Tailoring Dementia Care Mapping and Reflective Practice to empower Assistants in Nursing to provide quality care for residents with dementia

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KEYWORDS

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ABSTRACT

Objective
The study addressed one central aim. This was to explore the experience of Assistants in Nursing being exposed to Dementia Care Mapping coupled with reflection to improve older residents care in a residential aged care facility.

Design and Setting
A qualitative exploratory design was employed to gain an in-depth understanding of Assistants in Nursing experience of creating new care for older residents using Dementia Care Mapping and feedback. The study was conducted in a dementia specific nursing home, located in urban Sydney, New South Wales, Australia.

Subjects
The study participants were ten Assistants in Nursing and five older residents diagnosed with mild to moderate dementia by a Physician.

Results
For the first time, the study illuminated the Assistants in Nursing innovative care following Dementia Care Mapping feedback and reflection. Their experience was highlighted in three major themes: (i) Reflecting on Care (ii) Creating a Caring Connection and (iii) Empathetic Communication.

Conclusion
These Assistants in Nursing valued and used findings from Dementia Care Mapping feedback coupled with reflection to improve contemporary practice. In addition, they felt empowered to create new nursing strategies for quality care. The study highlighted the usefulness of providing Assistants in Nursing with these types of educational strategies to encourage the development of creative caring for residents with dementia living in a residential aged care facility.

INTRODUCTION

In Australia, the number of people diagnosed with dementia is projected to increase, with cases escalating from 245,000 in 2009, to 1.13 million by 2050 (Alzheimers Australia, 2009). For older people aged 65 and over, the likelihood of living with dementia doubles every five years. Dementia is a syndrome encompassing a progressive effect on cognition, personality, and activities of daily living (Nicholls et al 2014). Older persons with dementia were more likely than those without dementia to require high care (87% vs. 63%) (Australian Institute of Health and Welfare, 2013; Australian Institute of Health and Welfare, 2012). The Australian government identified dementia as a National Health Priority (NSW Department of Health, 2006). Critical questions in contemporary nursing practice continue to arise concerning enhanced quality care for older residents living with dementia in Residential Aged Care Facilities (RACFs). For example, what type of educational strategies can be implemented with Assistants in Nursing (AINs) to improve resident outcomes? In Australia, AINs are also known as Nursing Assistants (NAs), Personal Carers, Care Aides or Care Workers as they comprise the majority of workers in residential aged care facilities (Nancarrow, 2012). They interact with residents every day to provide basic hygiene needs including showering, toileting, assisting residents with eating, transferring and positioning residents with the central aim being to achieve holistic care (Coleman and Medvene, 2013). Their practise is under the supervision of a registered nurse to whom they communicate any associated changes in the resident's care (Nancarrow, 2012).

Dementia Care Mapping

Dementia Care Mapping (DCM) is a systematic observational tool developed by Kitwood and Bredin in the United Kingdom (1992). The tool is used by nurses to assess and improve the care of people living with dementia (Sloane et al 2007). By using observational skills whilst implementing the tool, nurses use the findings to support each individual living with dementia to improve their care. The underlying principle of DCM concerns recognition that dementia fundamentally affects a person's psychosocial skills as well as their cognitive and physical abilities (Surr et al 2006; Younger and Martin 2000). Therefore, it is driven by the person-centred care approach (Kitwood 1995), which is individualised from the perspective of the person living with dementia and it also identifies new nursing opportunities for improvement in resident's care (Smy 2005). Findings from the literature suggests that DCM can prove useful in implementing quality nursing care to improve outcomes for residents with dementia.

Only a few studies have addressed the efficacy of DCM, and implementation of the tool. In Chenoweth and Jeon's study (2007) they found that the outcomes from DCM prompted and improved staffs' attention to monitoring and attending to resident's well-being. In another study, a randomised controlled trial (RCT) (n=236) which emphasised DCM, and used a control group of usual care, it found reduced agitation in people with dementia in RACFs (Chenoweth et al 2009). Further, in a clustered-RCT which used person-centred care and DCM, results indicated a significant improvement in the reduction of agitation in patients in the intervention group, compared to usual care (Ballard and Aarsland 2009). Hence, DCM can be employed to assist nurses to identify resident's facial and body expressions indicating either well-being or ill-being (Bruce 2000). The term 'well-being' in this paper refers to the resident's pleasant, psychological and emotional affect, with 'ill-being' the opposite of 'well-being' (Bradford Dementia Group 1997). Thus little attentions have been given to using DCM as a tool to empower AINs to build knowledge, understanding and meaning given to their care.

Reflection

The concept of reflective practice has become 'commonplace' in nursing and nursing education. As a result, it is well documented in the literature (Booth 2010; Carroll 2009; Clark 2009; Glen et al 1995). However it remains unclear whether reflection on practice, is genuinely implemented by health care professionals,

academics, undergraduate or postgraduate nursing students, to the level of satisfaction required for excellence in practice (Ranheim et al 2010; Skovdahl et al 2004). Other studies concerning the usefulness of reflection have highlighted that reflection was the building block of knowledge (Sumner 2010) and professionalism (Wainwright et al 2010) in nursing practice. Further, reflection enabled students to move from being passive recipients of information to being more questioning and critical of their practices (Mann et al 2009; Smith 1998). In an earlier study by the current authors, it was found by incorporating reflective practice with DCM, was a catalyst for enhancing interaction between AINs, the residents and the RACF (Mansah et al 2008).

The role of AINs in providing effective dementia care, following DCM coupled with reflection to improve resident care, has not been previously explored in detail and there remains a paucity of literature addressing their contemporary role in aged care. This study now attempts to address this imbalance. Therefore, the aim of this study was to explore the experience of AINs in relation to Dementia Care Mapping and reflection to improve older residents' care in a residential aged care facility.

STUDY DESIGN

Method

A qualitative exploratory design (Polit and Beck 2010) was employed to gain an in-depth understanding of AINs experience of creating new care for older residents using Dementia Care Mapping feedback. Additionally, observations of each resident were undertaken using Dementia Care Mapping (Bradford Dementia Group 1997).

Ethical consideration

Ethics approval was granted by the Australian Catholic University National Human Research Ethics Committee and the Residential Aged Care Facility's Ethics Committee Board. Assistants in Nursing were given an information letter and consent form to participate in the study. Each resident's Person Responsible, who was usually their next of kin, was provided with the information letter and the consent form to join the study. All participants were informed that their participation was voluntary and they could withdraw from the study at any time without any consequences for their work or care. Pseudonyms were used for each participant (Schneider and Whitehead 2013).

Study setting

A dementia specific RACF located in Sydney New South Wales was selected for this study. It was chosen because DCM had never previously been implemented in this RACF. None of the AINs had prior knowledge or experience with DCM, nor had reflective practice been planned, implemented or encouraged.

DCM inter-rater reliability

Prior to the study commencing, DCM training was undertaken by three of the study authors, so that each was qualified as a DCM evaluator (Bradford Dementia Group 1997). Two of the authors proceeded to become Mappers for the project (the first author was referred to as the Chief Mapper in this paper). A concordance score above 0.7 was regarded as a sufficient score for inter-reliability testing between the Mappers, prior to study commencement (Surr and Neilsen 2003). The inter-reliability score of the Mappers was assessed and based on the Kappa coefficient and was found to be 0.95.

Study Inclusion Criteria for Residents

Following ethics clearance, the Chief Mapper proceeded to meet with each resident and their respective families. The purpose of each meeting was to describe and discuss the study details with them and create opportunities for any study questions to arise and be answered. Five residents with mild to moderate dementia consented to participate in the study. In order for each resident to participate, they needed to have been diagnosed by a physician as having mild to moderate dementia. Mild dementia is defined as diminished

ability to perform complex tasks, decreased knowledge of current and recent events and withdrawal from challenging situations. In moderate dementia there is clear evidence of cognitive deficits and associated behaviour changes which often require some level of supervision or assistance with tasks of daily living (Miller and Hunter 2012). DCM has been well tested for effectiveness with this group of residents (Bradford Dementia Group 1997). Informed consent to participate in the study was sought and obtained from each resident's person responsible, who was usually their next of kin. As a sign of respect consent to participate was also sought from each individual resident. No participants chose to withdrawn from the study.

Study Inclusion Criteria for the Assistants in Nursing

Ten AINs volunteered to participate in the study during a convened meeting (see table 1, Phase I). Each AINs qualification was a Level Three Certificate in Aged Care. This was typically required by the Nursing Director of the Aged Care Facility where each nurse needed to provide individualised care plans for residents on a day-to-day basis. Their respective daily care of the residents was usually supervised by one Registered Nurse who had a three year Nursing Degree qualification. The AINs work experience ranged from one to twenty three years with a median of eight years in the study RACF. They were either employed as full-time, or rostered as permanent part-time nursing employees. All nursing participants remained in the study throughout it is entire duration.

DATA COLLECTION

Data was collected from the residents in terms of observation using the DCM tool. Additionally, data was collected from the AINs relating to education and feedback as reported from the DCM observations of residents.

Dementia Care Mapping Tool Observations of Residents

During Phase III of the study (see table 1), the two Mappers used the DCM tool to record observations concerning the resident's interaction with the environment including social, verbal and nonverbal communication. In this process, two Mappers both tracked each resident over a representative time period of eight hours (Bradford Dementia Group 1997). For example, the resident's verbal skills and non-verbal actions were observed and recorded for every five minute period. Each code, described the resident's behaviour at the time they were mapped. Scores, based on a scale of plus five to minus five addressed each resident's state of well-being or ill-being. It also identified the resident's level of interaction with the RACF environment (Bradford Dementia Group 1997). In addition, during Phase III of the study (see table I), the Chief Mapper used an educational process to provide DCM feedback to the AINs, based on the observations of residents. This detailed process was supported by the Bradford University Training Manual (Bradford Dementia Group 1997). It is contended that this type of educational feedback can be an integral driver that leads to the development of person-centred care practice. During Phase IV of the study (see table I), the AINs developed a collaborative care plan for each resident, which they then implemented, monitored and evaluated. These new care strategies were documented by the Registered Nurse in each resident's nursing care plan.

The Chief Mapper's Education Session with AINs

During Phase II of the study, the Chief Mapper conducted an educational session with the AINs (N=10) including an educational overview concerning the nature of DCM and a description of the process of reflection and how it could be applied to the delivery of resident care. The Chief Mapper explained to the AINs that they were required to keep a nursing journal in which they would record, describe their nursing observations, ideas and new care strategies, actions and interactions with each resident during the study period and to also ensure that confidentiality was maintained. This was subsequently followed by their evaluation of care plans and implementation strategies with supervision from the Registered Nurse on duty (see Table 1, Phase IV). The benefits of journaling often allow chaotic experience to be clearly documented. According to Greenwood

(2001), opportunities may also arise to establish hidden connections and meanings concerning attitudes, culture, values and clinical situations. Greenwood later confirmed (2001 p.14), that through writing "we create and recreate (reconstruct, reinvent) ourselves and nursing…practice…" In this study, the AINs provided their clinical reflections in their journal and throughout the DCM feedback sessions (see table 1, Phases II-V).

The Focus Group with Assistants in Nursing

In Phase V of the Study (see table I), the Chief Mapper conducted a focus group interview with the AINs. The purpose was to identify and discuss with the AINs their experience of using feedback from DCM coupled with their reflections in order to create new care strategies for each resident. In addition, they were asked to determine whether they felt empowered by using DCM feedback, coupled with reflection as a learning process, which assisted them to plan creative care for residents living with dementia. The focus group process was audio-taped and lasted for one hour.

Two months later, the Chief Mapper returned again to the RACF for the final time to discuss with the same AIN's the study findings and to obtain the AIN's recommendations for improving practice with older residents. The study findings including the emergence and naming of the three major study themes were discussed. For each finding, the following questions were asked: "Does it ring true?" and "Do you wish to correct/develop/delete any part of these findings?" This process helped to ensure authenticity and led to confirmation of the study findings (Byrne 2001).

Table 1: The Study Method: Overview of the Five Phases

Phase 1	**Phase II**	**Phase III**	**Phase IV**	**Phase V**
Informed Consent obtained	***Educational Session***	***Residents Observations and DCM feedback***	***DCM Feedback Implementation and follow up***	***Focus Group and follow up***
Study initiated Ethics clearance obtained Chief Mapper provided study details to the AINs. The AINs volunteered and provided written consent. The Chief Mapper met with each resident and also their person responsible (next of kin), who provided written consent for their relative to participate in the study.	The Chief Mapper conducted an educational session with the AINs (N=10) including: (i) DCM details (ii) Reflective practice and how to keep a journal. (iii) The Chief Mapper answered any questions about the study method.	Two Mappers conducted DCM observations of each resident (N=5). (n=5). Informal feedback given by the Chief Mapper to the AINs. Formal, planned feedback were provided based on DCM observations and analysis of the data provided to the AINs. The ten AINs in-depth discussion and review (with approval from the resident's families and Director of Nursing) led to the development of new care strategies for each resident.	Each AIN implemented the new care strategies for each resident and repeated these for 2 weeks. The Chief Mapper and AINs met and discussed outcomes from their implementation of the new care strategies. In addition, they identified ongoing opportunities to review, monitor, evaluate and create further strategies for the improvement of resident's ongoing care.	In the focus group interview, the AINs discussed with the Chief Mapper their experience of using feedback from DCM coupled with their reflections to create new care strategies for each resident (findings presented in this paper). Two months later, the Chief Mapper again returned to the RACF to present and discuss with the AINs the study findings, outcomes and also to obtain from the AINs their recommendations for improving practice with older residents.

DATA ANALYSIS

Data transcripts were analysed using content analysis. This included the use of open, line-by-line coding and reading and rereading, browsing and validating codes (Strauss and Corbin 1998). Hence the data analysis involved an in-depth examination and interpretation of the collected data (Polit and Beck 2010).

FINDINGS

From the study findings, a feedback report was given to the AINs concerning the DCM observations undertaken by the two mappers (a summary of the report has been provided below). Information gained from the focus group interview (Phase V) resulted in the identification and development of three major themes. These themes were named as: (i) Reflecting on Care (ii) Creating a Caring Connection and (iii) Empathetic Communication.

A summary of the Dementia Care Mapping observations for each resident was provided to the AINs. This now follows below.

Joseph

Analysis of Joseph's behaviours indicated that his time was divided between sleeping, being in the lounge room, interacting with others, being socially uninvolved, walking, and at times was the recipient of physical care by the AINs. There were few interactions between Joseph and the AINs and other residents. His attempts at communication were few, short-lived and rarely initiated by him. Joseph spent much of the early observational time sleeping or dozing. However, he appeared to be content most of the time and never complained about any aspect of his care or well-being.

Mary

From observations conducted by the two Mappers, Mary's time was divided between sleeping, sitting in the lounge room, interacting with others, being socially uninvolved or walking. She needed minimal physical care from the AINs. There were few interactions between Mary and the AINs or other residents and she was asleep for a period of thirty minutes of the observation, including before the meal, and after the meal she dozed on and off at the meal table for a further fifteen minutes. It was suggested that Mary's well-being had the potential for improvement because she showed obvious signs of engaging in some interaction and activities if encouraged by the AINS.

Rachel

Rachel had several small interactions with other residents whilst eating. She seemed to tolerate her diet with obvious signs of satisfaction. There was a game of cards being played by one of the other family members around a table. Rachel showed signs of wanting to participate, but did not physically join in, nor was she encouraged to take part. Rachel was socially involved by staying present. There were small numbers of interactions with other residents around the table. On several occasions she was observed to be socially uninvolved with other residents, but she still seemed to remain reasonably alert to her environment by actively looking around. Rachel initiated only a few interactions between herself and the AINs. These findings suggested that Rachel's well-being can be further enhanced or improved by providing more stimuli within her environment. For example, initiates her interests in gardening and listening to music from the 1940s, 1950s, and 1960s may heighten her engagement and participation.

Nicolas

Nicolas seemed reasonably alert to his surroundings but mostly was not actively engaged with other residents in the lounge room, only minimally in the day room, and hardly at all whilst walking. The

feedback identified there were few interactions between Nicolas and the AINs. He enjoyed moving and rearranging chairs and tables. He seemed interested in the religious ceremony which was taking place and participated in it. This suggested that Nicolas was sometimes motivated to initiate interaction with other residents and AINs. More importantly, there was a potential for further interaction and the development of new care strategies to enhance his quality of life.

Jackie

Jackie was observed to be interacting with other residents. She would frequently go and hold one of the other resident's hands, engage in eye-contact and walk up and down the corridor next to the lounge room. Jackie was observed to spend a significant period of time walking. It was felt that there was a need to help her reduce the level of walking. The feedback identified that there were only a few interactions between Jackie and the AINs. This finding suggested that Jackie's well-being has the potential to improve or be enhanced by exploring a range of strategies to engage Jackie in doing activities that she previously enjoyed such as knitting, making bread and listening to music.

MAJOR THEMES

Reflecting on Care

Essentially, this first theme identified and described the AINs reflections on their care and opportunities for creating new directions in care for these older residents. This finding addressed their professional caring work with each resident, by describing ways in which they benefited from engaging in reflective practice aimed at improving each resident's outcomes and the teamwork involved. They also reported that by reflecting on their care, it provided opportunities for gaining clearer insights and a deeper understanding of each resident's unique behaviour and need for unique care.

For instance, Candice, AIN with seven years' experience explained it like this:

> *Since our meetings, I have started to reflect all the time on my work, to improve my weak points and see new ways in caring for these residents…I think it has really improved our teamwork …*

And Michelle, AIN with five years experience supported Candice's story:

> *I now think of each interaction I have with the residents. I mean, before I just carried out my activities and rushed through them. I understand the process of engaging, becoming involved in their care not only routinely, but emphasising the uniqueness of each individual. Reflecting on care has been something I lacked in the past, not anymore. DCM has highlighted the key needs of each resident…I think it is really important to think about your work, re-evaluate your decisions and see how things can be done better.*

From the meetings with the AINs, they pointed out that by reflecting on care, and combining it with the DCM feedback from the Mapper, it assisted a deeper understanding of individual resident's unique care needs. In addition, it provided new opportunities for creative planning and implementing innovative care and evaluation of their care decisions. In this way, these nurses were able to create new care strategies to improve their residents' day to day outcomes.

Creating a Caring Connection

Most AINs described this second major theme as establishing a clinical framework in which heartfelt care could be provided for these residents. This involved maintaining open, clear effective communication with each resident and other health team members. For the nurses it meant building rapport, showing the resident respect and creating a warm interpersonal environment. They maintained that therapeutic communication skills were important to improve interpersonal relationships and to create an environment in which meaningful

dialogue and exchange could occur. Furthermore, they identified that stronger caring bonds were formed between the residents and team members, when the AINs reflected on practice, prior to and following nursing care. Overall, this meant improving their daily interaction with each resident, their families and other AINs. This also involved maintaining open, clear effective communication with each resident and the health care team on a daily basis.

Sarah with seven years experience explained it like this:

> *Jackie and I became close…she connected well with me…DCM was good at helping me to identify this. Reflecting on care proved useful to my care…I now feel connected with the residents and the family members as well. Like yesterday, I walked past a family member who I haven't seen visiting for a while, I asked him how he was doing and he started telling me he had been ill and was hospitalised for treatment. You know, in the past, I would have just walked past him… not that I didn't care, I assumed I had too much work to do….and taking time to communicate with the family members was time consuming…*

Naomi AIN with ten years experience said:

> *When you approach them [residents] with a warm voice and good manners, they can feel it. They respond to you well. Nicolas came in here very aggressive and sometimes withdrawn…I [now] try to approach him with a very calm voice and use the DCM techniques we discussed. He responded to it….*

Later, Naomi further explained:

> *He [Nicolas] started talking to me about his wife. We made a connection with each other…I also told him personal stuff about me, like about my children and husband. It made it easier to care for him. In a way, he cared for me too.*

Here, these AINs reflected on the multiple benefits of expressing mutual feelings, such as warmth, kindness, and tenderness. This involved feelings of closeness and connection. They believed that this was important for establishing a sense of mutual togetherness. In ways such as these, the AINs created a caring connection with their residents.

Empathetic Communication

Evident throughout the third theme was the AINs perception that effective interaction was deemed appropriate and necessary to improve care. They highlighted that this assisted them to manage situations where a resident may become aggressive, agitated or anxious. They believed the goal of person-centred care was highly useful and important in order to encourage residents to become more involved in their daily care.

As Samantha an AIN with five years' nursing experience, reflected:

> *We have no excuse here…nurses have to deliver care that is identified for every resident. The thing is when we engaged in this DCM process and reflection…It just makes sense. I realised that care delivery is when residents can be themselves, and comfortable with themselves. This can only be done by talking to them warmly and sharing in their experiences…*

As Mary an AIN with only one year's experience, explained:

> *One of the residents is very social. She said she liked to be dressed up, have makeup on and her pearls on. After, I showered her, talked with her and asked her to choose her clothes. In the end, she was dressed up like she was going out to the Opera. It did make her happy and that's what she wanted. Before, I always put her in trackies, which I thought would make her comfortable. However, after our discussion, I changed, by communicating with her, learning about her…and understanding her.*

And later Mary continued:

> *Communicating is so important! This works well, when the residents can see in your eyes that you understand them. When you show it by putting understanding in your conversation…It certainly helps to manage [their] distress and agitation….*

In a nutshell, the third major theme highlighted the importance of AINs using empathetic communication. These nurses saw it as a springboard to improve aspects of quality care, which they believed enhanced the residents and the AINs interactions. They considered that it opened new ways to care and facilitated effective ways of supporting each resident's well-being and their need to express individuality during their activities of daily living in the residential aged care facility.

DISCUSSION

Our study found that these AINs appreciated the usefulness of DCM coupled with opportunities for reflection on their care. This acted as a catalyst for innovate nursing practice, which importantly assisted with improving outcomes for older residents. In contrast, one recent study found that AINs employed in dementia specific RACFs were more likely to be confronted with physical violence (Tak e al 2010). Consequently, it could be argued that there is a real need to use DCM feedback and reflection to prepare AINs to better navigate specialised care for this group of older residents. In addition, this may also reduce the risk of disruptive, violent behaviour experienced by some residents with dementia. As acknowledged earlier in this study, these AINs reported that they felt empowered, had increased knowledge and enhanced confidence to connect with each resident. They also recognised that their teamwork had improved and that they had new positive directions for future care of these residents.

In a report by the Royal College of Nursing Australia (May 2011), they identified two critical challenges in caring for older residents. These included: (i) that AINs typically have a minimal qualification, yet represent the majority of staff employed in RACFs, and (ii) ongoing education for AINs is not mandatory in this occupation. Thus, there remains an urgent need to ensure that AINs are provided with ongoing research based educational opportunities to fulfil and advance their caring role as respected health professionals. Previous studies identified that AINs felt empowered and equipped when provided with educational programs (Clark et al 2006). These findings suggest that RACF administrators, nurses and allied stakeholders, can create ongoing learning opportunities for AINs to improve practice when working with older residents in residential aged care facilities.

The importance of effective empathetic communication in the role of AINs in nursing has been identified in this study in their reflections on practice, and in their described stories of empathetic communication. Employing DCM and reflection strategies needs to be activated, implemented and evaluated by all concerned. Further, these empowered AINs, felt creative and discussed with the wider nursing team, a range of new strategies to improve clinical outcomes for residents.

Essentially, this study innovatively explored Assistants in Nursing experience concerning the usefulness of DCM coupled with reflection to improve older residents care in RACF. It also highlighted the professional role of AINs in building interactive relationships with both residents and staff, based on qualities of rapport, respect, and warmth. Moreover, the DCM feedback provided by the Mapper coupled with their ongoing reflection on care, created new opportunities for caring connections and empathetic communication between the AINs and the residents. These AINs believed by employing such creative strategies it empowered them to reduce resident's aggression, agitation and anxiety in the residential aged care environment. Thereby a win-win situation was created for all concerned.

Limitations

The relatively short time spent with the AINs during the focus group interview may have been insufficient to ensure total ongoing commitment and use of the combined DCM and reflection as tools to improve the resident's care. Consequently, strategies such as DCM education should be provided at repeated intervals, for example, during nursing education programs and clinical assessment, and evaluated to determine if any improvements occurred in the residents' care. The Hawthorne effect could also be considered in light of these findings. However, the researchers remained as unobtrusive as possible and both the Mappers were Registered Nurses with a gerontology nursing background. These factors combined should potentially help to reduce the Hawthorne effect (Casey 2006).

Implications for practice

Most AINs indicated they felt confident applying DCM feedback, and welcomed and accepted the benefits of reflecting on their individualised care, in order to enhance older residents' well-being. They also reported feeling more empowered as their body of knowledge continued to grow. They maintained that DCM feedback incorporated with reflection was beneficial and heightened their senses in providing quality care for each resident. Therefore, residential aged care facilities commitment to employ the DCM tool may prove useful for resident's care delivery and quality outcomes.

Recommendations

Residential aged care facilities need to create: (i) innovative dementia nursing policy; (ii) develop specific DCM educational processes and monitor related outcomes; (iii) nurses need to be at the frontier of creating a national DCM strategy. This could be combined with enhanced opportunities for reflection on clinical care. This means residents living with dementia, including their families, will benefit from enhanced caring connections and empathetic communication by AINs, empowered to provide innovative practice. Further, extensive research also needs to be undertaken concerning future DCM education, feedback and reflection which must be incorporated into best nursing practice.

CONCLUSION

It is evident that for RACFs organisations, Directors of Nursing, Supervisors, and Assistants in Nursing, the challenges that remain are profound. Vigilance must inform caring gerontology practice in new innovative ways. Quality nursing care can be instigated and delivered when templates supporting and structuring new opportunities such as DCM with reflection on care are provided. In this study, AINs considered DCM feedback and reflection on their practice valuable. They recognised that inevitably, without such innovative care their residents' health would continue to decline. Essentially, these study participants sought to improve their resident's well-being which was a fundamental and central goal supported by caring strategies.

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