were then implemented in practice was unclear. Molly also discussed elements of the training and education, that appeared to be repetitive and less engaging, such as stories of the experiences of patients with dementia:

> *"So usually we, I say usually, umm, there are usually some videos around people's (with dementia) stories. Um which might sound boring, but obviously it's not the same stories every year."* (Molly/ED)

4.6: Theme 2: Need for support from others

Participants identified the need for support from others to care for patients with dementia. This included people beyond the ward or nursing team. Support from others involved non-dementia specialists, dementia specialist nurses and teams, and also support from someone to just sit with the patient with dementia. Each of which will be discussed in detail below.

4.6.1: Sub-theme: 2a. Support from non-dementia specialists

The nurses who worked on older adult wards, oncology wards and in emergency departments ask for support from other trained and untrained healthcare professionals, such as doctors and healthcare assistants, who were not specialists within dementia care. Nurses also discussed reaching out to non-healthcare professionals such as security personnel within acute non-mental health hospitals. The nurses within the study identified, the support, care and treatment provided for their patient from non-dementia specialist personnel was not necessarily the most appropriate, but felt it was the only option available to them at the time. For example, Arthur, who worked on an oncology ward, identified this approach was not right:

> *"You don't, you know it's not right, but if you haven't got any about any other way of managing it, sometimes you just need another pair of hands just to try and help the situation, and that's not right."* (Arthur/O)

Nurses also recognised the actions of non-dementia specialists may have a negative impact on the patient with dementia. A recurrent example provided by participants (in oncology wards and emergency departments) involved patients with dementia who became unsettled, agitated, when the nurse attempted to provide care such as personal care. Nurses acknowledged they really didn't know how to support the best interest of the patient with dementia in these circumstances and focused on the need and options available to support the provision of care. Arthur describes this process, but defers his responsibility of the situation by stating "people phone security":

> *"When you are really up against it, because you know you have to provide care, and you've got patients (with dementia) who are perhaps getting quite violent, umm, your only option; well, you would talk to your medics first, but people phone security and it's terrible. It's awful."* (Arthur/O)

The two elements of Arthur's explanation, have the potential to provide an inappropriate approach and result in negative experiences for the patient with dementia. The discussion of involving doctors to intervene once a patient with dementia has become agitated and possibly violent, leads to the use of medical restraint, through the prescription and administration of an antipsychotic drugs, such as Haloperidol. The nurses in older adult wards discussed that the use of antipsychotic drug is considered to be inappropriate, but one seen as necessary for the nurses working in emergency departments, as recognised by Ginny:

> *"OK, actually in this case we do need to sedate them slightly. We gave them Haloperidol. They seemed a lot calmer and didn't fully sedate them, so it was just a like a smallish dose, because otherwise, if we're given a big dose, it wouldn't have helped either, so we had to start off like that." (Ginny/ ED)*

4.6.2: Sub-theme: 2b. Support from dementia specialists

Nurses discussed seeking support from dementia specialist nurses or teams, these included an Admiral Nurse, a dementia lead and a specialist care team. The role of the Admiral Nurse was not to provide care for the patient with dementia, but to advise nurses on a wide range of topics, as Ron described:

> *"They (Admiral Nurses) don't do personal care or anything with patients (with dementia), but they can advise us on medications and things and they'll look at what the patient needs."* (Ron/OA)

Admiral Nurses were identified by Ron as being helpful, and supported the development of the nurse's knowledge regarding dementia, including elements of care, medications, and appropriate assessment and communication skills. This was similar to the role of the dementia leads in oncology, who support the development of nurse's knowledge through the provision of information and promoting awareness of dementia education:

> *"The Admiral Nurse helps us with assessing our patients even better and treating them for sort of uncommunicated symptoms and things."* (Ron/OA)

> *"She (dementia lead) was very visible. People knew who she was. She's very approachable and she would go round the wards and promote whatever education was going on as an extra."* (Arthur/O)

The dementia lead nurses, similar to the Admiral Nurses, were a source of support through the provision of relevant information and holistic assessments of the patients with dementia to support the nurses' role in caring for the individuals with dementia, similar to the Admiral Nurses, they also did not provide direct care for the patient. Dementia lead nurses were called when nurses cared for a patient with dementia whose behaviour they found challenging, and were unsure of the reason for the behaviour, as Arthur described:

> *"So any support needed for dementia patients who were challenging to manage, you could always call on her (dementia lead) and she would come, or she'd give you lots of information sheets, but she would have that patient on her list and she would visit and*

> *talk to staff, assess the patient, assess what they drugs they were on and need and what might be adding to the problem"* (Arthur/O)

An specific element of the role of Admiral Nurses was the provision of support and advice to the families of the patient with dementia. The support provided to families ranged from enabling the family to accept the diagnosis of dementia and difficult conservations such as nursing home placement or end-of-life care. Admiral Nurses support of families, indirectly supported nurses by conveying information to families, as demonstrated by Ron's quotes below:

> *"They're (Admiral Nurse) able to support us with how the families are coping and difficult conversations around sort of the acceptance of their family having dementia"* (Ron/OA)

> *"But if a patient's family have complex needs and the patient's got complex needs, they (Admiral Nurses) have a caseload, because they'll talk regularly with the families and update them and liaise. So they are a go between sometimes."* (Ron/OA)

Finally, Ron discussed how the role of the Admiral Nurse was about ensuring care provision and that the environmental design was evidence-based. Ron used the example of developing the ward into a dementia friendly ward. An approach, which has been recognised to positively impact on the care and support for patients with dementia.

> *"We're planning for a refurb (of the ward) towards the end of the year and one of the Admiral Nurses has done a bit of research in terms of colour coordinating"* (Ron/OA)

Dementia lead nurses were also defined as a reliable source to obtain information on evidence-based dementia care. They were identified by Fred, as an ideal and reliable resource:

> *"I think it's knowing where good reliable resources are, as anyone can Google, but to have that reputable good evidence-based care that's maybe from like a national society or certainly you know from government linked affiliates is an ideal resource to have, which she brings (dementia lead)"* (Fred/O)

Similar to the role of Admiral Nurse and dementia lead nurses, the role of the 'specialist care team', was not to provide care directly for a patient with dementia, but to support with patients with dementia and encourage their engagement with meaningful activities, which reduced the potential need for one-to-one nursing, as George explained:

> *"It all depends on the needs of the patients, to what the "specialist care team" would do. They're not, they're not a replacement for one-to-one nursing. That's not what they're there for, but we tend to use them rather than try and get a one-to-one nurse, if that makes sense, because they will come and sit with the patient and do activities."* (George/ OA)

4.6.3: Sub-theme: 2c. Support from someone to just sit with them

The nurse working in oncology wards and emergency departments highlighted the need for support from others to come and stay by the side of the patient with dementia. The identification of this person and their expertise was not discussed, just simply the need to have someone, who would be able to come and stay with the patient with dementia continuously. The main reason for this was explained by Arthur, who suggested nurses do not have the time to stay with just one patient, due to their responsibilities to other patients:

> *"The time factor is the problem, because you would have to spend that extra time to really try and scrutinize to see what the root cause potentially is, but really they just want somebody to sit with them"* (Arthur/O)

Arthur went on to explain, the role staying with and provided one-to-one time with a patient with dementia was usually the role of healthcare assistants (HCAs), unqualified members of staff. This was because the want by the nurse was for someone to just 'sit' with the patient with dementia, and not because the patient required care, treatment or to ensure their safety. However, a lack of staff meant there was not always an HCA available.

> *"You haven't got access to somebody to come round who can sit with this person. You haven't got multiple HCA's, that might be able to just sit with them for a while, hold her hand or just be there"* (Arthur/O)

Nurses working in emergency departments also identified the need for someone to ‘sit’ with patients with dementia. Molly described the process within her department, and the collaborative working across emergency units to support the availability of HCAs to come and spend time with a patient with dementia. However, Molly also acknowledged a lack of staff meant this was not always possible:

> *“Don't get me wrong, there's no ideal situation permanently available, but we (emergency department staff) don't work in isolation. We're part of a group, so we have ED, EAU & CCU. And so we manage, and we can, if we need to pull HCAs, from another unit, so we have got the ability, the flexibility to pull somebody to be with them (patients with dementia), but it's not always possible.”* (Molly/ED)

Nurses working on older adult wards did not discuss the need to have someone to ‘sit’ with a patient with dementia, this may be due to the implementation of the ‘specialist care team’ as described by one nurse working on an older adult ward. Members of this team would not only come and ‘sit’ with the patient with dementia, but also engage in activities.

> *“... the “specialist care team” ... they will come and sit with the patient and do activities. ... they work shifts like the nursing team up to 8pm ... but not over the weekend”* (George/ OA)

George did recognise the ‘specialist care team’ only worked regular shifts of Monday to Friday, and less team members were on duty over the weekend, suggesting not a lack of staff, but a lack of service provision over the weekend.

4.7: Theme: 3. Lack of support

Nurses also discussed that support was not available when the need for support arose, and/or not in a format that the nurses found helpful. These discussions lead nurses to reflect on both the impact of care they provided for patients with dementia and their own emotions and morale. Each of which will be discussed in detail below.

4.7.1: Sub-theme: 3a. Support is unavailable when required

All nurses discussed the limitations of the availability of support. This included both the availability of dementia specialists and dementia specialist teams and how support was provided, which was not always in a suitable format, such as information that nurses would need to search for on the work webpages. Molly and Arthur captured both elements:

> *"There's certainly plenty of times when you can't have the support that you need in the way that you want it."* (Molly/ED)

> *"I know I can go on the Intranet and search… but I can't do that when I'm in the middle of things."* (Arthur/ O)

Nurses focused on the limitations of available support when support was required. Support during unsocial hours was discussed as important by nurses, as this was a time when patients with dementia became unsettled. Dementia specialist nurses supporting patients on oncology wards and within emergency departments were not available outside of routine office hours, as Ginny, and Arthur described:

> *"It was the middle of the night and they (dementia lead) weren't able to help us"* (Ginny/ ED)

> *"Saturday evening. You haven't got access to a specialist nurse. You haven't got access to somebody to come round who can sit with this person"* (Arthur/O)

Nurses working on older adult wards identified the 'specialist care team' worked longer hours than routine office hours, but still did not provide support during the night, and had less availability to support over the weekend. The extended working hours of the 'specialist care team' was identified as beneficial, but support during the night was still required, as George described:

> *"They (specialist care team) work shifts, so it's more of a Monday to Friday, there's less of them at the weekend to be fair, but Monday to Friday from 7:00 to 9:00 PM so it covers a large period of time. It doesn't cover night shifts" (George/ OA)*

Not all nurses acknowledged or were aware of the dementia specialist roles within their Trust, for example Fred, who worked in a Trust specifically focused on the treatment of cancer, was unaware of a dementia specialist role within their Trust:

> *"Those roles (dementia specialists) don't seem to exist obviously, being a specialised trust"* (Fred/O)

Nurses within emergency departments were aware of dementia specialist roles within their Trust, but believed they did not provide support in a suitable format that was helpful. Ginny for example identified only e-learning was provided, and resources were all online, but this was unhelpful in the moment of caring for a patient with dementia:

> *"There are leads for the Trust for dementia care, other than e-learning, I haven't physically met a dementia specialist, nurse or a dementia lead in the department. Often, we don't have that information to hand straight away, easily accessible, but if we did, that would make our jobs a lot easier than to have that straight away."* (Ginny/ ED)

4.7.2: Sub-theme: 3b. Nurses were unable to support patients with dementia

Nurses explored the emotional impact caused by the experience of a lack of support to care for patients with dementia, airing their frustrations and voicing how it left them feeling guilty and frustrated for feeling drained and being unable to care for the patient with dementia effectively, as Arthur acknowledged:

> *"It that that's really, I mean it's draining. It's very draining, but you do feel, well I do personally, you know, I feel the frustration then I feel guilty because it's not their fault, it's me that's getting frustrated, but they're already frustrated and they're frustrated with me and I can't help them, I don't know, know where to go, what is the answer?"* (Arthur/O)

Nurses however, did identify initiatives to support each other in providing care for a patient with dementia, which occurred across both oncology wards and within emergency departments. One approach was the allocation of a patient with dementia to one specific nurse, to support the patient to become familiar with one nurse. It was acknowledged this approach is difficult for the allocated nurse, as Molly described:

> *"Usually the person that's allocated, we try for it to be the same person. Although it's, it's a long time to be in that situation for everyone, um, but we try and keep it to that one person, especially if the individual (patient with dementia) likes them"* (Molly/ED)

Another approach involved teamwork which supported nurses to spend time with a patient with dementia, and when they began to feel frustrated or overwhelmed with the situation, a colleague would step in and continue to provide care for the patient, as described by Arthur:

> *"When you're in the moment with somebody who is challenging, you know, you just got to rely on some colleagues that are there with you so that you can take it in turns to try and deal with situations."* (Arthur/O)

Lastly, nurses discussed the need to ensure the basic needs or fundamental needs of patients with dementia were adequately addressed, such as focusing on hydration and nutrition, and the patient being able to walk safely to the toilet. This approach reassured nurses they were able to provide adequate care to patients with dementia, as Molly discussed:

> *"And it's more about, um, ensuring that individual's fed, watered, cared for, safely able to get to a bathroom as they need it, is safely able to navigate around if they want to"* (Molly/ED)

Nurses working on an older adult ward also acknowledged the impact of environments when caring for patients with dementia, especially when the ward has been converted to a dementia friendly ward. This impact can sometimes involve inappropriate patients with dementia from across the hospital, that have different medical needs, being transferred to the dementia friendly ward because they have dementia. Ron identified that this was not an appropriate approach. Nurses on the ward were trained to support patients with dementia, but when most patients on the ward had dementia, this became very challenging, and nurses struggled to maintain the level of support required by patients, impacting on their morale, as Ron discussed:

> *"I think the morale on the ward was really bad because our ward is seen as a dementia ward, but it's not actually a dementia ward. We do get a lot of the challenging behaviours, so I think the morale and the ward was really bad at one point because we've got a ward of really challenging behaviours and it's not realistic to manage."* (Ron/OA)

4.6: Part B. Dataset from dementia specialist registered nurses

4.7: Participant characteristics

Registered nurses from dementia specialist services (n=5) participated in this study. The participant pseudonyms and characteristics are shown in table 16 and table 17. The abbreviations used as relating to role CDN (consultant dementia nurse), AN (Admiral Nurse) and DSN (dementia specialist nurse).

Table 16: Part B: Participant pseudonyms

Participant pseudonyms
28401 – Percy - CDN 26502 – Rose – CDN 04709 – Hugo – AN 16606 – Charlie – AN 25711 – Bill - DSN

Table 17: Part B: Characteristics of participants

Sex	**Number of participants**
Female	4
Male	1
Nurse Grade Band	**Number of participants**
6	2
7	1
8	2
Years of registered nurse experience	**Number of participants**
Less than 5	1

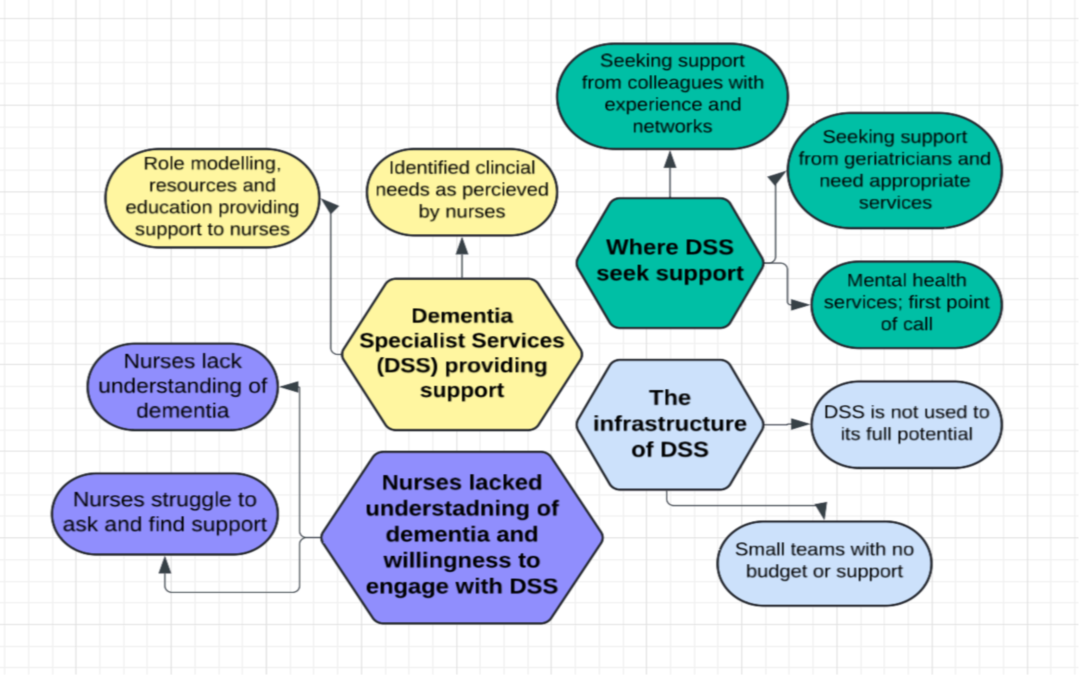
6 - 20	1
21 - 30	2
More than 30	1
Role	**Number of participants**
Dementia Specialist Nurse	1
Admiral Nurse	2
Consultant Dementia Nurse	2

All participants within this section, were registered nurses working in a non-mental health acute setting within a dementia specialist service, which included dementia and delirium teams and Admiral Nurses. The above table 17 shows the specific roles, grades, and years of experience.

4.8: Overview of the findings

The themes discussed in this section explore how registered nurses in dementia specialist services provide support to other nurses, patients with dementia and their families, but also how they seek support themselves. The themes are shown in the Thematic Map 4 and include **dementia specialist services (DSS) providing support**; **DSS seeking support**; the **infrastructure of DSS**; and **nurses lacked understanding of dementia and willingness to engage with DSS**.

Thematic Map 4: Theme Diagram



The first theme, **dementia specialist services (DSS) providing support**, explains the types of support and the application of support that the DSS provide. There are two subthemes, which show the elements of support and characteristics of support given to registered nurses, families and people with dementia. The first subtheme identified *the clinical needs of a person with dementia, as perceived by nurses*, which explores the types of support given to nurses and identifies the specific aspects of care where nurses asked for support. The second subtheme, *role modelling, resources and education providing support to nurses*, explores the ways in which support is implemented by DSS in non-specialised areas.

The second theme, **DSS seeking support,** explores the experiences of specialist nurses finding support for themselves from a variety of healthcare professionals, services and tools. There are three subthemes within this theme, which showcases the specific directions or places registered nurses go to seeking support for specific clinical needs when caring for a patient with dementia. The first subtheme, *mental health services; first point of call*, focuses on when and why specialist nurses seek further clarity, and specific support for a clinical need or mental health service to enable them to care for a patient with dementia. The second subtheme, *seeking support from geriatricians and the need for appropriate services*, explores specialist nurses experiences of accessing services outside of mental health services both within and outside the acute hospital include using charities. The last subtheme, *seeking support from colleagues with experience and networks*, focuses on the relationships with other healthcare professionals using supervision and previous expertise of others.

The third theme, **the infrastructure of DSS**, explores the experiences of DSS of being unable to provide the support that nurses perceive are their role, nurses not using the DSS correctly and the DSS not having the resources to provide appropriate support. There are two subthemes within this theme, which highlight the barriers that specialist nurses feel affect them being able to provide the support that is needed by nurses. The first subtheme, *DSS is not used to its full potential*, focuses on how nurses misunderstand the abilities and roles of DSS and therefore leave them underutilised. The second subtheme, *small teams with no budget or support*, showcases the difficulties DSS have providing support to others due to having small staff numbers and a lack of budget and support from senior management.

The final theme, **nurses lacked understanding of dementia and willingness to engage with DSS**, examines how nurses in DSS felt that nurses struggle with comprehending the needs of patients with dementia and at the same time struggled to ask for help. There are two subthemes which unpick the gaps of knowledge and explore the rationales behind why seeking help can be difficult. The first subtheme, *nurses lacked understanding of dementia*, explores the nurses level of knowledge and recognition of dementia as perceived by specialist nurses. The second subtheme, *nurses struggle to ask and find support*, delve into the experiences of specialist nurses attempting to provide meaningful support that nurses accepted and were guided by. This theme shows the needs of nurses to be able to provide care to a patient with dementia and explores the relationship between the nurse seeking support and the nurse providing the support. The themes and subthemes are developed from the dataset is presented in Table 18 below.

Table 18: The identification of the themes and subthemes from the individual interviews of registered nurses in dementia specific services

	28401 Percy (CDN)	26502 Rose (CDN)	4709 Hugo (AN)	16606 Charlie (AN)	25711 Bill (DSN)
Dementia specialist services (DSS) providing support					
Identified clinical needs as perceived by nurses	X	X	X	X	X
Role modelling, resources and education providing support to nurses	X	X	X	X	X
DSS seeking support					
Mental health services; first point of call			X	X	X
Seeking support from geriatricians and need appropriate services	X		X	X	X
Seeking support from colleagues with experience and networks	X		X	X	X
The infrastructure of DSS					
DSS is not used to its full potential	X	X	X	X	X
Small teams with no budget or support	X	X	X		X

Nurses lack of understanding of dementia and willingness to engage with DSS					
Nurses lack understanding of dementia	X	X	X		X
Nurses struggle to ask and find support	X	X	X		X

The next section discusses the thematic findings from the interviews with the dementia specialist nurses working within dementia specialist services where they were asked to response to the five main open-ended questions (as previously mentioned). The participants will be referred to as specialist nurses, the use of the term nurse will only apply to non-dementia specialist registered nurses.

4.9: Theme 1. Dementia specialist services (DSS) providing support

The main priority recognised by all the specialist nurse participants was their responsibility to provide support to other healthcare professionals including nurses to care for a patient with dementia. The provision of support included support provided directly to families of patients with dementia, as well as the patient themselves. Specialist nurse participants also discussed methods of providing support to nurses and identifying needs of nurses when caring for a patient with dementia. Two subthemes emerged, which are: *the identification of clinical needs as perceived by nurses, provision of support to nurses through role modelling, resources and education*.

4.9.1: Sub-theme: 1a: Identification of clinical needs as perceived by nurses

The specialist nurse identified a variety of areas, which nurses continued to approach them for further support even after Trust wide education, which focused on changes in behaviours, personal care, medication and eating and drinking. Specialist nurses discussed the most common area that nurses asked for support, which was how to manage changes in behaviours. Specialist nurses voiced that nurse struggled with agitation and aggression shown by patients with dementia. Specialist nurses believed that nurses believed when a patient with dementia became agitated or aggressive they were demonstrating their non-compliance with care related activities, such as personal care. Rose expressed how nurses linked behaviours to non-compliance:

> *"The most common, seeking support is behaviour and that will be a mixture between agitation, aggression, noncompliance, sometimes distress. More commonly, behaviour that causes problems for the staff generally, so it will be they won't stay in bed, trying to hit people when they do personal care."* (Rose/ CDN*)*

The support the nurse participants in Part A sought from dementia specialist services was to identify how to obtain compliance from a patient with dementia, and for them to accept a care related activity or to prevent them from trying to leave the ward. Bill identified the most common reason why nurses sought support was the perceived refusal by patients with dementia to accept personal care or medications:

> *"Two key behaviours in an acute hospital that we get called for would be someone does not want nurses doing something which is primarily around personal care. Really, people not being very receptive to personal care by far the biggest…How do you get someone to let you do something they don't want you to do? They refuse."* (Bill/ DSN)

Specialist nurses also recognised they provided nurses with support that went beyond patients with dementia on their wards but extended to nurses who had family members who had a diagnosis of dementia. The specialist nurse participants suggested that they supported nurses in being able to manage a work/life balance, which included an informal check in with them and exploring if the nurse was concerned about whether they were providing the right care for their family member. Hugo discussed supporting nurses to return to work, and offered help and support to nurses on a personal level:

> *"I support staff and personally if they've got their own personal situations and with a staff member being prevented from coming back to work because of their dad with dementia, for example. And so I've have had a few staff reach out just to check what they're doing is right. And if there's anything else that I can support with."* (Hugo/ AN)

4.9.2: Sub-theme: 1b. Role modelling, resources and education providing support to nurses

Specialist nurses described several different ways in which support is given to nurses including the use of role modelling, resources and education. The need for there to be a variety of ways to provide support was identified by specialist nurses as essential to ensure that information was understood and absorbed by nurses. One method discussed by specialist nurses was the use of role modelling, which was incorporated into formal training days. However, role modelling was also a continuous approach applied by all the specialist nurses when supporting or working with nurses on the wards. Rose highlighted role modelling was applied demonstrate both the best and poor practice of nurses:

> *"Role modelling the right way to do something, or maybe just spotting someone and going over and saying: Hey, why don't you try it this way."* (Rose/ CDN)

Specialist nurse participants also discussed how they provided resources to support nurses to engage in physical activities with patients with dementia. The physical resources mentioned included electronic resources, such as computers and mp3 players, which could both be personalised to support person-centred care for patients with dementia. Further resources that were seen to be more practical included physical objects for patients with dementia to engage with, such as twiddlemuffs. These resources were felt to support and engage the patient with dementia, which supported nurses to be able to provide appropriate care. As Rose explored:

> *"We have physical resources, so we have things like televisions, cows (computers on wheels), music, twiddlemuffs, we have various things like that"* (Rose/ CDN)

Specialist nurses identified that a large part of their role was providing education or training for nurses. They showcased the different levels of training that aimed to develop the skills needed to support caring for a patient with dementia. The provision of training was also reported to be responsive to the needs of nurses, for example, following an incident with a patient with dementia. Specialist nurse participants also supported the wider training of staff within acute hospitals, and the training and development of dementia champions, as Bill described:

> *"We train everyone really. We do we run at least 48 open full day Dementia training days. We also do student nurse training days, we do TNA (trainee nursing associates) training days, and we do a second dementia training day, which is more skills based, we also do bespoke sessions and dementia champion sessions."* (Bill/ DSN)

> *"We also do bespoke training ... if any department just wants training or something we'll do it. So yeah, there are ways we try and be as flexible as possible. There was an incident where staff didn't know what to do, the patient became agitated, and the ward asked us to put together training to learn from"* (Percy/ CDN)

An element of education and training for nurses that specialist nurses focused on was exploring the experiences of nurses working on the wards. These experiences were then incorporated or addressed within the training provided, to ensure the training was relevant for the nurses and directly addressed any of their concerns. An important element of specialist nurse's role was understanding the beliefs and fears nurses held regarding dementia to identify their own needs, as Rose explained:

> *"We do a session where literally we get the nurses to talk about their experiences and their fears when they're dealing with people who have dementia or delirium and what support they needed" (Rose/ CDN)*

4.10: Theme: 2. DSS seeking support

Although specialist nurses provided support to nurses, they also required support themselves to be able to provide appropriate, relevant and contemporary advise, support, education and training to nurses. Specialist nurses discussed seeking support from a variety of sources, which they believed were trusted and were experienced healthcare professional with expertise in dementia. These experts would provide advice regarding different aspects of care for patients with dementia in an acute setting. Three subthemes developed including *mental health services - first point of call; seeking support from geriatricians and appropriate services;* and *seeking support from colleagues with experience and networks*.

4.10.1: Sub-theme: 2a. Mental health services - first point of call

Specialist nurses discussed that the first place they would seek support from was mental health services, including mental health teams, memory clinics and psychiatric liaison teams. Specialist nurses discussed the need for extra support around the complex needs of patients with dementia, including changes in behaviour. Support was also sought to help understand the individual patient with dementia, and their relevant medical history. As mentioned by Charlie, this included contacting a memory clinic:

> *"It's to do with patient support in terms of any BPSD (Behaviour and Psychological Symptoms of Dementia) or anything like that, we would seek support from AMHP (Approved Mental Health Practitioner), which is our mental health service, and we would also maybe seek support from memory services, if they're known to the memory service, for collateral history, for example."* (Charlie/ AN)

Specialist nurses sought general support from specialist teams, such as psychiatric liaison teams, especially when they identified a limitation in their understanding of how to provide care for a specific complication of dementia or required extra support to manage their own caseload. Specialist nurses described the relationship between themselves and psychiatric liaison teams as supportive, although there was no formal process of collaboration between teams, there was an informal understanding of the provision of support. Hugo describes his relationship with psychiatric liaison teams and his belief that his work supports their workload:

> *"If I don't understand something or I need that extra support, I will reach out and I feel like I do have a good base around me, such as psychiatric liaison, for the most part, people are quite receptive if I do need them, the Psychiatrist does carve out time because I think they know that if they don't help me, I will be giving the case to them."* (Hugo/ AN)

An important area of support from psychiatric liaison teams focus on was support with medication queries. The need to prescribe medication and the prescription of appropriate medication was discussed by specialist nurses. A general consensus was that medication was not recommended to support patients with dementia with elements of agitation or aggression, and however specialist nurses did seek support regarding the inappropriate prescription and use of anti-psychotic medications within medical wards. Bill explored the need to seek support when being unsure how to resolve his concern:

> *"It would usually be for some kind of medication issue really, a reaction or oversedation of the person (with dementia), how do we resolve it."* (Bill/ DSN)

4.10.2: Sub-theme: 2b. Seeking support from geriatricians and appropriate services

Specialist nurses discussed they sought support from geriatricians in the acute hospital, who they believed were experts in dementia and the care of patients with dementia. Specialist nurses identified a close and good working relationship with geriatricians and would regularly seek support from them, especially if the geriatrician knew the patient with dementia. Bill described how working with geriatricians was a normal part of his role:

> *"The people we used to get support from. It normally would be working with geriatricians. So, I think when you know the people we would most usually ask for support around the care of someone with dementia it would be one of the 'gerries'."* (Bill/ DSN)

Specialist nurses called on geriatricians to support them with specific tasks, especially when these tasks were more likely to be completed successfully if initiated by a doctor. For example, Rose needed information from a GP, and requested support from a geriatrician as she felt another medic would be more successful in gaining a response from the GP than a nurse. An important element was the close working relationship expressed by Rose. This is similar to when Bill identified specialist nurses 'normally worked with geriatricians', who were seen as a "colleague" (Rose/CDN). The collaborative working is further identified by Rose to have a beneficial impact on the care provided to the patient with dementia:

> *"I got in touch with one of my colleagues who is a consultant geriatrician and said 'I'm trying to get hold of the GP; maybe if it's coming from a doctor, this will get a response. Absolutely we got a response. So, I sought help to get a door opened, to stop something happening, that shouldn't have been happening, and he (the person with dementia) didn't want it happening, but he got his gentamicin and he wasn't re-catheterized without it."* (Rose/ CDN)

Specialist nurses also discussed the need to seek support with certain referrals they received, which identified complex needs of the patient with dementia and possible comorbidities. Specialist nurses recognised the need from wider support services depending on the clinical needs of the patient with dementia. In these cases, specialist nurses sought support from different services within the acute hospital setting, community services and charities. Charlie discussed the use of a variety of services, whilst Bill identified other specialist healthcare professions, such as Speech and Language Therapists (SALT):

> *"We've got a referral come in and I needed further support with that person, it's more about the multi-disciplinary team as well. So, in the community I used services such as adult social care and other services such as Age UK, Carers Trust. In the acute setting it's very much the same but just in a different way, as they are all there."* (Charlie/ AN)

> *"If you have someone with dementia who is not eating or drinking. Then we work with SALT or even if we just want some kind of advice around that kind of thing."* (Bill/ DSN)

4.10.3: Sub-theme: 2c. Seeking support from colleagues with experience and networks

Specialist nurses discussed seeking support from others and how gaining this support from colleagues led to them being able to find appropriate and constructive answers. Colleagues' specialist nurses approached included those they believed had 'the' relevant knowledge to be able to support them and provide practical experienceable support and advice, such as complex needs relating to dementia or advice about eating and drinking from SALT team. Percy discussed seeking support from colleagues was one of the best options available:

> *"I think colleagues, colleagues with knowledge that I know about from previous experience has been my best bet".* (Percy/ CDN)

Admiral Nurses explored the support gained from the supervision networks for Admiral Nurses, which had been created by Dementia UK and introduced as part of their induction. Specialist nurses discussed how they would link with other specialist nurses in the same role, and they would also provide support to newly appointed specialist nurses. Hugo discusses his approach of engaging with his network:

> *"I will seek it out and we as Admiral nurses we get linked up with other acute Admiral nurses. So, I'm linked up with a couple around the country who are always there to offer support, and somebody's just started in the in the neighbouring city to me, so I support them."* (Hugo/ AN)

Specialist nurses also discussed the wider networks they accessed, which provided support through notifications of the most recent evidence-based practice, research and legislation which they received through emails and online teaching sessions. Charlie discussed the usefulness of receiving updates regarding all elements impacting on dementia care:

> *"We get our support from Dementia UK, so we have regular webinars, we have regular updates through emails on legislation, any sort of updates in policies nationally. We have an acute community of practice as well, so the latest sort of evidence they'll share with us and any new developments with any areas that might be relevant to us."* (Charlie/ AN)

4.11: Theme: 3. The infrastructure of DSS

All specialist nurses in this study discussed the same negative aspects to their role that related to the organisation and structure of the DSS within an acute hospital environment. Specialist nurses voiced their concerns regarding the impact of these negative aspects on the support and care of patients with dementia. The two subthemes within the infrastructure of the DSS include: DSS are not used to its full potential and the DSS involve small teams with no budget or support.

4.11.1: Sub-theme: 3a. DSS are not used to its full potential

Specialist nurses repeatedly discussed their frustration about ward nurses, as they believed neither nurses nor other services understood the provision of dementia specialist services, and the support they could offer to improve the care of patients with dementia. Therefore, they felt their service was not being used to its full potential, and patients with dementia were not receiving a high standard of care and support. Charlie, for example, identified the problem was a lack of understanding, which was enhanced by miscommunication:

> *"I think it's just a bit of about miscommunication with services and what they do, what we do and things like that."* (Charlie/ AN)

The misunderstanding of DSS, ranged from simple elements such as confusion of the name of services, such as Admiral Nurses. The participants perceived a lack of understanding and confusion regarding the service provision of Admiral Nurses, was another element that was a reported source of frustration for specialist nurse participants, along with perceived underutilisation of the service. Hugo explored how he felt a lack of understanding prevented nurses from asking Admiral Nurses for support:

> *"The title of Admiral Nursing doesn't really help because people don't really know what that is. They think I'm something to do within the Navy or something like that. So, referrals are quite difficult."* (Hugo/ AN)

The design and infrastructure of each DSS was different within each NHS Trust, which was also perceived to impact on nurses understanding of the support and provision of each DSS. Each specialist nurse identified the goal of their DSS was supporting and improving the care and outcomes of care for patients with dementia. The focus of each DSS also changed over time, as Bill discussed how their DSS use to hold a caseload and support nurses, through a referral system, more recently their remit has changed, and the focus is now on education.

> *"We don't do a lot of referrals anymore, but what we primarily do is teaching and coaching."* (Bill/ DSN)

The specialist nurse participants, felt that there was a continued to focus on the development of their dementia service. The specialist nurses all identified and agreed that nurses needed a point of call available anytime to significantly improve the care and care outcomes for patients with dementia, this approach involved the ability of nurses to have access to a direct line to call when support was needed. Percy explored this approach:

> *"Whoever you are at, whatever point, you know who you can call and that they'll have an answer or be able to get an answer for you, that's the most important thing."* (Percy/ CDN)

Due to the miscommunication and confusion of the services provided by DSS, specialist nurses were concerned nurses would not attempt to access their support their services. Another factor that influenced specialist nurses concerns of a lack of engagement from nurses, was due to feeling that nurses were seeking a quick response and answer to support them to provide care to patient with dementia, and this was not always possible, as Bill identified:

> *"If teams refer people and the referral doesn't help them at all, after awhile, people just stop referring, it becomes pointless." (Bill/ DSN)*

Specialist nurses also all recognised the importance of every NHS Trust having a form of dementia specialist service, to support patients with dementia on wards which were not older adult wards and were where ward nurses lacked the experience to care for patients with dementia. The view was that nurses working on these wards did not tend to refer to DSS or specialist nurses, as they did not recognise their actions, or their lack of understanding could potentially result in patients with dementia receiving poor care. Rose talks about the right care not being given by nurses leading to poor outcomes for patients with dementia.

> *"So, all the patients that are actually getting the worst care, they are getting lost, because they're the ones that are on the wards where they're not referring. That's where the patients are getting the worst care, because they're not getting anything done."* (Rose/ CDN)

4.11.2: Sub-theme: 3b. DSS involve small teams with no budget or support

A concern for all specialist nurse participants appeared to be the lack of support they received from their own NHS Trusts. They also recognised that they are asked to provide support to nurses but as a specialist nurse they felt that they did not get support themselves from others. Bill discusses how he does not feel supported although is being sought after to provide the support:

> *"We're the people being sought to support rather than be supported, but the lack of support we get, it's kind of the opposite to what we give (to nurses), it's not there really."* (Bill/ DSN)

A key factor that specialist nurses identified, which impacted on their ability to provide support, was a lack of people resources in their teams to provide adequate support to nurses. Some of the DSS within this study, only had one specialist nurse, supporting a non-mental health acute hospital, which impacted on how they could provide support to nurses. Hugo focused on the stress of being a single member team and the impact on his well-being:

> *"There is only me in the team at the moment, unfortunately. I have recruited somebody just because it's too big a job for one person. I am, it's quite lonely."* (Hugo/ AN)

The negative impact on the wellbeing of the specialist nurse was echoed by Percy, who struggled to provide support when they were not supported or shown what was expected of the DSS by the senior executive team of the acute hospitals.

> *"It's hard. There aren't people coming in to us and saying this is the best way to do it. We could support you to do that. We are a bit on our own."* (Percy/ CDN)

The lack of support and direction given to DSS by the senior executive team of the acute hospital was further discussed by specialist nurses. Rose, for example, expressed her opinion that the DSS was not seen as its own department on a day-to-day basis by the management of the acute hospital but when the DSS achieves recognition on a national platform the management of the acute hospital acknowledged them as part of the acute hospital.

> *"So, we don't get treated like a real department, but we get treated like a novelty. They all love it because we get loads of attention and kudos. We do quite a lot of things that get quite a lot of attention nationally and stuff. And they like it and take the credit."* (Rose/ CDN)

4.12: Theme: 4. Nurses lack of understanding of dementia and willingness to engage with DSS

The final theme discusses the perceived knowledge and recognition of dementia had by nurses by specialist nurses and how specialist nurses concluded that there was a significant gap in a nurse's knowledge of dementia and how to provide care for a patient with dementia. Specialist nurses also discussed their relationship with nurses when trying to provide support and the need for nurses to recognise they need support. Two subthemes were developed, these were *nurses lack understanding of dementia* and *nurses struggle to ask and find support*.

4.12.1: Subtheme: 4a. Nurses lack understanding of dementia

Specialist nurses discussed routines with the provision of care on acute hospital wards, and the task orientated approaches of nurses. The institutionalisation of task orientated care can impact negatively on patients with dementia, who many not fit within this structure of care, due to their own routines, and a lack of insight to acknowledge and accommodate new routines. Hugo discussed how even in their personal experience they have worked to a structure:

> *"You know it's - nursing is very task orientated unfortunately, I've been on the ward myself and you've got to get your tasks done by certain times, you just have to get it done."* (Hugo/ AN)

Specialist nurses voiced that they felt there is not a general awareness and knowledge of dementia care across the whole acute hospital setting, this included nurses. Nurses and other healthcare professionals within an acute hospital focused on medical needs of a patient, such as surgery or emergency care, and dementia is not seen as an important medical need. Bill vocalised his frustrations over the gap in knowledge:

> *"It's just a huge gap across, every discipline, every team, there's just huge gaps in knowledge about dementia. It's not important."* (Bill/ DSN)

Specialist nurses discussed the specifics of when they have seen nurses unable to recognise the differences in how certain clinical needs can present differently in patients with dementia than other patients. Specialist nurses also discussed how they felt nurses did not recognise that changes in behaviour of a patient with dementia is due to a change in their needs, which they were unable to express to the nurse, such as pain. Percy identified the negative impact on patients with dementia, when a nurse was not seen to recognise their needs:

> *"Nurses don't always recognise the impact that it's (dementia) had on people and their responses to situations. Their behaviours that challenge, or behaviours of unmet need, are response to the disease process as opposed to a characteristic or a personality trait. It's an awful experience where nurses think patients with dementia are just being*

> *awkward or noncompliant, that kind of thing. That's what nurses aren't necessarily very good at getting."* (Percy/ CDN)

Specialist nurses spoke about pain specifically as being one of the care needs that was often not recognised by nurses. Rose echoed Percy in stating that they perceive that a large number of nurses do not recognise that pain is expressed differently by patients with dementia.

> *"Erm, I think the other side of it is poor recognition and that sometimes obviously pain is a big issue because people with dementia express pain in different ways than the rest of us."* (Rose/ CDN)

4.12.2: Theme: 4b. Nurses struggle to ask and find support

A reoccurring thread throughout all the interviews with specialist nurses was their concern regarding the lack of engagement of nurses with DSS, which were there to support them. Hugo empathised with the fact that nurses may find it difficult it is to ask for help as they, he perceives, believe they should know how to care for their patients and may not recognise that there is a learning need.

> *"Especially, admitting that you are struggling with an element of care that you probably or maybe think you should be 'O fay' with, erm it's hard to admit."* (Hugo/ AN)

Specialist nurses also identified it maybe hard for nurses to ask for help, especially if they have decades of experience and may feel they should know the answer. Specialist nurses highlighted that nurses used their previous experience of patients with dementia in their care, and how this had worked previously, but now this approach wasn't working, and this caused frustration. Hugo identified that some nurses blamed the 'dementia' for the poor care outcomes rather than focusing on meeting the needs of the patient with dementia:

> *"It's hard to accept if you need a little bit of help, especially when you have nurses who have been nursing for 30 years, erm, you kind of think well … it obviously must be the dementia."* (Hugo/ AN)

Specialist nurses discussed their roles and the interactions with nurses, which focuses on DSS not being widely recognised or understood by many nurses and some nurses lacked an understanding of how to access the DSS. Percy discusses how nurses focused on the criteria for a referral and did not recognise how the DSS can help them.

> *"I think we're (DSS) one of the things nurses have looked at us and been unsure, they don't know what the services are, how they can access us or what the criteria is that makes that patient the right patient to refer."* (Percy/ CDN)

Specialist nurses acknowledged that they felt the underlying cause of why many nurses lacked knowledge was due to the focus of departments, which managed several different medical conditions and care needs, therefore need to have a little bit of knowledge about a lot of things. Bill discusses how these elements do not include dementia as again the focus is the acute needs of patients:

> *"It's really hard to learn those skills and apply those skills cause you are constantly juggling different things as well, you know, you got acute stuff you gotta do."* (Bill/ DSN)

4.13: Chapter Four Conclusion

My study aimed to answer how nurses sought support to care for people with dementia in an acute setting. Although the majority of the research questions were answered, there are areas that could be further explored and new research questions that have been identified. The study highlighted the experiences of nurses and dementia specialist nurses in seeking support when caring for a person with dementia. In asking this question, another question was answer which was unexpected, which was how do dementia specialist nurses provide support. The study's findings discussed the types of support that nurses accessed, however also highlighted the specific areas of dementia care that nurses seek support about. The study found several areas of challenge from both the perspectives of the nurses and the dementia specialist nurses, the overall consensus was that they all experienced a lack of support. Through the exploration of the lived experience of nurses and dementia specialist nurses seeking support to care for patients with dementia a new and significant contributions have been found in this field of research. The use of hermeneutic phenomenological concepts supported the understanding of the meaning surrounding the participants experiences.

The findings highlight the complex interplay between the need for support, the availability of specialist services, and the existing gaps in knowledge and infrastructure within acute hospital settings. Both nurses and dementia specialist services faced significant challenges, but there were also clear opportunities for improvement. By addressing the identified needs through targeted interventions, such as improved support systems and pathways, enhanced education, and better integration of dementia specialist services, NHS Trusts, can significantly improve the care of patients with dementia. This, in turn, will not only enhance patient outcomes but also support the well-being of nurses.

Chapter 5: Discussion

This chapter provides a discussion of my findings through a hermeneutic lens, enabling a deeper understanding of the complexities involved in nurses seeking support to care for patients with dementia in acute hospital settings.

The first section of this discussion will present the key findings and how these addressed the study research questions. The second section will explore the application of the hermeneutic circle as a nuanced interpretive framework for understanding the lived experiences of nurses and dementia specialist nurses. The third section of this discussion will focus on the lived experiences of nurses seeking support in caring for a patient with dementia. This will explore the three identified themes, contextualising them within contemporary literature and highlighting systemic inadequacies within infrastructure, institutional support, and professional recognition. The fourth section of the discussion will examine the lived experiences of DSNs, and how they seek and provide support in acute hospital settings. This discussion will be structured around the four identified themes, exploring the systemic, relational, and interpretative challenges that shape their roles. The fifth section will examine how my findings revealed notable differences in how nurses and Dementia Specialist Nurses (DSNs) perceive and approach support within dementia care.

The concluding section will synthesise insights from both groups of participants, emphasising how the hermeneutic circle enabled a deeper understanding of the interconnections between individual experiences and systemic factors. The conclusion focuses on the nuances of how nurses seek support when caring for patients with dementia, highlighting potential areas for improvement in practice, policy, and education. These conclusions contribute to ongoing discussions and identifying recommendations about enhancing the support provided to both nurses and DSNs in acute hospital settings.

5.1 Key Findings

The key findings identified nurses and dementia specialist nurses experienced a lack of support when caring for a patient with dementia, due to a lack of infrastructure and unable to find support when needed. Due to the lack of support experienced by nurses, evidence-based practice was not always implemented. Dementia specialist nurses felt unsupported from both an organisational perspective with limited to no budget or resources and from nurses who did not understand their role or the support provided.

The themes “Support from others” and “DSS seeking support” answered the first question (*What is the lived experience of registered nurses and dementia specialist nurses seeking support in caring for patients with dementia in a non-mental health acute hospital setting?*) through identifying the key people nurses and dementia specialist nurses sought as a method of support when caring for a patient with dementia. Each theme explored the different experiences of both participant groups leading to positive and negative experiences of support.

The themes “Need for an appropriate infrastructure to care for a person with dementia” and “The infrastructure of DSS” answered the second question (*What types of support are accessed by registered nurses and dementia specialist nurses to care for people living with dementia?*). These themes focus on non-human methods of support that involved factors such as the environment, resources and manpower. Each theme explored initiatives, education and resources which were either available or unavailable to the participants when seeking support.

The themes “Lack of support” and “Nurses lack of understanding of dementia and willingness to engage with DSS” answered the last question (*What challenges do registered nurses and dementia specialist nurses experience in implementing or not implementing the support provided?*). These themes highlighted the negative experiences of nurses and dementia specialist nurses identifying a lack of support that impacted on their abilities to care for patients with dementia. These negative experiences highlighted nurses’ level of understanding of dementia and how evidence-based interventions should be and can be implemented.

One theme, which did not answer a research question, “DSS providing support”, was specific to how dementia specialist nurses provided support. This element was important to explore as was intertwined with the experiences of nurses when seeking support from dementia specialist nurses.

5.2: Through the Hermeneutic Lens

The application of the hermeneutic circle as an analytical framework provides a sophisticated lens for examining the lived experiences of nurses engaged in dementia care, both in seeking and providing support. This approach brings attention to the intertwined and recursive dynamics of understanding, situating nurses' experiences within a broader epistemological and ontological framework (Peck and Mummery, 2023). These challenges are not discrete occurrences but are continuously reinterpreted through historical, institutional, and personal contexts, reflecting the dynamic process of meaning-making that underpins professional practice (Tomkins and Eatough, 2017; Peck and Mummery, 2023).

In contrast to reductionist models of interpretation, which often compartmentalise individual elements for analysis in isolation, the hermeneutic circle emphasises the dialectical interplay between parts and wholes. Meaning is continuously negotiated and reconstructed as nurses encounter new experiences and engage in reflective practice (Heidegger, 1962; Young, 2001; Smythe et al., 2008). Each interpretative iteration informs subsequent understandings, thereby generating a self-perpetuating loop of meaning-making. For example: a nurse initially frustrated by the absence of dementia-specific support may, through exposure to DSNs, reframe their perceptions of available resources and their professional role. Similarly, DSNs must navigate an evolving landscape of NHS mandates, policy constraints, and professional autonomy, necessitating ongoing reflexivity and adaptation.

The hermeneutic circle also highlights the centrality of pre-existing knowledge structures, or pre-conceptions, in shaping interpretation. Heidegger (1962) argues understanding is never neutral or detached, it is always embedded within specific historical and cultural contexts. These frameworks shape how individuals interpret the world, including their roles, responsibilities, and identities within professional settings. The hermeneutic circle further facilitates an in-depth exploration of the relational dynamics between nurses and DSNs. These professional interactions constitute a complex and evolving process of co-constructing meaning. While DSNs frequently report underutilisation by their colleagues, nurses often perceive dementia-specific support as inaccessible. Through sustained engagement in reflective discourse and collaborative praxis, these different perceptions can be recalibrated, fostering interdisciplinary synergy and enhancing the efficacy of dementia care strategies. Through using the hermeneutic circle accentuates the indispensability of reflexivity in professional practice. Beyond interpreting patient needs, nurses must interrogate their own cognitive thoughts, assumptions, and epistemic limitations. Reflexivity demands an ongoing process of self-scrutiny, whereby practitioners critically appraise the ways in which their historical positioning and institutional environments inform their clinical decision-making.

From a Heideggerian hermeneutic perspective, nurses' understanding of support is shaped through their lived experience as part of their Being-in-the-world and their lived, embodied engagement with the social and professional contexts in which they practice. The discourse surrounding dementia care, whether articulated in policies, training and education, or informal professional interactions, fundamentally frames how nurses perceive their responsibilities and construct their understanding of dementia. If dementia is consistently depicted as a ‘problem’ necessitating ‘management,’ a task-oriented paradigm may emerge, instead of focusing on holistic, patient-centred approaches. If dementia is framed phenomenologically, recognising the lived experiences of patients, nurses may be more inclined toward compassionate and individualised models of care.

The inherently contextual nature of understanding necessitates is that each interpretative act is situated within a broader socio-cultural and institutional setting (Dahlberg et al., 2008; Patel and Metersky, 2022). The hermeneutic circle serves as a conduit for bridging theoretical abstractions with empirical realities, facilitating a continuous dialogue between conceptual frameworks and clinical practice (Benner, 1984; Spouse, 2001). This continuous process supports the ongoing development of professional practice, ensuring that theoretical insights remain responsive to the evolving complexities of dementia care.

Using the hermeneutic circle in protocol-driven support models for dementia care challenges the dominance of fixed approaches and allows for greater sensitivity to the complexities of lived experience. This iterative methodology was central to my study of nurses’ and DSNs experiences in seeking support within acute hospital settings. Each nurse’s narrative is enmeshed within a broader constellation of systemic factors, illuminating the challenges inherent in navigating NHS Trust support structures. The hermeneutic circle facilitates an ongoing dialogue between individual experiences realities and the larger sociopolitical context (Warnke, 2011), advocating for a dynamic recalibration of nursing practices in response to emergent complexities in dementia care.

5.3: Nurses' Lived Experiences of Seeking Support

5.3.1: Need for an Appropriate Infrastructure to Care for a Person with Dementia

Nurses working in acute hospital settings continually highlighted the necessity for a well-structured and resourced infrastructure to support dementia care. This extended beyond basic resource provision to include comprehensive educational programmes, well-equipped environments, and interdisciplinary collaboration. Several key factors were identified to support the development of a robust infrastructure, including knowing the patient on a deeper level, having access to appropriate resources for meaningful engagement, receiving robust dementia education, and working in environments designed to support people with dementia.

5.3.1a: The Need to Know a Person with Dementia

All nurses expressed the importance of knowing the patient with dementia as an individual rather than just another clinical case. Nurses also expressed the care for patients with dementia should extend beyond their physical needs to encompass their emotional, psychological, and social dimensions. This holistic perspective aligns with the person-centred care model (Kitwood, 1997), which advocates for a shift away from biomedical interpretations of dementia toward a recognition of the individual's lived experience. Nurses in my study expressed frustration over fragmented care pathways, which often resulted in limited access to specialised dementia expertise The lack of continuity in dementia care further compounded these challenges, leading to instances where nurses were unable to develop meaningful therapeutic relationships with patients. Stress and burnout were commonly reported as a consequence of the emotional burden of providing dementia care. A recommendation developed from the nurse's experiences in this study is the implementation of structured mentorship programmes and ensuring the availability of DSNs, offering and supporting nurses ongoing professional development and the provision of emotional support.

5.3.1b: Resources to Support Meaningful Activities

Nurses working in older adult wards and emergency departments (ED) acknowledged meaningful engagement activities were key for patients with dementia, as they provided cognitive stimulation but also contributed to emotional well-being and behavioural regulation. Meaningful activities such as music therapy, reminiscence therapy, and sensory engagement have been shown to reduce agitation and distress while promoting positive emotional states in patients with dementia (Cohen-Mansfield et al., 2010; Rybacka et al., 2017; Regier et al., 2022). The findings from my doctoral study revealed nurses in ED often lacked the time to implement such activities, leading to a reliance on specialist care teams or occupational therapists. This reliance highlights the structural challenges within acute hospital environments, where the prioritization of acute medical care often sidelines dementia-specific interventions. These findings resonate with existing literature, which suggests that emergency departments are not optimally designed for dementia-friendly care due to time constraints, high patient turnover, and inadequate staffing levels (Griffiths et al., 2015).

5.3.1c: The Need for Appropriate Dementia Education

Despite the availability of the dementia education standard frameworks (Skills for Health, 2015; 2018), the findings from my doctoral study indicated existing training modules often fail to translate effectively into clinical practice. Nurses reported dementia training provided at Tier 1 and Tier 2 levels was too generic and lacked practical applications that would enable them to manage complex dementia-related challenges effectively. Systemic barriers, including a lack of institutional support and time constraints, further compounded these issues. Traditional dementia education models need to be supplemented with hands-on training approaches, including case-based learning and simulation exercises, to enhance practical preparedness (Kang et al., 2021; Surr et al., 2022). Cultural change within NHS Trusts has also been identified as a fundamental prerequisite for embedding dementia education into everyday clinical practice (RCP, 2019).

5.3.1d: The Need for Appropriate Environments

The physical hospital environment was frequently cited as a significant determinant on the provision of dementia care. Nurses working in both older adult wards and ED discussed the need for dementia-friendly environments to reduce patient anxiety and optimise care delivery. Challenges encountered in high-paced ED settings included heightened confusion, sensory overload, and changes in behaviours among patients with dementia, all of which were exacerbated by the unfamiliar and often chaotic hospital environment (Livingston et al., 2020; Kang and Hur, 2021). Some nurses reported in the absence of dementia-friendly designs, sedation was frequently used as a behavioural management tool, despite evidence highlighting the risks, including increased falls, longer hospital stays, and heightened mortality rates (Huhn et al., 2019; Kirkham et al., 2017). Dementia-friendly wards incorporating wayfinding cues, reduced noise levels, and designated quiet spaces were associated with improved patient outcomes and nurse satisfaction (Brooke and Semlyen, 2019).

5.3.2: Support from Others

5.3.2a: Support from a Dementia Specialist

Nurses frequently sought support from Admiral Nurses and DSNs when confronted with changes in behaviour among patients with dementia. The expertise of these specialists provided nurses with practical strategies for managing changes in behaviours, aligning with the broader literature and research in dementia care interventions (Griffiths et al., 2015; Ye et al., 2024). Nurses reported significant accessibility barriers, as there are only 437 Admiral Nurses across England, an insufficient number to meet the increasing demand for dementia care support (Dementia UK, 2023). Consequently, many nurses found themselves navigating dementia-related challenges without specialist guidance, leading to suboptimal care delivery and heightened stress levels.

5.3.2b: Support from a Non-Dementia Specialist

Due to the limited availability of DSNs, nurses often turned to doctors and security staff when patients with dementia became agitated. While well-intentioned, these responses were not always effective, as many non-dementia specialists lacked training in managing changes in behaviours for people with dementia. (Kim and Park, 2017; James et al., 2023). Sedation was frequently employed as a management measure despite substantial evidence cautioning against its routine use due to associated risks (Livingston et al., 2014). Security staff involvement was also found to be counterproductive, as it often heightened patient distress and escalated changes in behaviour rather than mitigating them.

5.3.2c: Support from Someone to Just Sit with Them

Nurses in oncology and ED settings noted the importance of continuous supervision for patients with dementia, particularly those who wandered with purpose or experienced heightened agitation. Due to staffing constraints, nurses often relied on healthcare assistants or family members to support patients with dementia when they became agitated. Literature strongly supports the benefits of one-on-one supervision in reducing distress and promoting emotional stability among patients with dementia through engagement and meaningful activity (Cohen-Mansfield et al., 2015; Featherstone et al., 2019; Abbott et al., 2022). Many acute hospital environments lack the workforce capacity to provide such individualised attention consistently.

5.3.3: Lack of Support

5.3.3a: Support is Unavailable When Required

Despite the availability of some forms of support, my findings found nurses identified a lack of support, which was a barrier to the provision of effective dementia care in an acute hospital setting. The availability of support such as a dementia specialist service was identified by nurses, as not being available at the time support was needed, such as evenings or weekends. The reliance on sedation and physical restraint highlights systemic failings in dementia care provision. The Prime Minister’s Challenge on Dementia 2020 (NHS England, 2009; RCoP, 2019) advocates for round-the-clock access to dementia specialists. Inconsistent implementation across hospital trusts has led to significant variations in service availability. Nurses’ awareness of dementia pathways varied considerably, further limiting their ability to provide effective care (Alzheimer’s Society, 2015). Nurses working in ED and oncology reported a lack of involvement in the development and implementation of dementia care pathways, which suggests nurses who participated in my study lacked the knowledge of strategic guidelines. This gap is concerning, as the effective management of dementia is dependent on interdisciplinary collaboration and the consistent application of care pathways across all settings (Alzheimer's Society, 2016; Livingstone et al, 2020). My findings are supported by broader research indicating that the successful implementation of dementia care strategies often falters due to insufficient communication and training within NHS Trusts (Surr et al, 2020; Smith et al, 2019).

5.3.3b: Nurses Were Unable to Support Patients with Dementia

My findings identified that nurses felt isolated, as well as unsupported, particularly when providing care to a person with dementia who demonstrated changes in behaviours or had complex needs relating to eating and drinking. Stress and burnout were prevalent among those nurses who felt unsupported, aligning with research indicating that structured debriefing sessions and psychological support can mitigate emotional distress in dementia care settings

(Galvin et al., 2015; Dewing and Dijk, 2016). My findings highlighted a lack of understanding and regular support from colleagues and senior staff, which can exacerbate feelings of isolation among nurses. The literature review findings identified nurses had to find their own support and therefore developed informal networks with those they had worked with over the years, to the exclusion of newer nurses who may be less experienced (Rybacka et al, 2025 *TBS*).

5.4: Dementia Specialist Nurses' Lived Experiences on Providing and Seeking Support

5.4.1: Dementia Specialist Services (DSS) Providing Support

The meaning of the responses and lived experience of dementia specialist nurses in my study working within dementia specialist services identified an element of their role was targeted assistance to nurses to support them to provide care for patients with dementia in an acute hospital. Dementia specialist services served as a resource, providing expertise that enhanced the quality of care for patients with dementia.

5.4.1a: Role modelling, resources and education providing support to nurses

DSNs play a key role in supporting both people living with dementia and the wider multidisciplinary team in acute hospital settings. Their support extends beyond the provision of direct patient care to include role modelling, mentorship, emotional support, and facilitating non-pharmacological interventions. My study found that DSNs often act as intermediaries, bridging the gap between nurses and specialised dementia care knowledge, ensuring people with dementia receive person-centred care that aligns with best practice guidelines (Moreno-Morales et al., 2020; Cohen-Mansfield et al., 2010).

DSNs provide tangible resources such as MP3 players preloaded with personalised music, Twiddlemuffs for sensory engagement, and reminiscence therapy materials. These non-pharmacological interventions are widely supported in literature as effective strategies to manage changes in behaviour in patients with dementia (Cohen-Mansfield et al., 2010). Nurses in my study emphasised that while such tools were useful, they needed adequate staffing and time to integrate these interventions effectively into patient care routines.

A significant finding was the emphasis on the need for tailored education rather than generic training programmes. DSNs who engaged in hands-on training, case-based learning, and reflective practice sessions with nurses reported better engagement and application of dementia care principles. Traditional dementia training often lacks practical implementation, leading to a disconnect between theoretical knowledge and clinical practice (Surr et al., 2017). Consequently, DSNs advocated for a shift towards embedded learning approaches that integrate dementia care principles into daily nursing routines rather than separate, didactic training sessions.

5.4.1b: Identified Clinical Needs as Perceived by Nurses

One of the most pressing concerns raised by nurses was the management of changes in behaviour and the need for cooperation to complete personal care with patients with dementia. Nurses frequently sought guidance from DSNs on how to de-escalate aggression, reduce agitation, and engage patients in activities of daily living without resorting to pharmacological interventions. Person-centred approaches were emphasised as the most effective means of addressing these concerns (Brooker, 2009). Despite this, many nurses expressed frustration over the lack of consistency in dementia care approaches across different acute care settings. Some nurses reported feeling inadequately trained or unsupported when dealing with patients with dementia, particularly in ED where time constraints and acute medical concerns often took precedence. DSNs highlighted the need for systemic changes to prioritize dementia care within acute care settings, ensuring nurses had both the knowledge and resources to provide optimal support.

5.4.2: DSS Seeking Support

My findings highlighted how dementia specialist nurses sought support, which revealed they often required support to effectively perform their roles. The two main areas for support was to seek further understanding of patients’ physical needs and medication.

5.4.2a: Seeking Support from Colleagues with Experience and Networks

DSNs frequently sought support from experienced colleagues, specialist networks or other DSNs, when managing complex needs of patients with dementia Structured peer support networks, such as the Admiral Nurse Academy, provided a platform for shared learning and professional development. These networks and support systems were found to be instrumental in reducing burnout among DSNs, as they allowed for case discussions, shared decision-making, and emotional support (Jackson et al., 2018; Henshall et al., 2020; Surr et al., 2017). Mentorship and interdisciplinary collaboration were also key factors in enhancing DSN efficacy. Those who had access to regular case conferences and interdisciplinary team meetings reported higher confidence levels in their ability to manage challenging dementia cases. The availability of these support structures varied significantly across NHS trusts, leading to inconsistencies in DSN practice and support mechanisms.

Collaborative networks among dementia specialist services, opportunities for peer support, and access to mental health resources were significant for sustaining the effectiveness of dementia specialist services. Dementia specialist nurses should be enabled and empowered to provide high-quality care and support to nurses and patients, when they themselves are also supported (Molina-Mula and Gallo-Estrada, 2020). The literature review found nurses sought support from other peers, supporting this finding (Rybacka et al, 2025 *TBS*).

5.4.2b: Seeking Support from Geriatricians and Need for Appropriate Services

The complexity of dementia care often involves input from multiple specialties, particularly when patients present with co-morbidities such as frailty, cardiovascular disease, or mental health concerns (Bunn et al., 2014). DSNs frequently consulted geriatricians to ensure holistic, multi-faceted care approaches that addressed both cognitive decline and physical health deterioration. Despite the recognised value of interdisciplinary collaboration, barriers such as time constraints, hierarchical structures, and lack of standardised referral pathways often hindered seamless integration between dementia specialist services and geriatric teams (Dewing and Dijk, 2016). The literature review findings discuss how nurses seek support from other peers who they deem experts. The criteria of an expert were linked to years of experience, trustworthiness and availability (Rybacka et al, 2025 *TBS*). My findings align with the literature, which identified dementia specialist nurses need peer support, as dementia specialist nurses discussed their close relationships with geriatricians, which was identified as an important element within their supportive networks. A recommendation of my findings includes the need for more structured collaborative models to streamline communication and enhance shared decision-making.

5.4.2c: Mental Health Services; First Point of Call

Due to the behavioural and psychological symptoms of dementia (BPSD), DSNs frequently worked alongside psychiatric liaison teams to manage acute distress, changes in behaviours and medication for patients with dementia. Access to mental health services remained a significant challenge, with many hospitals experiencing long waiting times and inadequate psychiatric support for dementia care (NICE, 2018). The limited availability of mental health specialists resulted in DSNs shouldering much of the responsibility for crisis management, often without adequate resources or personnel to implement best practice interventions. My study highlighted the need for integrating mental health expertise into dementia care pathways, ensuring timely access to support and reducing reliance by nurses on inappropriate interventions such as sedation and physical restraint.

5.4.3: The Infrastructure of Dementia Specialist Services

My findings identified the infrastructure of dementia specialist services, such as the organisational and structural factors were seen to influence the delivery of dementia care in acute hospitals. Effective dementia care required a well-established infrastructure that included dedicated roles for dementia specialist services, clear protocols, and seamless integration of specialist services into the broader healthcare system (Surr et al., 2016).

5.4.3a: DSS is Not Used to Its Full Potential

DSNs discussed their thoughts regarding nurse’s underutilization of dementia specialist services within NHS trusts. DSNs found their role was primarily viewed as an educational resource rather than an integral component of patient care. Some reported their time was disproportionately spent delivering training rather than providing direct patient support. Experienced nurses were frustrated as they who sought immediate, case-specific guidance. My findings found dementia specialist nurses were frustrated nurses did not understand the dementia specialist services. My findings identified dementia specialist nurses believed ward nurses wanted a quick response or a quick fix, to a certain scenario. This lack of clarity often led to unrealistic expectations, with many nurses seeking immediate responses or for complex dementia-related issues. This phenomenon is not uncommon in healthcare settings where specialised services exist. A lack of understanding of the roles and responsibilities of dementia care providers can lead to misaligned expectations (Surr et al, 2017). The expectation for rapid responses can undermine the person-centred care approach essential in dementia care. Effective interventions often require comprehensive evaluations, collaboration with other disciplines, and time for implementation, which conflicts with the desire for immediate solutions (Brooker and Latham, 2015).

5.4.3b: Small Teams with No Budget or Support

A recurring discussion by DSNs was the underfunding of dementia specialist services compared to other hospital departments. DSNs often operated within small teams with limited resources, making it difficult to provide consistent support across large hospital settings. Compared to other specialties such as infection control, dementia services received disproportionately less funding, despite the growing prevalence of dementia within an acute hospital setting (Livingston et al., 2020; NHS England, 2016). Lack of dedicated budgets resulted in fragmented care pathways and inconsistent service availability. DSNs expressed concerns that without sustained investment, dementia specialist services would struggle to meet the increasing demand for dementia care support (Alzheimer's Society, 2015).

The variability in service availability means that dementia specialist nurses, within my study, did not have access to the same resources or support services as their counterparts in other areas. This results in disparities in the support being offered to nurses, with patients in under-resourced areas receiving less comprehensive or timely care. The under-resourcing of dementia specialist services can limit the time and attention that dementia specialist nurses can devote to supporting nurses. In an environment where nurses are stretched thin and resources are scarce, it can be challenging to provide the level of support that nurses need to feel that they are able to provide the individualised care that patients with dementia require. The Fix Dementia Care: Hospitals report (Alzheimer's Society, 2016) explored how such disparities contribute to delayed or missed diagnoses and inadequate care. The success of healthcare interventions relies heavily on the availability of adequate resources and support (Greenhalgh et al, 2017). Without sufficient investment in both human and material resources, even the most well-designed care pathways can fail to deliver their intended outcomes.

5.4.4: Nurses’ Lack of Understanding of Dementia and Willingness to Engage with DSS

5.4.4a: Nurses Lack Understanding of Dementia

My findings identified dementia specialist nurses felt nurses showed a lack of understanding of dementia and willingness to engage with dementia specialist services, which was a barrier to effective dementia care in acute hospitals. Despite the availability of dementia specialist nurses, the findings suggest many nurses lack a comprehensive understanding of dementia, leading to a reluctance to engage with dementia specialist services. Dementia specialist nurses in my study discussed how nurses lack of insight on how patients with dementia acknowledge and accommodate new routines, which occur when being admitted to an acute hospital. This lack of insight can hinder effective care delivery, as understanding patients’ cognition is important when supporting the care needs of a person with dementia.

Task-oriented nursing can reduce the quality of care for patients with dementia (Dewing and Dijk, 2016; Kang and Hur, 2021; Fazio et al, 2018). When nurses focus primarily on completing tasks, such as administering medication, assisting with personal care, or providing support at mealtimes, rather than engaging with patients in a meaningful way, it can lead to increased feelings of confusion, isolation, and distress in those with dementia. Patients with dementia often struggle to understand rushed or impersonal care routines, which can exacerbate their symptoms, increase agitation, and diminish their overall well-being (Carrarini et al, 2021). This approach stands in contrast to person-centred care, which emphasises individualised attention, empathy, and a focus on the unique needs and preferences of each patient (Brooker and Latham, 2015). When nurses take the time to understand the personal history, routines, and changes in behaviours of patients with dementia, this improves patient care and outcomes (Kim and Park, 2017; Lee et al, 2022).

5.4.4b: Nurses Struggle to Ask and Find Support

My findings suggest that a combination of professional pride, time constraints, and knowledge gaps prevented nurses from actively seeking DSN support as perceived by DSNs. Some nurses were unaware of dementia pathways within their institutions, while others hesitated to ask for help due to fear of judgment (Bamforth et al., 2023; Adlbrecht et al., 2024). Nurses in departments with a lower prevalence of dementia may lack sufficient exposure and familiarity with dementia care pathways, which can lead to disengagement from available resources

(Adlbrecht et al, 2024). This disconnect is exacerbated when departments do not regularly encounter patients with dementia, resulting in limited awareness of specialist services and how to access them. Improving the engagement between nursing staff and dementia specialists requires ongoing interprofessional education and clear communication about how and when to access dementia services (Giebel et al, 2021; Giebel et al, 2024).

5.5 The Convergence of Experiences Among Nurses and Dementia Specialist Nurses

The provision of dementia care within acute hospital settings involves the engagement and collaboration of both nurses and DSNs. This section explores the shared experiences, challenges, and professional tensions between nurses and DSNs within acute hospital settings, emphasising the systemic issues, which may effect the provision of dementia care.

5.6: The Liminal Spaces of Interaction Between the Two Groups

In healthcare settings, the liminal space between nurses and DSNs is characterised by an indistinct division of labour, resulting in professional strain, uncertainty, and role ambiguity (Giebel et al., 2015). Professional liminality is especially pronounced in acute hospital settings, as nurses are required to support and care for patients with dementia despite lacking the necessary training, while DSNs encounter systemic barriers to fully integrate their expertise within the applied biomedical model of care (Bunn et al., 2012).

5.6.1: The Complexity of Liminal Spaces in Dementia Care

The ambiguous boundaries between the roles of nurses and DSNs created significant professional tension. From a hermeneutic perspective, this in-between state created an existential burden for both groups. Firstly, nurses often felt discomfort and ethical distress when dealing with the behavioural and psychological symptoms of dementia, especially when they felt unprepared to support people with dementia (Livingstone et al., 2020). The absence of structured dementia training in many nursing programmes further exacerbated this issue, leaving nurses reliant on reactive, rather than proactive, strategies when addressing changes in behaviour of patients with dementia (Surr et al., 2017).

Secondly, DSNs struggled to validate their professional contributions within an acute hospital setting dominated by acute biomedical interventions. Their role was frequently perceived as ancillary rather than essential, which limited their ability to influence clinical decision-making

(Griffiths et al., 2014). This structural marginalisation resulted in DSNs operating in professional silos, unable to fully implement dementia person-centred care practices across interdisciplinary teams (Giebel et al., 2015). Tensions were further exacerbated by the fundamental epistemological differences between the biomedical model, which underpins much of acute hospital care, and the person-centred framework championed by DSNs (Kitwood, 1997; Brooker, 2007). While DSNs advocated for holistic, psychosocial approaches to providing care for patients with dementia. Nurses were often constrained by NHS protocols, which prioritised efficiency, task-driven care, and risk mitigation (Eisenmann et al., 2020). The misalignment of paradigms created friction, reinforcing the sense of liminality both groups experienced in delivering dementia care.

5.6.2: Role Conflict and Professional Strain

The liminal nature of the nurse-DSN relationship led to increased stress, professional dissatisfaction, and suboptimal patient outcomes. Research has highlighted role conflicts arising from unclear delineation of responsibilities contributed to fragmented care, where nurses and DSNs operated in parallel rather than in collaboration (Livingstone et al., 2020). Parallel working impacted on both staff well-being and impacted on the consistency and quality of care provided to patients with dementia.

The lack of formalised interdisciplinary mechanisms further entrenched these challenges. Many hospital policies did not include structured referral pathways for nurses to seek support from DSNs, which led to ad hoc and inconsistent interactions between the nurses and DSNs (Bunn et al., 2012). Nurses struggled to access DSNs guidance and support in a timely manner, while DSNs remained underutilised and unable to contribute meaningfully to the care of patients with dementia (Giebel et al., 2015), which contributed to professional alienation. DSNs often reported feelings of frustration when their recommendations were overlooked in favour of acute interventions, which did not align with evidence-based practice in dementia care (Griffiths et al., 2014).

5.6.3: Overcoming Liminality: The Case for Structured Interdisciplinary Integration

The need to address the liminality in RN-DSN interactions has become apparent and requires systemic reform to foster structured interdisciplinary collaboration. Recommendations include formalised models of shared decision-making, such as DSN-led ward rounds and structured case discussions, which may mitigate role conflict and enhance integration (Eisenmann et al., 2020). The embedding of DSNs within routine hospital workflows, initiatives ensure their expertise is both recognised and readily accessible to nurses (Livingstone et al., 2020).

5.7: Why Support Doesn't Work

Despite the presence of DSNs within many NHS Trusts, structural barriers significantly impacted on ability to provide meaningful support to nurses. Issues such as inconsistent staffing, unclear referral pathways, bureaucratic inefficiencies, and competing NHS priorities contributed to the perception dementia care remained a peripheral rather than an NHS concern (Livingstone et al., 2020). Nurses often struggled to access DSNs for timely guidance, leading to crisis-driven rather than proactive interventions, which ultimately compromised the quality of dementia care (Dementia UK, 2022). The failure of these support structures is not just a matter of competency or staffing shortages, it reflects broader systemic disregard, where dementia care is undervalued compared to other medical specialties.

5.7.1: Barriers to Effective Support

The disconnect between DSNs and nurses was exacerbated by hospital hierarchies, resource allocations, and acute medical interventions over dementia care (Eisenmann et al., 2020). The nature workflow in acute hospital settings often required DSNs to balance multiple roles, including advocacy, education, and direct patient care, without having a formalised structure, which allowed them to function effectively within multidisciplinary teams (Alzheimer's Society, 2015). The impact is a fragmented approach to dementia care, where DSNs have limited influence over policy-making and minimal recognition within hospital governance (Surr et al., 2017). For nurses, systemic constraints translated into limited access to support for caring for patients with dementia. Unclear referral pathways and the absence of structured collaboration mechanisms prevent nurses from integrating dementia-specific strategies into their practice (Abbott et al., 2022). Nurses often felt unsupported when managing changes in behaviour patients with dementia, as they needed to navigate barriers, which included an absence of clear guidance on when and how to involve DSNs (Dewing and Dijk, 2016). The impact of barriers and lack of support reinforced a reactive approach to dementia care, where interventions occurred in response to a crisis rather than a coherent, supportive strategy.

5.7.2: The Marginalisation of DSNs

DSNs experienced professional marginalisation within acute hospital settings, which further weakened the effectiveness of support structures they tried to implement. DSNs expertise in dementia care was often overlooked in favour of more dominant, biomedical models of healthcare, which emphasised acute medical management over holistic, person-centred approaches (Livingstone et al., 2020). This marginalisation was manifested in several ways, including a lack of DSN representation in key decision-making forums, minimal investment in dementia care training initiatives, and a reluctance to integrate dementia care into standardised hospital policies (Dementia UK, 2022; Alzheimer's Society, 2015).

DSNs frequently reported experiencing professional isolation, as their role was often seen as auxiliary rather than integral to hospital operations. The limited formalisation of the responsibilities of DSNs impacted on their ability to advocate for dementia care, as systems that did not prioritise people with dementia, and therefore, meaningful change was impossible to drive forward (Surr et al., 2017). Professional isolation not only undermined the more of DSNs but restricted their ability to provide consistent and high-quality support to nurses, which further compounded the deficiencies in dementia care.

5.7.3: The Need for Structural Reforms

Structural reforms are necessary to integrate DSNs into acute hospital settings and enhance their ability to provide meaningful support to nurses. Embedding DSNs within multidisciplinary teams, rather than positioning them as isolated specialists, can improve collaboration and ensure dementia expertise is incorporated into daily nursing practice (Alzheimer's Society, 2015). Acute hospitals, which have successfully implemented DSN-led mentorship programmes report higher levels of nurse engagement and improved overall patient outcomes (Dewing and Dijk, 2016). Increased managerial recognition of the value of DSNs, including greater investment in dementia-specific training and clearer career progression pathways, can help mitigate the professional marginalisation that DSNs frequently experience (Surr et al., 2017).

5.8: Infrastructure

The physical environment of acute hospitals is often inadequately designed to accommodate the complex needs of patients with dementia, exacerbating anxiety for both patients and nurses.

The overstimulating nature of many acute hospital settings, characterised by excessive noise, disorientating ward layouts, inadequate wayfinding signage, and limited access to dementia-friendly spaces, contributes to disorientation, and changes in behaviour among patients with dementia (Giebel et al., 2021). Nurses frequently find themselves engaged in reactive, one-to-one interventions to manage changes in behaviour in patients with dementia, intensifying their workload and placing additional strain on already limited staffing resources (Bunn et al., 2012).

5.8.1: Environmental Barriers in Acute Hospital Settings

The traditional design of acute hospital environments fails to support the cognitive and sensory needs of patients with dementia. The combination of bright fluorescent lighting, high levels of ambient noise, and unpredictable ward routines can heighten confusion and anxiety among patients, leading to increased incidences of wandering, falls, and agitation (Mitchell et al., 2021). Patients with dementia are particularly susceptible to environmental stressors, with overstimulation often resulting in changes in behaviour that require further nursing intervention (Grey et al., 2019).

Poor signage and indistinguishable ward layouts create additional challenges for both patients and staff. Inconsistent or unclear wayfinding systems contribute to heightened patient disorientation, while also increasing the time nurses spend assisting individuals who are unable to navigate their surroundings independently (Quirke et al, 2023). The lack of dementia-friendly spaces, such as quiet sensory rooms or designated low-stimulation areas, further exacerbates the issue, leaving nurses with few alternatives for de-escalating and supporting patients with dementia.

5.8.2: Access to Dementia Pathways and How to Access Support

In acute hospital settings, timely and equitable access to dementia care pathways is essential to delivering person-centred care for patients with dementia. Dementia care pathways provide a structured framework for identification, assessment, treatment, and ongoing support, and their successful implementation is needed to coordinate the contributions of both nurses and DSNs. While nurses are frequently the first clinical touchpoint, often identifying subtle cognitive changes during admission assessments, DSNs possess advanced competencies in differential diagnosis, care coordination, and the deployment of specialist interventions (Royal College of Nursing [RCN], 2023; Health Education England, 2021). The convergence of clinical experiences between these roles supports a seamless, patient-centred trajectory across the dementia care continuum within an acute hospital setting (Kim and Park, 2017).

Navigating dementia pathways in acute hospital settings remains complex due to systemic fragmentation and regional inconsistencies in service provision (NICE, 2018). Although national guidelines such as the National Dementia Strategy (Department of Health, 2009) and NICE clinical guidance (NG97) delineate best practice standards, the operationalisation of these frameworks are often impeded by variable local commissioning, workforce constraints, and insufficient interdepartmental integration (RCN, 2023; Alzheimer's Society, 2022). In the acute hospital setting, this can result in delayed diagnoses, inconsistent care planning, and poorly coordinated discharge processes, which are compounded when staff lack sufficient dementia training (Turner et al., 2017; Featherstone et al, 2019).

Within this context, DSNs serve as key agents of system navigation. In acute hospitals, DSNs frequently act as dementia champions, advocating for the needs of patients with dementia and promoting the use of tools and interventions such as 'This is Me' documentation to personalise care (Alzheimer's Society, 2022). DSNs also facilitate non-pharmacological interventions, such as orientation cues and meaningful activity, that are integral to high-quality dementia care in acute settings (Skills for Health, 2015; Kitwood, 1997).

Furthermore, dementia pathways demonstrate the need for clear signposting, well-defined referral protocols, and a working knowledge of community liaison services to ensure continuity of care post-discharge. Nurses, particularly those in discharge coordination or liaison roles, must be familiar with local memory clinics, integrated care boards, and voluntary sector organisations to advocate for holistic, ongoing support (NHS England, 2023).

The convergence of nurses and DSNs perspectives creates a synergistic model of dementia care, one that values both breadth and depth of knowledge. Collaborative working between nurses and DSNs facilitates responsive, adaptive care planning. Interprofessional learning, reflective practice, and role-modelling are key to sustaining this integrated approach, particularly due to the increase of the prevalence of people with dementia and rising hospital admissions by this population (Prince et al., 2014).

5.8.3: The Impact on Nursing Workload and Patient Outcomes

The lack of dementia-friendly hospital design has profound implications for both patient safety and nursing staff well-being. Inappropriate environmental stimuli contribute to increased incidences of falls, agitated, and wandering with purpose, all of which require intensive staff intervention (Quirke et al, 2023). The cumulative effect of these challenges leads to an increased stress on nursing teams, who must allocate significant time and effort to reactive interventions rather than proactive care planning (Bunn et al., 2012).

Nurses often lack both the confidence and resources necessary to implement meaningful environmental changes at the ward level. Even minor adjustments, such as reducing noise pollution from medical equipment or rearranging furniture to create more navigable spaces, require approval that is frequently delayed or denied (Livingstone et al., 2020). This bureaucratic rigidity leaves nurses feeling disempowered and unable to advocate effectively for dementia-friendly adaptations (Menendez and Gracia, 2022).

5.9: Staff Lack of Knowledge

A significant barrier to appropriate dementia care within acute hospital settings is the lack of dementia education among healthcare professionals. Both nurses and DSNs encounter gaps in knowledge, albeit in different ways. While nurses often lack foundational training in dementia care, DSNs identified institutional barriers that impact the effective dissemination of their expertise. The disconnect between dementia-specific knowledge and its application within an acute hospital setting reflects a broader epistemological divide that can impact on patient care (Surr et al., 2017; Giebel et al., 2015; Muralidhar et al, 2025).

5.9.1: Knowledge Gaps Among Nurses and DSNs

My findings identified nurses reported a deficiency in dementia-specific knowledge, particularly regarding non-pharmacological interventions, person-centred approaches, and effective communication strategies (Lewis et al, 2022). As a result, their practice is often informed by ad hoc learning, peer observation, or trial-and-error approaches, leading to inconsistencies in care delivery and increased stress when supporting or caring for a patient with dementia. (Muralidhar et al, 2025).

In contrast to the nurses within my study, DSNs were advanced dementia experts, but still expressed they frequently struggled to integrate their knowledge into broader hospital pathways. Hospital structures, which are traditionally hierarchical and biomedical in focus, often undervalue dementia-specialist knowledge, prioritising acute medical interventions over holistic, person-centred dementia strategies (Livingstone et al., 2020). The lack of interdisciplinary education and the marginalisation of DSNs within hospital decision-making processes further limited opportunities for widespread knowledge translation (Giebel et al., 2015).

5.9.2: Systemic Challenges in Dementia Education

The disconnect between dementia education and clinical practice is exacerbated by systemic failures in both undergraduate and continuing professional education. While some nursing programmes include dementia-related content, the emphasis remains limited, often focusing on the pathology of the disease rather than practical, patient-centred care strategies (Surr et al, 2017). Dementia training in many acute hospital settings is typically optional or delivered in an inconsistent manner, resulting in fragmented knowledge application among staff (Gaugler et al., 2009). There is also a lack of formalised mentorship structures in dementia care, nurses who seek to develop expertise in dementia management often lack access to DSNs or senior colleagues who can provide guidance and support (Chenoweth et al., 2015). Opportunities for experiential learning, widely recognised as a key component of effective dementia education, remain underutilised within acute hospital settings (Muralidhar et al, 2025).

5.9.3: Bridging the Knowledge Gap: Proposed Educational Reforms

To address dementia care education concerns there is a need for comprehensive, experiential-based learning models that integrate dementia education into all levels of nursing training (RCN, 2021). Case-based simulations, problem-based learning, and direct exposure to dementia care scenarios can significantly improve nurses' confidence and competence in managing patients with dementia (Lewis et al, 2022; Surr et al, 2017).

The implementation of mandatory dementia education, both at the undergraduate level and as part of ongoing professional development, has been proposed as a strategy to standardise dementia care knowledge across the nursing workforce (Gaugler et al., 2009). This approach would ensure that all nurses, regardless of their clinical setting, increase baseline competencies in dementia care, reducing variability in practice and enhancing overall care quality.

5.10: Staff Being or Feeling Unable to Fulfil Their Role

Nurses and DSNs, frequently encountered systemic barriers that impacted their ability to provide dementia care. These challenges generated professional frustration and moral distress, ultimately affecting both staff well-being and patient outcomes. The interplay between institutional constraints and individual role limitations revealed critical deficiencies in hospital frameworks, demonstrating a need for systemic reform and strategic investment in dementia care resources (Abbott et al., 2022).

5.10.1: Barriers Faced by Nurses and DSNs

Nurses discussed workload pressures, competing clinical priorities, and hospital structures as fundamental obstacles that prevented them from delivering person-centred dementia interventions (Eisenmann et al, 2020). The persistent issue of time constraints further exacerbated this situation, as nurses struggled to allocate sufficient attention to patients with dementia amidst the broader demands of acute care settings (McGilton et al., 2018). The resultant emotional burden of knowing what constitutes best practice yet being unable to implement this approach resulted in moral distress, a phenomenon that has been widely acknowledged as a contributor to burnout and job dissatisfaction in nurses (Rushton et al., 2015; Salari et al, 2022).

DSNs, despite their specialised expertise in dementia care, frequently encountered institutional marginalisation, often perceived as auxiliary rather than integral to hospital operations (Griffiths et al, 2015). The lack of managerial recognition and limited organisational support impeded their ability to advocate for and implement dementia-informed strategies effectively (Clissett et al., 2013). Hierarchical hospital cultures often place dementia care in a lower priority tier, overshadowed by high-intensity medical interventions that dominate clinical agendas (Surr et al., 2017). This dynamic reinforced a cycle in which DSNs are positioned as peripheral figures rather than essential contributors to patient-centred care.

5.10.2: Phenomenological and Institutional Perspectives

From a phenomenological standpoint, the lived experiences of nurses and DSNs revealed significant existential challenges in dementia care delivery. Heidegger’s (1962) concept of 'thrownness' can be identified in the predicament in which nurses found themselves, which was embedded within NHS Trusts that dictated constraints beyond their control. The struggle to exercise professional autonomy in an environment where systemic limitations persistently obstruct optimal care encapsulates the broader institutional neglect of dementia as a clinical priority (Kinman and Leggetter, 2016).

5.11: Feelings of Being Unsupported and/or Unsupportiveness

The emotional and psychological impact associated with feelings of being unsupported is a prevalent and persistent finding of this study through the professional experiences of both nurses and DSNs. The absence of adequate institutional support, coupled with high job demands, contributed to emotional exhaustion, burnout, and a diminished sense of professional efficacy (Maslach and Leiter, 2016; Aiken et al., 2012). These detrimental outcomes not only affected individual nurses but also had broader implications for patient care quality and workforce sustainability.

Isolation and burnout among nurses have been extensively documented in literature reporting approximately forty per cent of nurses’ experience burnout (Aiken et al., 2012; McHugh et al., 2011; Ruiz-Fernández et al., 2020). Nurses and DSNs often expressed feelings of professional loneliness, stemming from insufficient peer support, limited managerial acknowledgment, and a perceived lack of appreciation for the specialised skills required in dementia care (Smythe et al, 2020). The systemic undervaluation of dementia care within acute hospital settings exacerbates these issues, leading to disengagement, decreased morale and poor outcome for patient with dementia.

The interplay between policies and workforce dynamics significantly influenced the support structures available to nurses and DSNs. Hospitals that fail to prioritise dementia care training, mentorship programmes, and peer-support networks contribute to an environment where nurses feel overwhelmed and underprepared to meet the complex needs of patients with dementia (Gaugler et al., 2020). The absence of these critical resources undermines the confidence of nurses and DSNs and negatively impacts patient outcomes, as nurses struggle to deliver optimal care in the face of systemic barriers.

5.12: Chapter 5 Conclusion

This chapter has provided an in-depth hermeneutic phenomenological exploration of the challenges faced by nurses and DSNs in providing and seeking support within acute hospital settings. My findings reveal a complex interplay between systemic, institutional, and relational barriers that impact the delivery of dementia care. By situating these experiences within a broader epistemological framework, the analysis has demonstrated dementia care is often relegated to the periphery of hospital priorities, leading to fragmented and inconsistent practices that fail to meet the needs of both patients and nurses (Alzheimer's Society, 2016; Dementia UK, 2022; Livingstone et al., 2020; Surr et al., 2017).

A theme emerging from my study is the structural inadequacy of dementia care support frameworks. The lack of institutional commitment to dementia related infrastructure, compounded by limited access to dementia expertise, has perpetuated a cycle of reactive rather than proactive care (Giebel et al., 2015). Nurses frequently found themselves managing challenges relating to patients with dementia without adequate support. DSNs struggled to assert their role within hospital hierarchies that prioritised acute biomedical interventions over holistic, person-centred dementia care (Kitwood, 1997; Brooker, 2009). This marginalisation resulted in underutilisation of their expertise, further exacerbating the divide between dementia-specialist knowledge and routine hospital practice.

Another critical finding is the epistemological conflict between the biomedical model that dominates acute hospital settings and the person-centred approach advocated by DSNs. While nurses operate within systems that emphasise efficiency, rapid intervention, and risk mitigation, DSNs promote dementia-informed strategies that prioritise patient dignity, engagement, and non-pharmacological interventions (Surr et al, 2017; Griffiths et al., 2015). The tensions between these paradigms create professional strain and limit the effectiveness of interdisciplinary collaboration. The concept of liminality, as explored in this chapter, highlights the uncertain and ambiguous professional spaces occupied by both nurses and DSNs, where role boundaries remain unclear and professional identities are continuously negotiated (Bunn et al., 2012).

The study also highlights the deficiencies in dementia education, which fails to adequately prepare nurses for the complexities of dementia care (McLaughlin et al., 2020). Current training models are often theoretical rather than practical, leaving nurses without the confidence or skills to implement effective dementia interventions. DSNs, while possessing advanced expertise, lack the institutional authority and resources to bridge this knowledge gap (Abbott et al., 2022). Addressing these issues requires a shift towards embedded learning models, interdisciplinary mentorship, and experiential training that integrates dementia care principles into routine hospital practice (Dewing and Dijk, 2016).

To move forward, NHS Trusts must prioritise structural reforms that enhance interdisciplinary collaboration and integrate dementia care as a core component of hospital practice. This includes redefining DSN roles to encompass not only education but also direct clinical involvement, policy influence, and leadership in dementia care strategies (Livingstone et al., 2020). Standardised referral pathways, formal mentorship programmes, and increased managerial recognition of dementia expertise are essential to fostering a more cohesive and effective dementia care model (Giebel et al, 2015; Alzheimer's Society, 2015).

My findings indicate that a paradigm shift in dementia care that moves away from fragmented, crisis-driven models towards sustainable, interdisciplinary frameworks that prioritise both patient dignity and professional well-being. The hermeneutic perspective reinforces the importance of continuous reflection, adaptation, and systemic engagement in achieving this transformation. Future research should explore the long-term impact of interdisciplinary dementia care initiatives, and the development of sustainable, reflective, and contextually responsive dementia care models (Surr et al, 2017). By addressing these critical issues, NHS Trusts can create a more resilient, compassionate, and effective system of dementia care, one that values the expertise of nurses and the dignity of those people living with dementia.

Chapter 6: Recommendations

6.1: Introduction

This chapter commences with a presentation of five recommendations based on the findings within my study. The strengths and limitations of my research study will then be presented. There will then be an overview of reflexivity focusing on how my prior experience has contributed to my doctoral journey. Finally, there will be the presentation of a dissemination plan for my findings before the thesis is concluded highlighting my contribution of new knowledge.

6.2: Recommendations

My five recommendations to support the provision of care for patients with dementia in an acute hospital will now be described, each recommendation will commence with an overview of my findings, discussion to wider literature, which will be followed by a clear recommendation.

6.2.1: Recommendation 1

My findings identified that nurses did not have time to support patients with dementia with meaningful activities. Studies indicate patients with dementia benefit significantly from engaging in meaningful activities, which can improve their mood, decrease agitation, and enhance overall quality of life (Abbott et al, 2022; Abdi et al, 2019). My findings found due to high demands and workflow pressures, nurses felt they found it difficult to provide the necessary time to engage patients with dementia meaningfully, leading them to seek support from other professionals, such as occupational therapists (OTs) in emergency departments and specialist care teams in older adult wards.

In ED, the fast-paced environment and the acuity of patient cases prioritise life-saving interventions, leaving less time for non-clinical interactions with patients with dementia. For this reason, nurses in EDs may rely on OTs, who bring specialised skills in cognitive engagement and therapeutic activities. OTs are skilled in facilitating activities that help to maintain cognitive function, reduce disorientation, and promote a sense of calm in patients, contributing to their comfort and safety during often stressful ED experiences (Karrer et al, 2022). In older adult wards, where patients with dementia may have longer stays, nurses report turning to “specialist care teams”. These teams often include dementia specialists nurses trained in tailored care strategies that reduce distress and promote therapeutic engagement (Harrison-Dening et al., 2019).

My study highlights although support from OTs and specialist teams is valuable, nurses still face challenges in providing the level of interaction and engagement with patients with dementia required due to time constraints. While patients with dementia do not require constant supervision, regular, meaningful engagement is known to support cognitive and emotional well-being and reduce distress or agitation (Jones et al, 2021). In high-paced environments like the ED, the pressure on nursing staff makes it difficult to allocate sufficient time for dementia care, creating a need for some to sit with a patient and provide consistent patient engagement (Dresden et al, 2022).

I recommend that nurses need to be supported to acquire and build the skills needed to identify the non-medical needs of patients with dementia, which includes the knowledge of understanding dementia care requires more than constant observation or supervision, whilst continuing to provide sufficient support for the nurses in ED.

6.2.2: Recommendation 2

The lack of out-of-hours dementia specialist nurse support is a significant gap in care, exacerbating the challenges faced by nurses. The absence of specialised support during evenings and weekends forces nurses to rely on alternative measures, such as sedative medications or security interventions, which may not be aligned with evidence-based practices in dementia care. Access to dementia expertise throughout the day and night reduces the likelihood of using emergency or invasive measures, promotes patient safety, and alleviates nurse burnout by providing consistent, timely support for critical situations (Abbott et al., 2022; Bridges et al, 2020).

The use of sedative medications or hospital security conflicts with person-centred care principles, which emphasise dignity, autonomy, and the use of de-escalation techniques to address changes in behaviour in patients with dementia (Ballard et al, 2018; Marulappa et al, 2022). The use of sedatives like Haloperidol in response to agitation and aggression in patients with dementia has raised ethical concerns and has been associated with increased risks of adverse effects, including sedation, falls, and a decline in cognitive function (Ralph and Espinet, 2018).

Nurses in my study expressed a need for additional training in non-pharmacological de-escalation techniques and how to support a patient with dementia with changes in behaviour. These approaches have shown positive outcomes in maintaining patient dignity while also protecting the safety of the care environment (Li et al, 2022). Investing in education and training for nurses on person-centred, compassionate approaches, including recognising triggers for agitation and applying individualised interventions, would support nurses in managing changes in behaviour more effectively, even in the absence of specialist support.

I recommend NHS Trusts should consider implementing continuous dementia specialist nurse support, including nights and weekends. This can be achieved by creating flexible staffing models or through an on-call model, ensuring nurses have immediate access to expertise when incidents arise.

I recommend the provision of comprehensive training on dementia care, focusing on non-pharmacological de-escalation techniques and the skills to manage changes in behaviour, which will empower nurses to handle complex situations compassionately and effectively, reducing reliance on sedatives and physical interventions.

These two recommendations, expanding out-of-hours support and investing in training will promoting a care culture that is safer and more supportive for both dementia patients and the nursing staff.

6.2.3: Recommendation 3

My findings indicate there is a need for nurses to receive education and support in understanding the specific and different needs and management of risks associated with mental health patients and patients with dementia. Education is needed to enable nurses to deliver safe, compassionate, and individualised care. Providing nurses with professional development opportunities, as well as emotional support, is essential in enhancing both their capabilities and resilience in these areas. The importance of ongoing training in dementia care, equipping nurses with the skills to manage complex situations (Dewing and Dijk, 2016).

Education and training on mental health and dementia would improve nurses understand and confidence in the provision of individualised care to these patients. In addition to training, creating a supportive work environment that includes access to sdementia specialist services, peer support, and opportunities for reflection is vital. A supportive framework can help reduce feelings of frustration and guilt among nurses, contributing to the well-being of nurses and improved patient outcomes.

In acute care settings, where nurses often have limited exposure to dementia care, responsive and practical training focused on addressing immediate concerns is especially effective. By addressing direct concerns raised by nursing staff, dementia specialist nurses can ensure that education is not only informative but also empowering, fostering both competence and confidence in dementia care (Surr et al., 2020; Aldridge et al., 2020). Addressing knowledge gaps among nursing staff through sustained education can foster a more comprehensive understanding of dementia within NHS Trusts. Furthermore, enhanced training in dementia care significantly improves staff confidence and competence, resulting in improved patient outcomes (Surr et al., 2017; Parveen et al., 2021; Martin et al., 2016). Enhanced training supports the multidisciplinary team, as staff feel more prepared to support individuals with dementia effectively and enables them to recognise changes in patients' cognitive abilities and provide person-centred care (Brooker and Latham, 2015).

I recommend enhanced dementia-specific training that emphasises the importance of patient’s cognitive abilities when engaging in patient care. Training needs to help nurses recognise and respond to cognitive changes in patients with dementia promptly, promoting proactive interventions.

6.2.4: Recommendation 4

An unexpected outcome of my study was the recognition of the unique support needs of dementia specialist nurses. Admiral Nurses who work in complex and emotionally demanding roles, discussed significant support from Dementia UK through the Admiral Nurse Network. This network provided not only resources but also mentoring and supervision, enabling Admiral Nurses to manage their roles effectively. These support structures addressed professional development and emotional well-being, fostering resilience among Admiral Nurses and enhancing the quality of advice they provided.

A structured network model, similar to the Admiral Nurse Network could benefit dementia specialist nurses. Replicating this network with a formalised system of mentoring, supervision, and access to comprehensive resources could strengthen support for dementia care teams across various NHS Trusts. This model would allow for shared knowledge and experience among dementia specialist nurses, promoting best practices and addressing the emotional toll of dementia care through peer connections and accessible resources. My study identified the need for dementia specialist nurses to have further education and tailored resources. The demands of dementia care are compounded when patients have additional physical comorbidities, as these add complexity to care plans and require nuanced clinical judgment. Tailoring specific resources for dementia specialist nurses, including management of physical comorbidities, would equip them to deliver more holistic and effective care.

A dedicated dementia specialist network could support access to tailored educational content and mentorship, which would empower dementia specialist nurses to develop their skills and confidence, particularly in managing complex cases involving patients with dementia with physical comorbidities. This knowledge would enable them to deliver a higher standard of individualised, holistic care that considers the full scope of a patient's physical needs. A dedicated dementia specialist network could also provide mentorship and supervision, supporting nurses' well-being by providing a space to share experiences, receive guidance, and connect with peers. My findings identified this support is essential and reduces feelings of isolation or burnout. By fostering resilience, this network would enhance job satisfaction and retention, as nurses feel more supported and valued within their professional community.

I recommend NHS Trusts need to establish structured support networks tailored specifically for dementia specialist nurses, drawing inspiration from the successful model of the Admiral Nurse Network. A national network would be designed to provide dementia specialist nurses with access to resources, ongoing education opportunities, and a system to access mentorship and supervision. The provision of this structured support would mitigate the emotional and professional pressures associated with supporting nurses to care for patients with dementia.

6.2.5: Recommendation 5

The disparity in the organisation of dementia specialist teams compared to other specialisms suggests an urgent need for reform. To elevate dementia specialist teams to services such as tissue viability and infection control, there needs to be a commitment to establishing dedicated dementia specialist teams with their own budgets. Dementia needs its own department, rather than being combined with frailty or delirium teams, to ensure that care is tailored to the specific needs of patients with dementia. Establishing a dementia department or team would not only centralise resources and expertise but also give dementia care the recognition and status it deserves, helping to reduce misunderstandings among colleagues, senior staff, and interdisciplinary teams regarding the work of dementia specialist nurses.

My findings found that dementia care lacks understanding and regular support from colleagues and senior staff, which can lead to confusion, inconsistency in care, and inadequate support for dementia specialist nurses. Rather than relying on broader teams, such as MHLTs as suggested in National Dementia Strategy, 2009; The Well Pathway, 2016; NICE, 2018), dementia specialist nurses are essential. These roles offer the targeted expertise and support patients with dementia and their families need, as they are specifically trained to address the cognitive, emotional, and psychological needs unique to dementia.

Nurses currently lack involvement in the development of care pathways that would be practical and effective for frontline care. Clear and well-communicated dementia pathways are necessary within and across NHS Trusts to avoid confusion and ensure consistent, high-quality support for patients with dementia (Dewing and Dijk, 2018). Research indicates improved interdisciplinary communication and clearer definitions of service roles across NHS Trusts mitigates misunderstandings and fosters stronger collaboration between healthcare professionals (Livingstone et al., 2020; Featherstone et al., 2019). The Fix Dementia Care: Hospitals report (Alzheimer’s Society, 2016) identified improving communication would clarify support roles but also enhance the quality of care provided to patients with dementia. For dementia specialist nurses, having well-defined communication protocols and clear guidelines for helping to create a seamless and supportive care network is essential.

I recommend the need for a dedicated dementia specialist team with their own budget and specific team members to elevate the recognition, status, and effectiveness of dementia care in acute hospitals. This approach would validate the expertise of dementia specialist nurses, provide them with the resources, visibility, and institutional support needed to offer skilled, compassionate, and consistent care.

6.3: Strengths of my study

This study has several strengths which includes the findings contributing to new and significant knowledge in dementia care, robust methodological stance and generalisability to how nurses seek support.

The application of hermeneutic phenomenology as the underpinning of my study has several strengths, particularly in exploring the depth of human experiences and subjective meaning. This approach, rooted in the works of philosophers Husserl and Heidegger, allows the researcher to uncover the underlying essence of individuals' lived experiences. Husserl's concept of going back to the things themselves emphasises a return to direct experiences, encouraging the researcher to focus on phenomena as they are perceived by individuals (Husserl, 1970). This emphasis on the lifeworld, the world of lived experiences, allows hermeneutic phenomenology to capture insights into the subjective essence of experiences in a way that quantitative approaches often overlook. This is an important approach in healthcare research, where understanding patients' and nurses' perceptions can reveal dimensions of care that are essential yet challenging to measure (Creswell and Poth, 2018).

Another strength of the application of hermeneutic phenomenology is the inclusion and emphasis on context and historical elements in understanding individual experiences. Heidegger argued that human experience is inherently 'being-in-the-world,' meaning an individuals' experiences are embedded within and shaped by their unique contexts, histories, and social environments (Heidegger, 1962). This approach enables the researcher to explore how individuals' lived experiences are influenced by these contextual factors, which add depth to understanding the phenomena within specific timeframes and environments. My study explored the experiences of nurses and dementia specialist nurses of seeking support post a pandemic.

The application of hermeneutic phenomenology's interpretive approach supported flexibility in exploring complex phenomena. Husserl and Heidegger's work suggests understanding is not a simple extraction of facts but a process of co-creation between the researcher and the participants, allowing meaning to evolve throughout the research. Heidegger emphasised the hermeneutic circle, where understanding emerges through a continuous dialogue between the parts and the whole of the experience (Heidegger, 1962). This iterative process allows researchers to uncover the layered, dynamic nature of human experiences as they evolve, especially within emotionally and ethically charged fields like healthcare and psychology. In my study I developed an interview schedule, but my engagement during interviews lead to further in-depth discussions identifying participants experiences of the phenomena.

6.4: Limitations of my study

All researchers need to recognise the limitations of their studies, some of which are unavoidable. Despite its strengths within my study, the application of hermeneutic phenomenology has several limitations, primarily related to the challenges inherent in subjective interpretation and the complexity of analysis. A limitation is the potential for subjectivity and researcher bias. In hermeneutic phenomenology, the researcher plays a central role in interpreting data, and their values, assumptions, and experiences inevitably influence the findings (Finlay, 2009). This involvement, while enhancing depth, introduces potential bias, as the researcher’s interpretations may affect the portrayal of participants' lived experiences. Unlike positivist research, which seeks objectivity, hermeneutic phenomenology embraces subjectivity, but this reliance on personal interpretation can raise concerns about the study’s credibility and validity if not carefully managed through the identification of the researcher’s pre-conception (Creswell and Poth, 2018).

A further limitation regards the concept of generalisability of the findings. This study recruited a small and specific sample and prioritised depth over breadth, making it challenging to generalise findings to larger populations (Polit and Beck, 2014). This focus on in-depth exploration is valuable for capturing the richness of unique experiences but caution needs to be applied when exploring the applicability of results to broader groups or settings. A further limitation found whilst writing my thesis, was the limited word count. The discussion was presented concisely and could be further developed. A further limitation relates to the several references throughout my thesis that were published over five years ago, this represents that dementia is not seen as a current focus.

The final limitation, particularly relevant for doctoral researchers, is the time-intensive nature of thematic analysis through a hermeneutic lens. This approach demands an ongoing, iterative process of interpretation, which involves re-reading, reflecting on, and re-interpreting data to uncover deeper meanings (Heidegger, 1962; Braun and Clarke, 2023). This can be especially demanding for doctoral students where there are constraints related to programme requirements. Unlike quantitative methods that may involve a straightforward application of statistical analyses, thematic analysis with a through a hermeneutic lens requires extended periods of immersion in the data and repeated cycles of analysis to approach a nuanced understanding.

6.5: Reflexivity

Completing a study using the hermeneutic circle identifies the reader of the data, does not read the data or understand the data from a position of nowhere. Therefore, my position was developed from reading and hearing the endless flow of individual experiences, knowledge and pre-conceptions. I had pre-conceptions of a phenomenon based on my own past experiences, these are identified as fore-structures, fore-having, fore-sight and fore-conception within hermeneutic phenomenology (Horrigan-Kelly et al, 2016). My pre-conceptions were identified within my methodology and method chapter. I will now reflect on my pre-conceptions and how they have changed since the analysis and interpretation of my findings.

While everyone carries a certain level of pre-conceptions, it does not mean we are confined by them. Instead, these pre-conceptions serve as the foundation through which we approach, question, and interpret (Finlay, 2008). My fore-structures, those prior understandings and experiences, played a constructive role in my interpretive research. In terms of fore-having, I had a foundational awareness of dementia care within nursing practice. I understood how nurses seeking support in dementia care often face unique challenges and was aware of potential gaps in research within this field. This perspective clarified my research aim and helped me focus on participant sampling. Regarding fore-sight, my experience working in dementia care, supporting nurses through education and initiatives gave me insight into areas of need. With this understanding, I could purposively sample nurses with varying experiences in dementia care, facilitating a deeper exploration of this phenomenon. Finally, in terms of fore-conception, I anticipated that different levels of support and interventions in dementia care would shape nurses' readiness and confidence in practice. I was mindful of how these pre-conceptions might influence my interpretation of the data. I aimed to give voice to participants' individual experiences, align with the philosophical principles of hermeneutic phenomenology, and maintain an interpretive stance. To enhance transparency, I focused on rigour, trustworthiness, credibility, transferability, dependability and confirmability which is discussed in greater detail in my methodology and method chapter.

6.6: Reflections on the research journey

Reflecting on my pre-conceptions, I now recognise that my prior experience played a significant role throughout my research study. My background in dementia care, particularly in supporting nurses within this area both clinically and as a researcher, was essential in identifying and exploring critical aspects of this under-researched topic of how nurses sought support in caring for patients with dementia. This experience helped me identify specific areas that required focus and contributed to discovering insights that could be used to enhance clinical practice, shape policy, and lead to further research studies.

Initially, I identified primarily as a phenomenologist, focusing on the essence of lived experiences of others in dementia care. However, as my research progressed, I found myself expanding into hermeneutics, recognising the importance of interpretation and context in understanding these individual experiences. This shift allowed me to appreciate the dynamic interplay between the researcher and the participants, as well as the influence of historical and social contexts on individual experiences. The hermeneutic approach deepened my engagement with the data, emphasising the significance of dialogue in revealing the complexities of the participants' narratives. Methodologically, I gained significant insights into hermeneutic phenomenology, developing skills and knowledge that will support my future research endeavours. One of the key strengths of hermeneutic phenomenology is its openness to researchers' pre-conceptions, allowing these experiences to deepen engagement with the research subject. My familiarity with the area of dementia care, policies and initiatives that referred to supporting nurses in dementia care and the challenges alerted me to gaps in the literature and compelled me to pursue this area of study. Additionally, my background fostered rapport and trust during interviews, as I could relate to participants' shared experiences and challenges in dementia care, creating a foundation for meaningful dialogue.

Investigating the experiences of nurses seeking supporting for patients with dementia has been a deeply enriching scholarly endeavour, one that I have aspired to undertake for several years working to resolve some of the challenges identified in my study. Initially, I approached this topic with a foundational understanding, but my engagement with it lacked the depth that comes from thorough exploration. Through my research, I have gained valuable insights and a more comprehensive understanding of the complexities in dementia care, particularly the specific challenges faced by nurses in delivering a good standard of care.

This journey has been particularly significant given my professional and personal experiences with inadequate care outcomes for patients with dementia. Witnessing these outcomes has shaped my understanding and heightened my awareness of the challenges within dementia care. Fix Dementia Care: Hospitals report (2015) has further informed my perspective, revealing areas where support and training for nurses can be improved. These insights resonate with the concept of ‘the clearing’ in hermeneutic phenomenology, where clarity emerges through a thoughtful process of interpretation and understanding. Through this research, I have gained a deeper appreciation for the complexity of dementia care, as well as the pressing need for changes that are needed in providing support to nurses that can lead to better outcomes for patients and their families. This recognition has fuelled my commitment to advocating for changes that will ultimately improve the support provided to nurses.

Reflecting on my research journey since 2017, I recognise how transformative my experience has been as I embarked on my clinical doctorate. From the outset, my studies provided a strong foundation for my development as a researcher. Initially, I approached my research with enthusiasm and naivety. I experienced many lows and high and times where expectations were not managed. However, as I progressed through my doctorate, I engaged deeply with the literature and refined my research skills, leading to several publications and conference presentations. These achievements not only signify milestones in my academic career but also reflect my growing expertise in the field.

Throughout my clinical doctorate, my research has involved a balance between my doctorate and other research projects, all focused on older adults and dementia care in different settings, including acute hospitals. This dual focus has allowed me to engage with research on multiple levels, enhancing my understanding of the intricacies involved in both theoretical frameworks and practical applications in nursing care. By continuing to work to completing my clinical doctorate alongside these projects, I have enriched my learning experience, applying theoretical insights directly to the real-world challenges faced by nurses working in healthcare settings.

My clinical doctorate marks the end of a chapter of my career, progressing from my early researcher status and positioning me for postdoctoral research opportunities and beyond. This transition is not merely a continuation of my studies but a significant step towards becoming a more established researcher within the field of dementia. The skills and insights I have gained during this period have equipped me to tackle more complex research questions and contribute meaningfully to advancing knowledge in dementia care.

My research journey has profoundly shaped my professional identity. It has expanded my capabilities as a researcher and deepened my commitment to improving care outcomes for patients with dementia. As I move forward, I am excited to continue building on this foundation, embracing new challenges, and contributing to the evolving landscape of nursing and dementia research.

6.7: Dissemination of findings

Firstly, my completed thesis will be submitted as part of the clinical doctorate programme. Secondly, as part of the clinical doctorate requirements the literature review was developed into a proposed journal article (Appendix 6). This proposed article has been developed using the guidelines by International Journal of Nursing Practice and will then follow the submission process of this journal. Thirdly, the findings of this study will be developed into another journal publication and submitted to an appropriate journal so as to disseminate the significant findings of this study to others within the field. I will also submit abstracts to Sigma Theta Tau Nursing Conference, Seattle, USA and Alzheimer’s Disease International 36th Global Conference, Lyon, France to disseminate the findings and encourage further discussions.

6.8: Thesis Conclusion

My study has been guided by hermeneutic phenomenological approach which supported the interpretation of the experiences of nurses to seeking support when caring for a person with dementia. This approach introduced to me an alternative lens and to be open to exploring the phenomenon through different windows of experience. Overall, this study has been able to contribute significantly and show new understanding to how nurses seeking support when caring for a person with dementia. These recommendations have implications for clinical practice, policy and dementia care infrastructure. These findings and recommendations, once disseminated, hope to improve, increase and clarify the support that nurses need to care for a person with dementia in an acute hospital setting.

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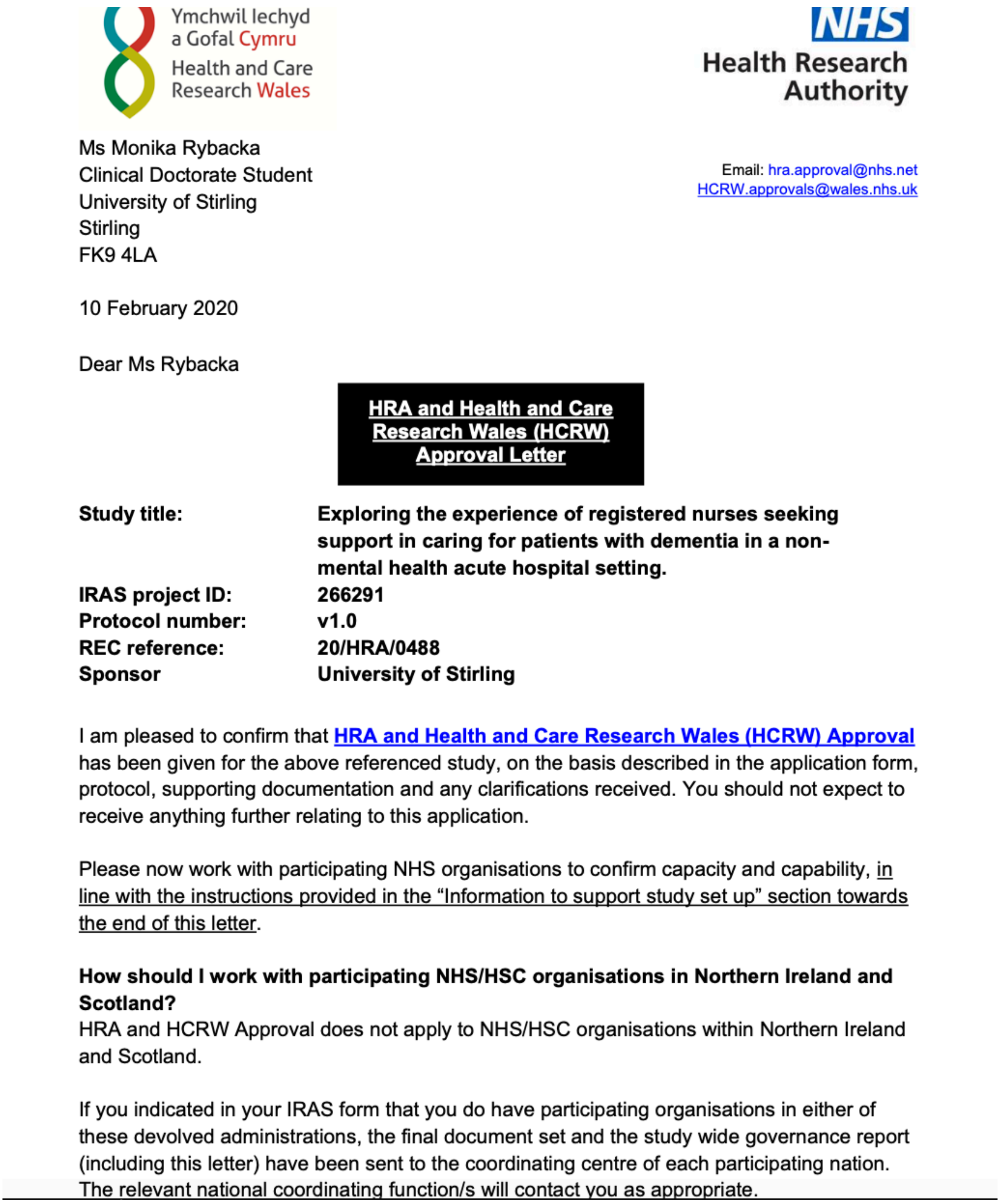
Appendix 1: Ethical Approval



Ymchwil Iechyd
a Gofal Cymru
Health and Care
Research Wales

NHS
Health Research
Authority

Ms Monika Rybacka
Clinical Doctorate Student
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FK9 4LA

Email: hra.approval@nhs.net
HCRW.approvals@wales.nhs.uk

10 February 2020

Dear Ms Rybacka

HRA and Health and Care Research Wales (HCRW) Approval Letter

Study title:	**Exploring the experience of registered nurses seeking support in caring for patients with dementia in a non-mental health acute hospital setting.**
IRAS project ID:	**266291**
Protocol number:	**v1.0**
REC reference:	**20/HRA/0488**
Sponsor	**University of Stirling**

I am pleased to confirm that **HRA and Health and Care Research Wales (HCRW) Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

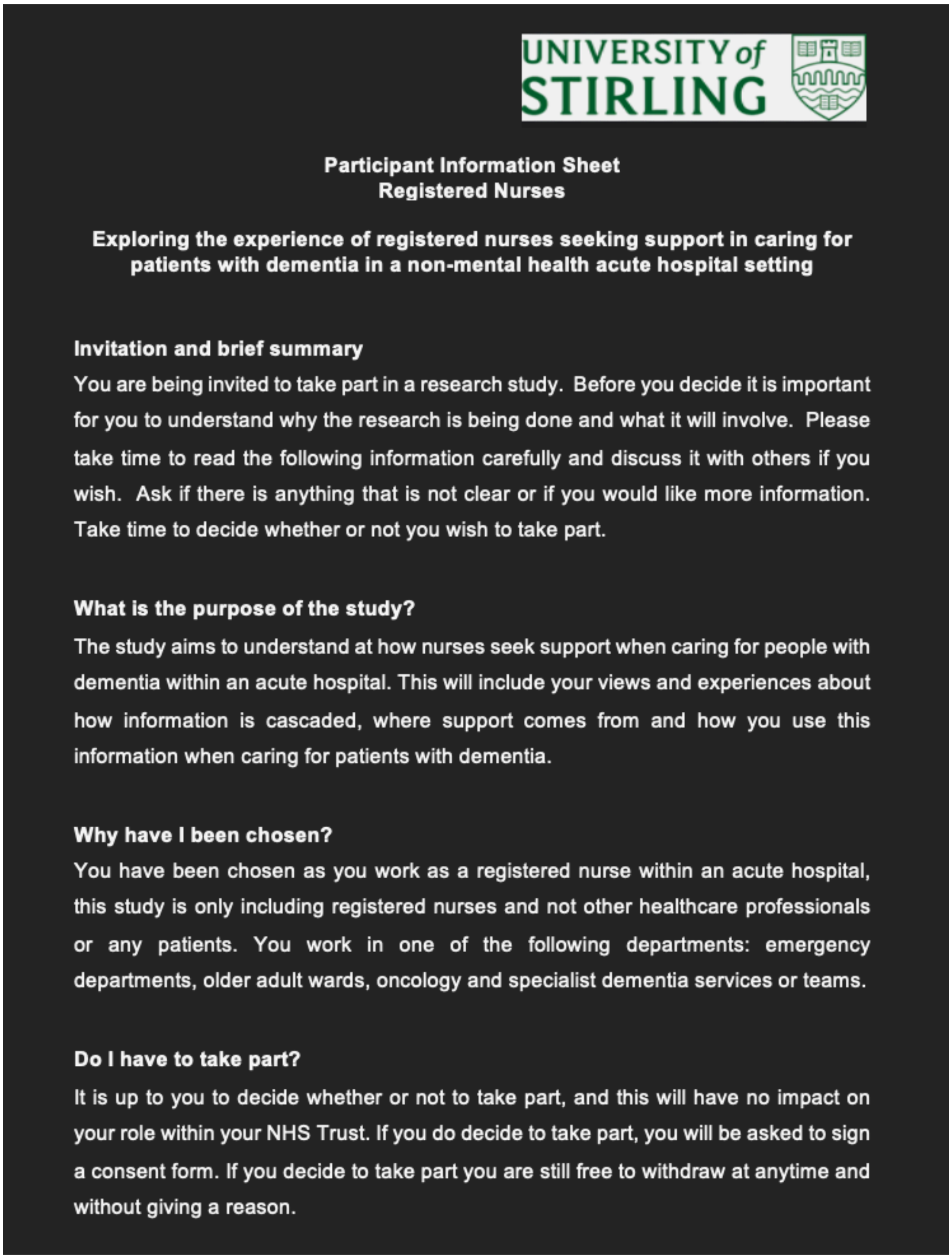
Please now work with participating NHS organisations to confirm capacity and capability, in line with the instructions provided in the "Information to support study set up" section towards the end of this letter.

How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?

HRA and HCRW Approval does not apply to NHS/HSC organisations within Northern Ireland and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report (including this letter) have been sent to the coordinating centre of each participating nation. The relevant national coordinating function/s will contact you as appropriate.

Appendix 2: Participant Information Sheet



UNIVERSITY of STIRLING

Participant Information Sheet
Registered Nurses

Exploring the experience of registered nurses seeking support in caring for patients with dementia in a non-mental health acute hospital setting

Invitation and brief summary

You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

What is the purpose of the study?

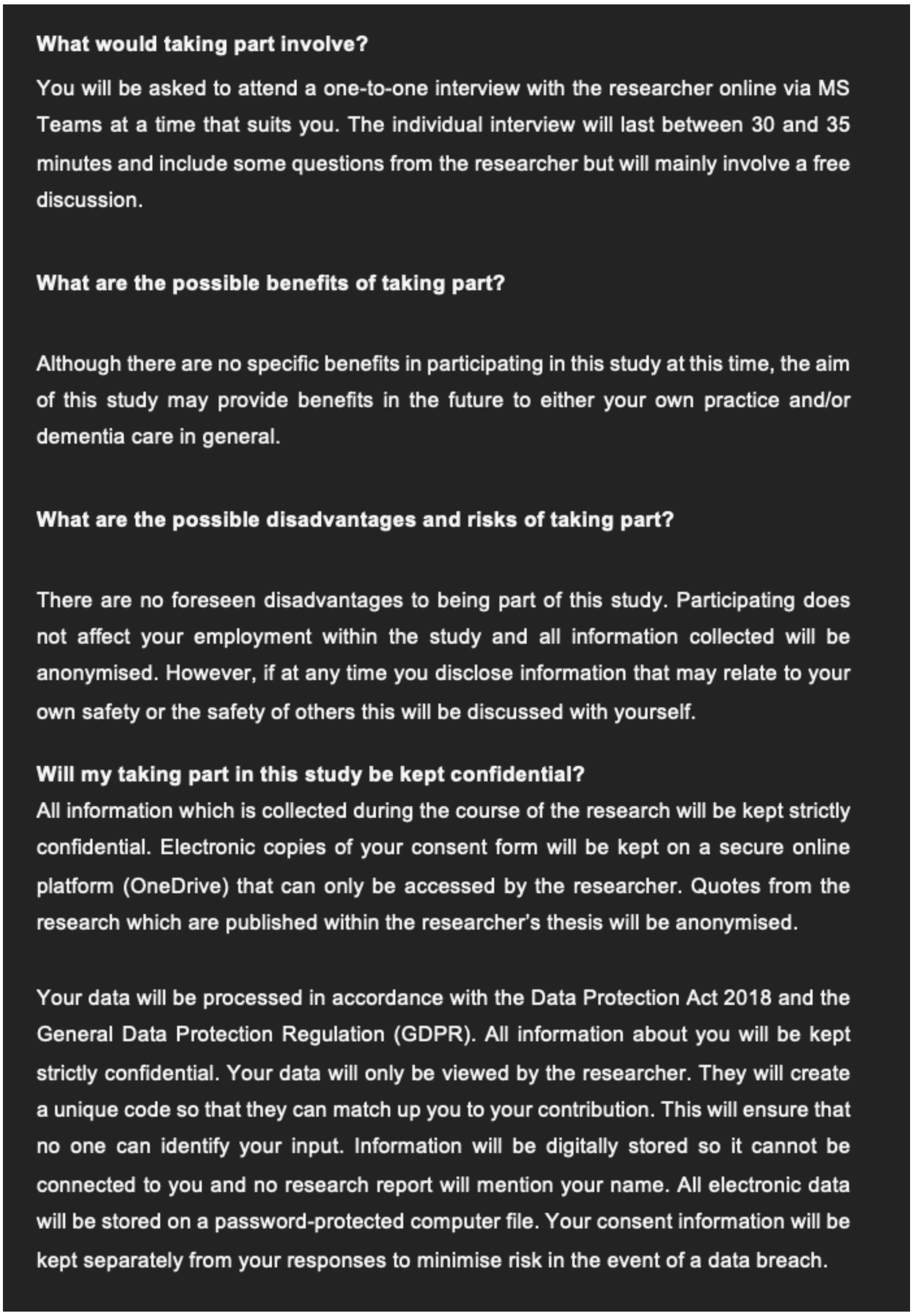
The study aims to understand at how nurses seek support when caring for people with dementia within an acute hospital. This will include your views and experiences about how information is cascaded, where support comes from and how you use this information when caring for patients with dementia.

Why have I been chosen?

You have been chosen as you work as a registered nurse within an acute hospital, this study is only including registered nurses and not other healthcare professionals or any patients. You work in one of the following departments: emergency departments, older adult wards, oncology and specialist dementia services or teams.

Do I have to take part?

It is up to you to decide whether or not to take part, and this will have no impact on your role within your NHS Trust. If you do decide to take part, you will be asked to sign a consent form. If you decide to take part you are still free to withdraw at anytime and without giving a reason.



What would taking part involve?

You will be asked to attend a one-to-one interview with the researcher online via MS Teams at a time that suits you. The individual interview will last between 30 and 35 minutes and include some questions from the researcher but will mainly involve a free discussion.

What are the possible benefits of taking part?

Although there are no specific benefits in participating in this study at this time, the aim of this study may provide benefits in the future to either your own practice and/or dementia care in general.

What are the possible disadvantages and risks of taking part?

There are no foreseen disadvantages to being part of this study. Participating does not affect your employment within the study and all information collected will be anonymised. However, if at any time you disclose information that may relate to your own safety or the safety of others this will be discussed with yourself.

Will my taking part in this study be kept confidential?

All information which is collected during the course of the research will be kept strictly confidential. Electronic copies of your consent form will be kept on a secure online platform (OneDrive) that can only be accessed by the researcher. Quotes from the research which are published within the researcher's thesis will be anonymised.

Your data will be processed in accordance with the Data Protection Act 2018 and the General Data Protection Regulation (GDPR). All information about you will be kept strictly confidential. Your data will only be viewed by the researcher. They will create a unique code so that they can match up you to your contribution. This will ensure that no one can identify your input. Information will be digitally stored so it cannot be connected to you and no research report will mention your name. All electronic data will be stored on a password-protected computer file. Your consent information will be kept separately from your responses to minimise risk in the event of a data breach.

What will happen to the results of the study?

The study is part of the completion of a Clinical Doctorate in Nursing at The University of Stirling and the results will be presented as part of the researcher's thesis and oral viva.

Who has reviewed the study?

The study has been reviewed by NHS, Invasive or Clinical Research Ethical Committee, Stirling University (No 19/20 - 063), the National Research Ethics Committee (IRAS 266291).

Further Contact

Any further questions or if you would like to make a complain regarding this research, please contact:

Monika Rybacka, Clinical Doctorate Student
Email: mor1@stir.ac.uk

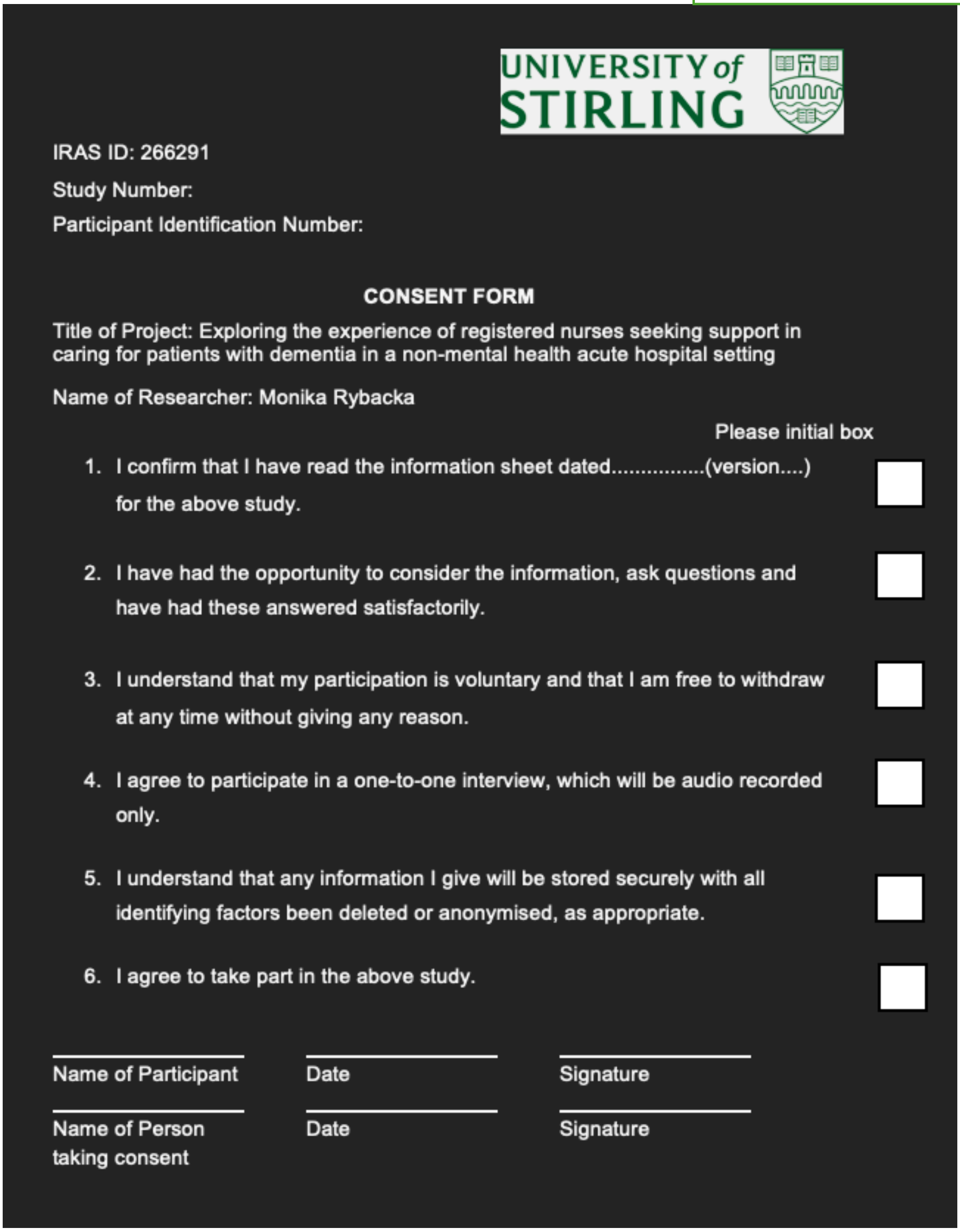
Jayne Donaldson, Head of Faculty, University of Stirling
Email: jayne.donaldson@stir.ac.uk

Further Signposting

If you wish to find out more information about dementia care or services, please access these relevant websites:

www.alzheimers.org.uk
https://www.nice.org.uk/guidance/ng97
www.demenitauk.org

Appendix 3: Consent Form



UNIVERSITY of STIRLING

IRAS ID: 266291

Study Number:

Participant Identification Number:

CONSENT FORM

Title of Project: Exploring the experience of registered nurses seeking support in caring for patients with dementia in a non-mental health acute hospital setting

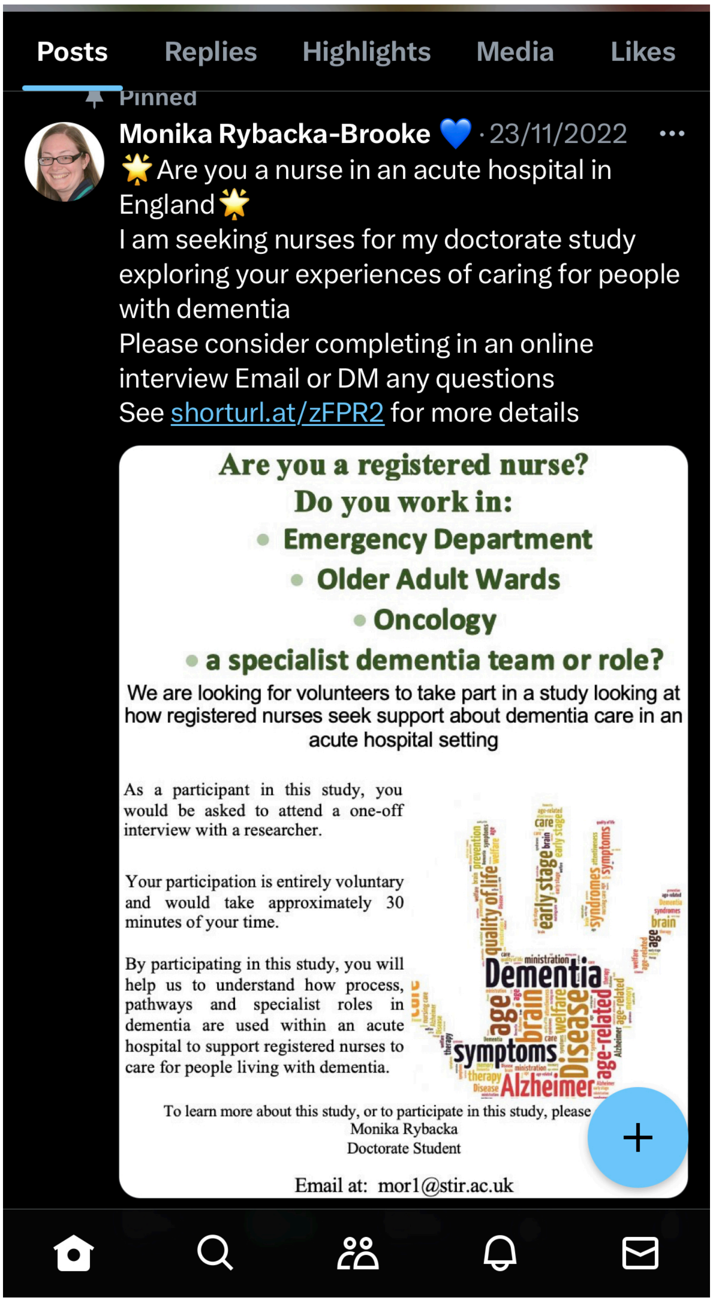
Name of Researcher: Monika Rybacka

Please initial box

1. I confirm that I have read the information sheet dated................(version....) for the above study. ☐
2. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐
3. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason. ☐
4. I agree to participate in a one-to-one interview, which will be audio recorded only. ☐
5. I understand that any information I give will be stored securely with all identifying factors been deleted or anonymised, as appropriate. ☐
6. I agree to take part in the above study. ☐

Name of Participant	Date	Signature
Name of Person taking consent	Date	Signature

Appendix 4: Social Media Posts



Monika Rybacka-Brooke 💙 · 23/11/2022

🌟 Are you a nurse in an acute hospital in England 🌟
I am seeking nurses for my doctorate study exploring your experiences of caring for people with dementia
Please consider completing in an online interview Email or DM any questions
See shorturl.at/zFPR2 for more details

Are you a registered nurse?
Do you work in:

- **Emergency Department**
- **Older Adult Wards**
- **Oncology**
- **a specialist dementia team or role?**

We are looking for volunteers to take part in a study looking at how registered nurses seek support about dementia care in an acute hospital setting

As a participant in this study, you would be asked to attend a one-off interview with a researcher.

Your participation is entirely voluntary and would take approximately 30 minutes of your time.

By participating in this study, you will help us to understand how process, pathways and specialist roles in dementia are used within an acute hospital to support registered nurses to care for people living with dementia.

To learn more about this study, or to participate in this study, please
Monika Rybacka
Doctorate Student

Email at: mor1@stir.ac.uk

Appendix 5: Interview Structure Guide

Hello. Thank you for agreeing to meet with me today.
Are you in a comfortable environment and happy to talk to me today?
Have you been able to read the PIS and consent form?
Do you have any questions regarding the PIS? Address accordingly
Do you have any questions regarding the consent form? Address accordingly

I will now start the recording

Can you tell me the department you work in?
How many years have you been a registered nurse?

Now I am going to ask you a series of questions that relate to my research topic of how staff seek support to care for people living with dementia. I would like this to be a comfortable conversation rather than me firing questions, so I will ask questions to start the conversation and then may ask some follow up questions depending on your responses.

Is that ok?

Can you tell me about a time that you sought support to care for a patient with dementia?

Prompt questions: what element of care did you need support about? what element of care did you need advice for? Where did you go? Who did you ask?

Where are the main areas of caring for a patient with dementia did you go to seek support about?

Prompt questions: did you seek education? Did you ask for problem-solving? Did you receive any follow up support following implementing the advice?

Can you tell me about a time when you have not sought support, as you have used support you received previously, or has this not occurred?

What other support do you think would be helpful?

Can you tell me about any barriers that you have experienced when seeking support?

Can you tell me what helped you seeking support?
Do you have anything else to add?

Thank you, that is the end of my questions. Do you have any questions for me?

So today you participated in my clinical doctorate, you have all the information you need on the PIS, you have my email if you have any further queries of questions.

I appreciate you agreeing to this interview. Bye!

Appendix 6: Journal Publication: Rybacka, M., Hoyle, L., Stoddart, K (2025) To Be Submitted (TBS)

Title

An exploration of how adult registered nurses seek support, help or guidance for their own clinical practice in an acute hospital setting: A systematic literature review

Abstract

Aims: To understand how and why nurses in acute hospitals seek support for a clinical need.

Background: Nurses are committed to providing skilled, compassionate care, often in challenging conditions that test their physical, mental, emotional, and ethical resilience. Nurses frequently engage in sensitive conversations with patients and families, confronting social and ethical dilemmas. However, there remains a need to understand a nurse's experiences of seeking support to manage these complex situations.

Design: A systematic literature review

Data Sources: The inclusion and exclusion criteria informed the search strategy of MeSH and Boolean operators, which were applied to search CINAHL, Psychinfo, MEDLINE, Google Scholar and Grey Open, for literature published between January 2000 and July 2024.

Review Methods: The PRISMA guideline for reporting systematic reviews guided the development of this paper. Manual searching of the reference lists of all identified studies were completed. Standardised critical appraisal instruments were applied to each included study. Data extraction and analysis was completed by adhering to narrative synthesis described by the Economic and Social Research Council Methods Programme (Popay et al, 2008).

Results: The electronic database and reference list search identified 24,851 studies which was reduced to the inclusion of eight articles. Following screening, studies were completed in Australia (n=3), USA (n=2), Ireland (n=1), Netherlands (n=1) and New Zealand (n=1). A total of 883 nurses sought support for a clinical need. Three themes were identified (1) the need for peer support; (2) the need for emotional support; and (3) unmet needs and competing tasks.

Conclusion: The complexities and demands of working in acute care settings often requires nurses to seek help not just for clinical expertise but also for emotional reassurance. Peer support was found to be a significant method in fostering and developing support networks.

Keywords

Systematic review, nursing, support, acute hospitals

Introduction

The inherent unpredictability of healthcare environments, especially in emergency departments and specialised care units, requires nurses to be adaptable, resilient, and capable of making rapid, high-stake decisions under significant time constraints (Benner et al, 2008). The pressures of these settings, with their high patient turnover, fluctuating caseloads, and diverse patient needs, create a unique set of challenges for nursing staff. Many of these patients present with acute or complex conditions that require specialised skills (Carayon and Gurses, 2008).

The need for support among nurses expands to the emotional impact associated with roles in healthcare (Pohl et al, 2022). Emergency department nurses regularly experience heightened stress from treating patients in critical conditions, which can lead to emotional fatigue and burnout if they lack adequate support (Guttormson et al, 2022). The rapid decision-making required in acute settings can be cognitively demanding, particularly when nurses are responsible for making independent clinical judgments in situations where patient needs evolve quickly (Friese et al., 2008). Therefore, the focus of this review includes how and why nurses seek support, help and guidance for a clinical need.

In this context, support could refer to the broad range of resources, staff, and systems available to help nurses manage their workload effectively. Support systems may include teamwork, collaborative care, and access to specialized expertise, which are critical in high-intensity settings. In many cases, interprofessional collaboration plays a role, as nurses may rely on occupational therapists, social workers, or physicians to address specific patient needs that extend beyond their scope of practice (Bosch and Mansell, 2015). Effective support could significantly reduce burnout among nursing staff and improve patient care by ensuring nurses have access to the expertise and resources needed to manage complex cases (Cohen et al., 2023).

Help represents immediate, direct assistance with specific tasks or patient needs, especially when nurses face time constraints or physical demands. Studies have shown that nurses often experience task overload, leading to increased stress and the risk of errors, which in turn can negatively impact patient safety (Carayon and Gurses, 2008). In settings with high demands, such as emergency departments, help from colleagues or additional personnel can be essential for providing timely and safe care (Hansen et al, 2020).

Guidance involves the provision of expert advice, protocols, or best practice frameworks that enable nurses to make informed decisions, especially in situations involving complex patient cases. Guidance may come from senior colleagues, clinical supervisors, or access to standardised care pathways designed to address specific patient conditions. This support is particularly critical when nurses encounter unfamiliar or high-risk situations, such as the care of acutely agitated patients, where safety concerns for both staff and patients are paramount (Mulkey and Munro, 2021).

The distinct roles of support, help, and guidance are foundational in the nursing profession, helping to alleviate the pressures associated with complex healthcare environments. These forms of assistance are important not only for delivering effective patient care but also for promoting a sustainable work environment for nursing staff. As nursing roles expand to encompass greater responsibilities and autonomy, structured systems of support, help, and guidance will become increasingly essential to address the dynamic demands of healthcare and ensure that nurses can provide safe, high-quality care.

Review Methods

Aim

The aim is to understand how and why nurses in acute hospitals seek support for a clinical need through a systematic review of the literature.

Design

The design of the review was a systematic review. The process of the systematic review was supported by adhering to the guidelines of Wright et al, (2007). The Preferred Reporting Items for Systematic review and Meta-Analyses (PRISMA) guidelines for reporting systematic reviews have been adhered to within this paper (Page et al, 2021).

Search methods

The following databases were searched, CINAHL Complete, which focuses on the nursing and allied health care research within north American and Europe; Medline (PubMED) an extensive medical, nursing and allied healthcare focus; APA PychINFO, which focuses on psychology and psychiatry focus. Google Scholar, Grey Literature and the manual searching of references lists did not produce any articles.

The search for and selection of, studies was informed by predetermined inclusion and exclusion criteria (refer to Table 1).

Table 1

Inclusion and exclusion criteria

Criteria	**Inclusion Criteria**	**Exclusion Criteria**
Date	Jan 2000 – July 2024	Any prior to December 1999
Exposure of interest	Seeking support Seeking knowledge or expertise	Seeking support for promotion Seeking support for a grievance or staff related issue
Geographic location of study	Worldwide acute hospital settings	No limitations
Language	English	Published in any language other than English
Participants	Adult nurses	Other healthcare professionals including doctors, midwives, newly qualified preceptor nurses and HCAs Child nurses, learning disability nurses, mental health nurses Obstetrics, paediatrics and other child- related departments
Peer Review	Peer reviewed academic journals	
Reported Outcomes	Clinical need Patient illness or presentation	Research involving staffing, retention or safety Support given to patients by nurses

	Own wellbeing	
Settings	Acute hospitals	Mental health settings Primary care setting including GPs Long-term care or nursing homes
Study Design	No limitations	
Type of publication	Primary research	Editorials, opinion or discussion papers, dissertations, case studies, reviews of the literature

Search outcome

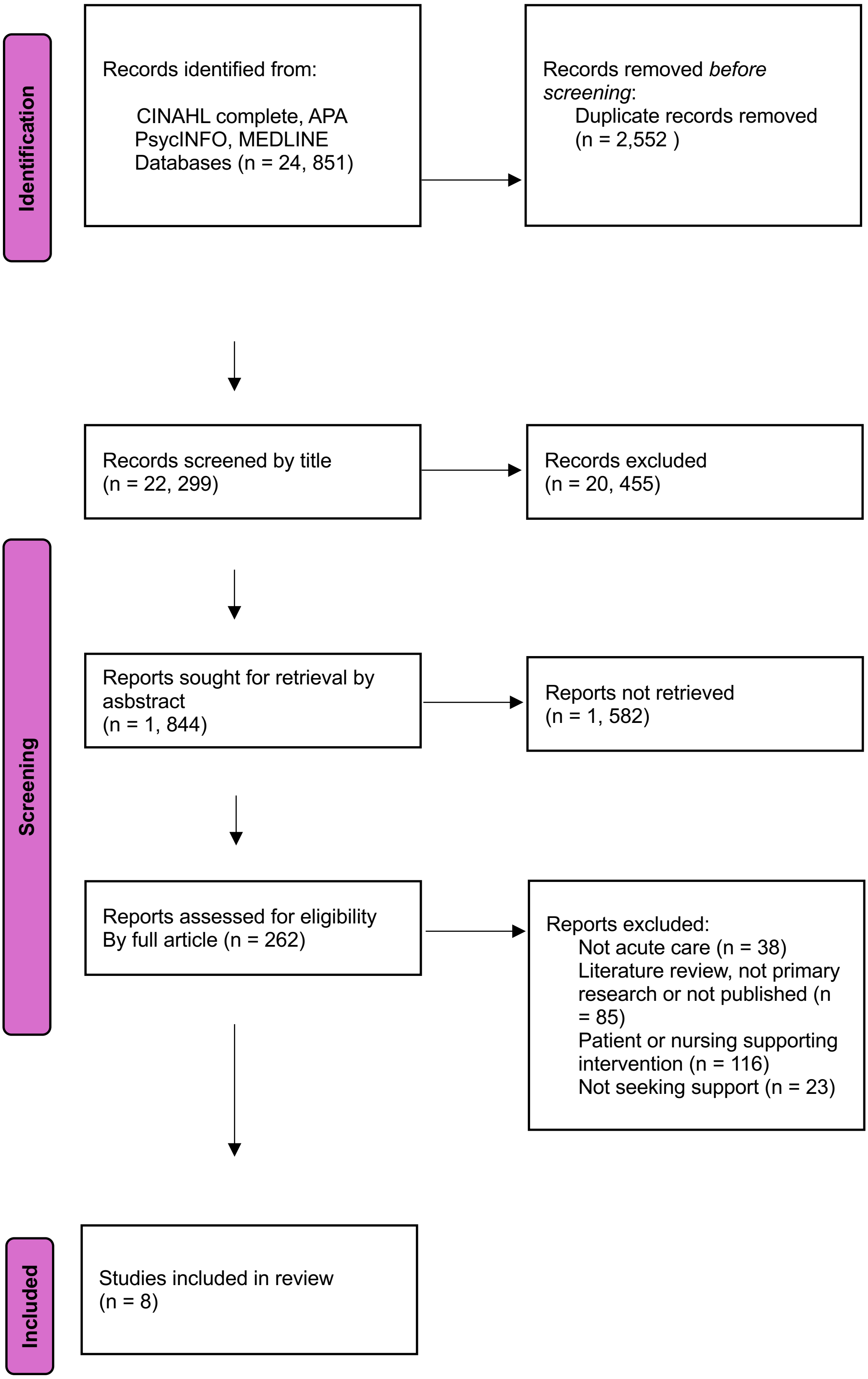
The search strategy was broad to ensure the capture of all relevant work. The following keywords were used to support the searching of the databases, with the inclusion of recognised Medical Subject Headings (MeSH) and Boolean operators of AND/OR:

(*Nurse or nurses or nursing or nursing staff or registered nurse)* **AND** *(seeking or use or practice*) **AND** *(support or help or guidance)* **OR** *(expert or expertise)* **AND** *(acute care or acute setting or acute hospital or inpatient).*

The initial searches identified 24, 851 studies, which was reduced to 22, 299 following the removal of duplicates. Titles and abstracts were read and screened for inclusion criteria and 22, 037 studies were excluded. The full remaining 262 articles were retrieved for full text review. Of these eight articles met the inclusion criteria (refer to Fig. 1, which presents an overview of this process and the reasons for excluding studies). Two authors completed this process independently and then discussed and agreed the inclusion of studies.

Fig. 1. PRISMA Flow chart of search data.

From: Page, M, J., McKenzie, J, E., Bossuyt, P, M., Boutron, I., Hoffmann, T, C., Mulrow, C, D (2021) The PRISMA 2020 Statement: an updated guideline for reporting system reviews. BMJ; 372:n71. Doi: 10.1136/bmj.n71



On completion of the application of inclusion and exclusion criteria eight studies were included within the systematic review, of which four applied a qualitative approach (Cronin et al, 2001; Currey et al, 2006; Peterson et al, 2010; Marshall et al, 2011), three a cross-sectional approach (Hofmann et al, 2009; Huijten et al, 2021; Bundz et al, 2016), and one a mixed methods approach (Irvine, 2024). Three studies were conducted in Australia (Bundz et al, 2016; Currey et al, 2006; Marshal et al, 2011), two in the United States of America (Hofman et al, 2009; Peterson et al, 2010), one in Ireland (Cronin et al, 2011) one in the Netherlands (Huijten et al, 2021), and one in New Zealand (Irvine et al, 2024). The number of participants in each study ranged significantly due to the methods of each study, participants within qualitative studies ranged from 5 to 38, with a total of 87 participants, the quantitative and mixed methods studies ranged from 50 to 315, with a total of 746 participants. Overall, the number of participants within the studies and this systematic literature review was 833 nurses.

Quality appraisal

The methodological rigor and quality of each study were independently assessed using standardised critical appraisal instruments. For four qualitative studies, the Critical Appraisal Skills Programme (CASP) checklist was applied (CASP, 2018). Each study presented clear aims, appropriate methodologies, effective data collection and recruitment strategies, and rigorous analyses with clearly stated findings (Cronin et al., 2001; Currey et al., 2006; Peterson et al., 2010; Marshall et al., 2011). However, three studies did not disclose the relationship between researchers and participants (Cronin et al., 2001; Peterson et al., 2010; Marshall et al., 2011). Additionally, two studies lacked explicit exploration of ethical considerations (Cronin et al., 2001; Currey et al., 2006).

For three cross-sectional studies, critical appraisal was performed using the Joanna Briggs Institute's (JBI) checklist (Moola, 2017). These studies defined clear inclusion criteria and described the participants, setting, and exposure, which included clinical practice, education, and experience of the nurses (Hofmann et al., 2009; Huijten et al., 2021; Bundz et al., 2016). However, two studies measured outcomes through study-specific questionnaires without discussing their validity and reliability (Hofmann et al., 2009; Bundz et al., 2016), while only Huijten et al. (2021) utilised previously validated instruments.

One mixed-methods study (Irvine, 2024) was appraised using the Mixed Methods Critical Appraisal Tool (Hong et al., 2018), which clearly articulated the research question and justified the mixed methods approach, employing qualitative data collection for in-depth analysis, illustrated with direct quotes. However, the quantitative component, a cross-sectional survey, did not address sample representativeness, response completeness, or confounding variables, and the integration of qualitative and quantitative findings lacked exploration of divergences and inconsistencies (Irvine, 2024).

Data abstraction

The data extraction process was completed following the guidelines of Wright et al (2007). A data extraction table was completed, and included the first author, year and country; aim; design, participant population, data collection and analysis; findings; and discussion. On completion an independent colleague checked the table for accuracy.

Data Synthesis

Narrative synthesis involves the development of synthesization of the data found within the included studies, rather than organising the data chronologically or by methodological sequence (Sutton, 2016). Due to the wide scope of the literature review question including the interventions and outcome measures, a narrative synthesis was completed. A narrative synthesis addresses the four processes described by the Economic and Social Research Council (ESRC) Methods Programme (Popay et al, 2008). The first stage will be to identify and explore the elements of how and why nurses seek support, this will enable the development of concepts exploring the practical elements of when, how and who provides support. This then will be followed by identifying patterns across the studies and any relationships between the data. Lastly, the generalisability of the results will be explored in the interpretation of the results.

Results

Each study examined how and why nurses sought support across various clinical practices. This support varied widely, covering areas such as burn care (Cronin et al., 2001), spinal cord injury management (Bundz et al., 2016), postoperative cardiac care (Currey et al., 2006), palliative care for dementia patients (Huijten et al., 2021), responses to violence in emergency departments (Irvine et al., 2024), clinical decision-making in ICU (Marshall et al., 2011), and coping with patient death (Peterson et al., 2010). One study focused more generally on nurses' support-seeking behaviours (Hofman et al., 2009).

Three key concepts of support emerged from the narrative synthesis analysis: (1) the need for peer support; (2) the need for emotional support; and (3) unmet needs and competing tasks.

Concept 1: The Need for Peer Support

Nurses often face complex clinical scenarios, prompting them to seek support from peers, which may include colleagues, senior nursing staff, or other healthcare professionals. In acute settings, informal discussions and consultations with experts were common methods of obtaining support. In spinal cord injury management, nurses consulted wound care specialists to address complex needs beyond their expertise (Bundz et al., 2016). Whilst anaesthetists' handovers were crucial in guiding nurses' patient care decisions (Currey et al., 2006). Furthermore, nurses sought advice from registrars and medical officers (Marshall et al., 2011).

Support from nursing peers, including team leaders and clinical nurse specialists, as nurses often preferred to consult nurses who they considered were experts (Peterson et al., 2010; Marshall et al., 2011). Peer support was frequently informal, taking place during breaks or outside work environments (Cronin et al., 2001), although some nurses viewed this approach as unhealthy. The role of religious support was identified, as nurses sought solace from clergy when coping with challenging situations (Peterson et al., 2010).

Nurses acknowledged their limitations and actively sought support from experienced peers they deemed trustworthy. Most of this support related to clinical decision-making, but it also provided comfort during emotional challenges.

Concept 2: The Need for Emotional Support

Nurses required emotional support to navigate the stresses of their roles, particularly when caring for patients with severe conditions or facing difficult outcomes. Effective emotional support included access to counselling services, peer groups, and mechanisms for stress relief, all of which are vital for preventing burnout.

Nurses in high-stress environments, such as burns units or palliative care, relied on strong informal networks to process the emotional impact of their work. For example, nurses described their units as “a type of family” where sharing experiences provided therapeutic relief (Cronin et al., 2001; Peterson et al., 2010). Emergency department nurses also expressed the emotional toll of aggression from patients, often leading to feelings of self-blame (Irvine et al., 2024). Despite the recognition of the importance of emotional support, many nurses did not seek support through their organizations, fearing it would be perceived as weakness. Instead, they often relied on prior education and peer discussions (Huijten et al., 2021). Additionally, some nurses found comfort in their religious beliefs, with spiritual discussions providing a means to cope with patient deaths (Peterson et al., 2010). This illustrates the blend of structured support systems and informal networks nurses utilise to address their emotional needs.

Concept 3: Unmet Needs and Competing Tasks

The competing responsibilities nurses experienced prevented them from addressing their emotional needs. Nurses identified insufficient time during shifts to express or cope with emotions, often prioritising patient care over personal well-being (Cronin, 2001; Irvine et al., 2024; Huijten et al., 2021). The demanding nature of emergency departments limits opportunities for debriefing after traumatic incidents (Irvine et al., 2024).

Nurses often postponed seeking support, deeming it inappropriate as they remained focused on patient needs. While many recognised the necessity of emotional support, 75% felt debriefing after difficult situations was crucial yet feared being seen as incapable if they asked for help (Irvine et al., 2024). Nurses felt isolated in their support-seeking efforts, with many stating, “We are very much left to find our own support” (Cronin, 2001, p. 346). Informal networks emerged as critical support mechanisms, especially for experienced nurses, while newly qualified nurses often lacked these informal networks. Nurses also reported challenges accessing literature for support, feeling overwhelmed by the process and critiquing research literature (Marshall et al., 2011). Nurses preferred human support but struggled to use electronic resources effectively, sometimes resorting to unreliable internet searches.

The need for time significantly affected how nurses seek support. The pressure to prioritise patient needs often prevents them from addressing their emotional well-being, leading to a perception that seeking help indicates weakness. Understanding these unmet needs is vital for creating a more supportive environment for nurses, ultimately benefiting healthcare systems.

Discussion

The systematic literature review illuminated several aspects of how and why registered nurses seek support, guidance, and expertise in their clinical practice, particularly in acute hospital settings. Findings revealed nurses frequently sought help from peers perceived as experts and required emotional support due to their roles, patient deaths, or complex clinical situations. Many nurses experienced a lack of time to express and cope with their emotions and had no structured support for seeking help (Bundz et al., 2016; Cronin, 2001; Hofmann et al., 2009; Irvine et al., 2024; Peterson et al., 2010; Huijten et al., 2021; Marshall et al., 2011). This review will discuss these findings within the wider published literature.

Concept 1: The Need for Peer Support

Acute care involves short-term, intensive treatment for patients with severe or life-threatening conditions, typically in emergency departments (EDs) and intensive care units (ICUs) (Hirshon et al., 2013). The demanding pace of these environments requires nurses to possess extensive knowledge. However, even experienced nurses may face challenges with complex cases, prompting them to seek expertise from senior nurses or consultants (Peterson et al., 2010; Marshall et al., 2011; Hofmann et al., 2011). This reliance on specialised knowledge highlights the importance of interdisciplinary teamwork in addressing the multifaceted needs of critically ill patients (Bendowska and Baum, 2023).

Nurses often sought support from peers with valuable experience (Hofmann et al., 2009; Currey et al., 2006). Peer consultation enhances professional development and patient care outcomes, allowing nurses to share knowledge and refine decision-making skills (Rosen et al., 2019). Moreover, peer mentoring correlates with increased job satisfaction and reduced burnout (Galanis et al., 2023).

Research emphasises the interplay of nurse education, experience, and clinical expertise, indicating that higher education positively impacts patient outcomes (McHugh and Lake, 2011). Trust and interpersonal relationships are also critical, enhancing teamwork and communication in patient care (O'Leary et al., 2012). Nurses seek both clinical and emotional support, valuing direct communication with trusted colleagues over literature (Peterson et al., 2010; Marshall et al., 2011). Real-time interactions provide immediate feedback in high-pressure scenarios, fostering a collaborative environment essential for building trust and teamwork (Papathanasiou et al., 2014; Benner et al., 2008).

Concept 2: The Need for Emotional Support

Emotional support among peers plays a key role in helping nurses manage stress and prevent burnout, especially in high-pressure environments like ICUs (Simms et al., 2023). This support is essential for coping with the emotional demands of nursing, given the profession's significant emotional burden (Browne and Tie, 2024). Studies by Cronin (2001) and Peterson et al. (2010) identified how nurses use informal interactions, such as coffee breaks or social outings, to share experiences and manage emotional stress. Such peer support allows candid discussions in a safe environment, mitigating stress and enhancing resilience (Pereira et al., 2021; Williams et al., 2022).

Informal networks not only foster camaraderie but also contribute to job satisfaction and provide professional development opportunities, as peers often share valuable insights and best practices (Ben Natan et al., 2015; Winslow et al., 2019). Many nurses liken these relationships to a "family" structure, where emotional bonds help reduce isolation and enhance well-being (McAllister and Brien, 2019). However, the need to appear "tough" in high-stress areas like EDs can lead nurses to suppress emotions, increasing their risk of burnout and compassion fatigue (Irvine et al., 2014; Han et al., 2023).

In addition to peer support, some nurses seek spiritual guidance, turning to religious figures for emotional relief (Peterson et al., 2010). While spirituality can provide solace, structured psychological support is also beneficial. Nonetheless, the lack of formal support systems in many healthcare settings leaves nurses to rely primarily on informal networks for emotional support.

Concept 3: The Unmet Need and Competing Tasks

Nurses identified a lack of time during shifts to seek necessary support, especially after clinical scenarios or patient deaths (Cronin, 2001; Irvine et al., 2024; Hujjten et al., 2021). Time constraints and workload pressures often prevent nurses from seeking emotional and peer support, leading to potential burnout and compassion fatigue (Montgomery et al., 2015). Nurses prioritise patient needs over their emotional distress, often suppressing emotional responses (Irvine et al., 2024; Hujjten et al., 2021). This phenomenon relates to "emotional labour," wherein nurses manage their emotions to meet professional expectations, potentially leading to emotional exhaustion over time (Kinman and Leggetter, 2016).

Many nurses lacked organisational support structures, relying on informal networks to manage emotional burdens (Peterson et al., 2010; Cronin, 2001). The absence of formal support, like debriefing sessions, increases the risk of burnout (Abram and Jacobowitz, 2021). NHS Trusts that implement structured emotional support systems report improved nurse well-being and retention, indicating that such initiatives are crucial (Sovold et al., 2021; Browne and Tie, 2024). Electronic resources for support were underutilised, as nurses often defaulted to general web searches due to inadequate skills and training (Fossum et al., 2022). This reflects a broader issue in healthcare technology integration, as many nurses feel unprepared to navigate electronic systems efficiently (Salameh et al., 2019).

Strengths and Limitations of the Studies

This literature review incorporated multiple databases and grey literature to capture relevant articles, ensuring rigor through independent screening processes. While it included studies from diverse healthcare systems, its limitation lies in including only English-language articles. Additionally, critical appraisal is essential when interpreting results and conclusions.

Generalisability and transferability of the findings

The systematic literature review reveals several elements that enhance the generalisability and transferability of its findings. The inclusion of studies from diverse acute care environments, such as emergency departments and intensive care units, broadens the applicability of the insights regarding nurses' support-seeking behaviours. The emphasis on interdisciplinary collaboration highlights that nurses seek support not only from peers but also from various healthcare professionals, suggesting that effective support dynamics are essential across different settings.

The significance of informal support networks, including casual interactions among nurses, emerges as crucial for emotional support and coping strategies. These findings can inform healthcare organisations aiming to cultivate a culture of open communication and peer interactions, ultimately enhancing job satisfaction and reducing burnout. This understanding of informal networks can guide policy changes and training programs, ensuring the insights remain relevant across various nursing and healthcare contexts.

Conclusion

In conclusion, the need for emotional support in nursing in acute care settings, has been found within the findings of this literature review. Nurses depend on trusted colleagues for both clinical advice and emotional reassurance, creating a collaborative and emotionally supportive work environment. However, challenges such as time constraints, inadequate formal support systems, and underutilized electronic resources continue to hinder nurses' ability to fully access the support they need.

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