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Close observation by ‘specials’ to promote the safety of the older person with behavioural disturbances in the acute care setting

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Abstract

This paper reports a two-phased pilot study that explored the concept of ‘specialling’ older patients with challenging behaviours in acute ward situations. Previous research suggests that the nursing workforce is not equipped with the skills and resources required to provide quality care for these patients. The hospital in which this study was conducted, instigated a model where these patients were closely observed by ‘specials’. Phase 1 of the study involved a retrospective analysis of de-identified ‘Specials’ Observation Charts’ and ‘Request for Patient Special’ forms of patients aged 65 years and above, over 12 months in 2006. Phase 2 involved in-depth interviews with the nurses caring for these patients. Findings revealed inadequacy of the forms, gaps in service provision for this vulnerable group of patients and the need for education of specials and ward staff, with suggestions to improve care for this patient group. Findings suggest the necessity to design and structure the observation forms more efficiently. It is important to formulate clear assessment criteria for these patients and incorporate in-service education programmes for ‘specials’ and ward staff and adequately prepare and support them to meet the challenges of caring for older persons with behavioural disturbances in ward situations.

Keywords: nursing; acute care; specials

INTRODUCTION

It is well documented that older people admitted to hospital may develop behavioural disturbances such as confusion, agitation, delirium or dementia (Andersson, Hallberg, Norberg, & Edberg, 2002; Fagerberg & Jonhagen, 2002; Holden, Jayathissa, & Young, 2008; Laurila, Pitkala, Strandberg, & Tilvis, 2004; Stenwall, Sandberg, Jonhagen, & Fagerberg, 2007). Management of these conditions are becoming a common duty of nurses in the acute hospital (Poole & Mott, 2003) given the increase in the rate of admission of older people in acute care.

In Australia, there is a higher rate of admission of older people to hospital than the general population and they also tend to stay longer. According to a recent national report (Australian Government Department of Health and Ageing, 2007), although Australians 65 years or older represented 13% of the general population, they represented 35% of all hospital admissions and 47% of all occupied beds, with an average length of hospital stay at 8.6 days in comparison to other patients at 3.8 days. Nurses working in wards where older patients with behavioural disturbance are admitted with other co-morbidities, often voice concerns about their ability to care for these particular patients along with others in the ward (Borbasi, Jones, Lockwood, & Emden, 2006; Tolson, Smith, & Knight, 1999). These patients are associated with self-care deficits, cognitive impairment, compromised communication, confusion and agitated behaviours in addition to the multiple and unique needs of elderly patients (Borbasi et al., 2006; Williams- Burgess, Ugarriza, & Gabbai, 1996). This paper reports a pilot study, which examined an initiative at an acute hospital in Sydney, Australia, that used the concept of 'specialling' this vulnerable group of older patients with behavioural disturbances in ward situations. The term 'specialling' refers to close, one to one nursing care of patients with challenging behaviours (Bowers & Park, 2001).

Literature review

Older people with behavioural disturbances are more vulnerable in an acute hospital setting, often being confused and with compromised or impaired communication (Cherry & Reid, 2001; Kovach & Wells, 2002). They also have an increased risk of falls and reduced nutrition or fluid intake (Mentes, Culp, Maas, & Rantz, 1999; Rohrer & Schiffer, 2000). There is evidence to suggest that these patients' length of stay in hospital is often three times longer in

comparison to that of other older patient with similar comorbidities (Cummings, 1999). Although hospital nurses are skilled in meeting the acute health needs of older people, they may not have the expertise required to manage challenging behavioural disturbances (Borbasi et al., 2006; McCloskey, 2004) and many nurses feel that they are poorly prepared to meet the special needs of older people (Poole & Mott, 2003). This limited knowledge, combined with the challenges posed in caring for people in confusional states, frequently results in the inappropriate use of chemical and physical restraints (Hsu, Moyle, Creedy, & Venturato, 2005).

Tolson et al. (1999) suggest that acute hospitals environments are not conducive to optimum care of people with behavioural disturbances and acute care is most effective when provided in tandem with specialist care. Cutillo-Schmitter (1996) suggests that hospitalisation can precipitate acute confusion and disorientation in people with dementia as they have been taken out of their familiar environment. Australian research suggests that nursing staff often struggle to manage these patients in situations where limited resources and lack of time hinder adequate supervision of these patients' unpredictable and challenging behaviours (Borbasi et al., 2006). Along with other researchers, they recommend more person centred, social and psychological focussed models of care for this group of patients (Borbasi et al., 2006; Taft, Fazio, Seman, & Stansell, 1997). It has also been found that the use of specialist nursing and/or social worker staff guiding the care of this group of patients is cost-effective and provides quality of care (Borbasi et al., 2006). Borbasi et al. (2006) and Moyle, Borbasi, Wallis, Oloenshaw, and Gracia (2010) have explored the use of unlicensed staff or volunteers as an option in the management of older patients with behavioural disturbances, in particular for patients with dementia. However, there is little research on the cost effectiveness of this model or its efficacy in providing best practice to these patients.

The use of close, one to one nursing care or 'specialling' is not uncommon in mental health settings to manage disturbed patients during periods of psychiatric crisis (Bowers & Park, 2001; Dennis, 1997; Neilson & Brennan, 2001). Early research suggests 'specialling' has been regarded as an unpleasant task commonly delegated to junior or untrained staff (Reid & Long, 1993). Duffy (1995) argues that 'specialling' is a psychiatric nursing activity and there is no consensus on what the role of the 'special' is (Bowers & Park, 2001). This paper aims to report on the initiative of 'specialling' the older person with behavioural disturbances in an acute care setting. This work builds on the research of Moyle et al. (2010) with an emphasis

on the 'specialling' role and gives a new perspective to this workforce issue at different hospital.

METHOD

Setting

The setting for this study was a 420 bed tertiary teaching hospital with 37 specialist aged care beds. The older patients with challenging behaviours were either in accident and emergency wards or in specialist aged care beds. Demand for inpatient services by older residents living in the area increased by 10% between 1998 and 2002, and over 70% of the inpatients are over 65 years. In response to the increased demand, the hospital initiated a model where they had a person specialling older patients with behavioural disturbances (sitting with them) and recording a 'Specials' Observation Chart over the shift. Nurse unit managers were responsible for requesting 'specials' by completing a request form. Between July 2005 and June 2006, the total costs of employing 'specials' was over a million Australian dollars (AUD 1,197,726.78).

During this period 'specials' were employed for 52,912 h to observe patients with challenging behavioural problems.

Study design

The study was conducted in two phases. Phase 1 was a retrospective analysis of data of older patients who had been specialised. Phase 2 involved in-depth interviews with nurses caring for these patients.

Phase I

Data collection. De-identified 'Special's ObservationCharts' and 'Request for Patient Special' forms of patients aged over 65 years over the previous 12 months were analysed to identify indications for 'specialling', shifts covered and actions taken to manage challenging behaviours of older patients while they were 'specialled'.

Data analysis. Data were collated and analysed using SPSS computer software and presented as descriptive statistics.

Phase 2: Interviews with health professionals

Sample. A purposive sample of nurses and ‘specials’ experienced in the care of older confused people in the acute health care setting.

Data collection. Semi-structured in-depth interviews were conducted with nurses and ‘specials’ to explore current care practices for older patients with challenging behavioural problems in the acute care setting. The questions were related to current practice and participant’s perceptions of best practice for care of older people with behavioural disturbances. The following questions were used as a guide to elicit responses from participants but subsequent questions depended on the participant’s responses: Questions in relation to current practice:

- What is your role in the care of older confused persons in the acute care setting?
- What do you think is the purpose of having a ‘special’, i.e., one on one nurse/assistant to look after a confused older person in an acute care ward?
- Can you think of someone who was ‘specialled’ and explain why they were ‘specialled’?
- What, do you believe, is the role of the ‘special’?
- Can you think of an occasion when the ‘specialling’ of a patient worked well?
- Please could you tell me about that specific example, what happened, why was it good?
- Can you think of an occasion when the ‘specialling’ of a patient did not work well?
- Please could you tell me about that specific example, what happened, why was it not so good?
- How involved do you think family members should be in the care of confused older people in hospital?
- What happens now and what do you think should happen?

Questions in relation to models of best practice:

- What, do you think, might be a better way to care for confused older people in acute settings?
- Why do you think these things/practices would work better?

- Why do we not currently use the ideas you have just outlined?
- What do you see as the barriers to good care for older confused people in acute care hospitals?

Data analysis. Transcribed interview data were coded and analysed using NVivo computer software.

Ethical considerations. All data were de-identified before use by the research team and all participants were volunteers who were given an information sheet outlining the study and provided signed consent before being interviewed. The participants for interview were recruited using advertisements attached to notice boards in wards of the hospital. The project was approved by relevant ethics review committee at the University of Western Sydney and the Area Health Service where the research was conducted. Privacy and confidentiality of participants and data base information was maintained at all stages of the research. Pseudonyms are used to report direct quotes from participants.

FINDINGS

Phase 1: Forms

Fifty sets of ‘Special’s Observation Forms’ and ‘Request for Patient Special Forms’ met the criteria for inclusion (age over 65 years) and were retrieved.

Request for patient specials

Seventy-two per cent ($n = 36$) requests were for 24-h ‘specialling’. When ‘specials’ were requested only for a particular shift, most requests were for night shifts ($n = 8$). Most patients had multiple indications for request although the majority ($n = 46, 92\%$) were agitated or confused (see Table 1).

Only 52% ($n = 26$) of patients had their level of care assessed and of these most 34% ($n = 17$) were required to be within 1 m reach of the ‘special’. Prior to being ‘specialled’, 48 patients had been on close observation due to severe agitation/confusion, wandering behaviour, falls risk and/or assessed as being in danger of self-harm or danger to staff/others.

Special’s observation form

The form was modified from one in use in the psychiatric ward at the hospital. As indicated in Table 2, the form was simple to complete and consisted of recording patient behaviour

over the period of the shift at 20-min intervals. The first part of the form consisted of six columns, with each column indicating observable patient behaviour and included the following behaviours: actual self-harm, self-harm ideas, psychomotor agitation, psychomotor retardation, resting and sleeping. Against each column the ‘specials’ had to tick any observed behaviour at 20-min intervals and actions taken to manage any challenging behaviours observed. The second part of the form had a question for ‘specials’ that asked them to indicate their opinion on whether the patient needed ‘specialling’. The major behavioural disturbance recorded was psychomotor agitation (n = 12, 24%), followed by psychomotor retardation (n = 4, 8%) and self-harm (n = 1, 2%) and these behaviours were only recorded once per patient during the entire shift covered by the special. The actions taken to manage these observed challenging behaviours included one or a combination of the following strategies: putting the bedrails up, continued observation, adequate pain control, review of medications or use of physical restraint. At all other times resting and sleeping were recorded as the most common observations, despite majority of ‘specials’ (n = 42, 84%) considering that the patient required specialling.

Phase 2

A sample of 10 nurses and ‘specials’ volunteered to participate (see Table 3 for participant demographic information). As illustrated in Table 3, 7 out of 10 participants were nurse managers, registered nurse, nurse educator or clinical co-ordinator. Three participants worked as ‘specials’ in the hospital. The specials were either a nursing student, assistant in nursing or an enrolled nurse. In-depth semi-structured interviews with the participants revealed the following major concerns in relation to the services provided for older people with behavioural disturbances in acute hospitals and with specialling. These include:

- Gaps in services for older people with behavioural disturbances in acute hospitals
- Education of ‘specials’ and ward staff
- Suggestions to improve care of the confused patient

Gaps in services for older people with behavioural disturbances in acute hospitals

In the nurses conversations there was the recognition that older people were a special group and they were becoming a major population in the hospital:

So, [this] Hospital I don't feel has ever seen the importance of Aged care, but that surprises me given the fact that this is an older

population now and that 50% or 60% of the clientele that walk into this place are over 70 and it just is an ongoing battle. People still have this vision that aged care is just where we are going to dump all our old people, whilst they are waiting for a Nursing Home.

(Betty – Nurse Manager)

However, there was also the recognition that many staff did not see them as a special population with special needs:

I think nurses no longer see it as part of their core business to look after anybody who is behaviourally challenging. Nurses see any patient who is challenging like that as a patient needing extra resources' (Mary – Nurse Manager).

Some nurses also mentioned the lack of resources and workload that made it more difficult to look after the older confused patient:

Lack of staff, sometimes lack of equipment, just the resources, ... I suppose the work load as well. Sometimes you don't have the time to sit and spend with that patient to reorientate them, because you have got 5 or 6 other things that you need to do as you are going along. (Debbie – Nurse Educator)

The nurses felt the use of 'specials' was a strategy for addressing the lack of resources and in providing relief to ward staff. However, there were different understandings held about the role of the 'specials' between hospital administrators and bedside nurses. Hospital Administration did not see the 'specials' as providing nursing care. Rather, they viewed the 'specials' as a custodial strategy for close observation and as a measure to enhance the safety of vulnerable patients. However, nurses had differing expectations of the special's role and the interviews revealed a belief that the 'specials' should be providing holistic patient care rather than a custodial observation role:

It is about defining the special role, about the special being aware that it is their role to provide all the personal care to the patient and that it is not just a babysitting role (Mary – Nurse Manager).

Mary also expressed concerns about costs to the organisation of hiring ‘specials’ particularly where the ‘specials’ did not seem to do much for the patient:

I have an issue with us paying from my point of view with the organisation paying for a staff member to sleep or to actually sit and read a book. But I also understand that the role is tedious and he needed some stimulation.

Education of specials and ward staff

Clearly, there was a lack of knowledge of the role of the ‘specials’ from the perspective of both the ‘special’ and other staff in the wards. Education of ‘specials’ and ward staff to adequately face the challenges imposed by older patients with behavioural disturbances was deemed necessary by study participants. In addition, trained ‘specials’ were considered integral to the caring process of older people with challenging behaviours:

I think specials are the way to go, educated specials. Yeah for sure, training, in-services and training on dementia, delirium and the challenges of behaviours, challenging behaviours, risk assessment’
(Jane – Special).

Overall, the participants felt that the ward staff needed specialist education to be able to care for this cohort of patients and the ‘specials’ indicated a need for education on how best to care for these patients:

Dealing with confused [people], there are so many different types of confusion and there are so many different ratings and levels of confusion that a person has. I should have been told in the beginning as to how to deal with people like this. (Ann – Special)

Suggestions to improve care of the confused patient At interviews, the study participants proposed number of approaches to improve care provision for older people with behavioural disturbances.

These included:

- Assessing the older confused person
- Changing model of care/Skill mix

- Special unit
- Use of modified environment

During the interviews in Phase 2, the nurses felt that the observation forms were inadequate and needed revision, although it was difficult to assess their effectiveness. As expressed by two nurses: *'The forms are really inadequate and they do not reflect the patient's condition or requirement for a special nor do they reflect the activity of the special'* (Mary) and *'I think they need to really change the special form and actually put down what observations that us specials see from the patients'* (Joe – Special).

Of the strategies suggested by nurses to improve the care of the older confused patient, a fundamental aspect was accurate and individualised patient assessment. Nurses sometimes felt that there could be a simple reason for patients becoming agitated:

Sometimes people's [staff] perception about patients [about needing a special]: they [patients] are trying to climb out of bed, so therefore they must need a special. Rather than actually work out that maybe they are trying to climb out of bed because there is something they particularly want. Sometimes it is about investigating why they are doing stuff, not necessarily thinking about ordering a special because they are trying to climb out of bed. (Betty – Nurse Manager)

Although participants spoke about having specialist assessment of the patient by a nurse practitioner before admission to hospital, they felt that the move from their [older person] normal environment could in itself trigger confusion:

I think sometimes the sheer fact that they are brought out of their normal environment from hostel or from Nursing Home and they are brought to a totally different environment where there are brighter lights, there is a greater amount of noise, there is more activity, there is more general stimulus. That sends them off even more. I think in a lot of instances particularly those elderly confused who are already in a facility for care, I think it would be more appropriate to have a team from the hospital go out and assess them in the facility that they are in and put management practices and treatments in place where they are than to create a whole new batch of problems by bringing them into hospital. (Liz – Nurse Manager)

Some participants believed that while the older person was in the hospital environment ‘specials’ could be utilised in a more resourceful way by placing the confused patients together in specialised units: ‘*Maybe if there was a special unit that was built say for confused elderly people, so in that way not only are you minimising the cost that is involved, but also it is better for [providing care]*’ (Ann – Special). Mary also expressed similar views about putting patients with behavioural disturbances in the same ward:

I think we could be better at cohorting [putting together] patients who need specialising. So rather than you know four separate patients across the hospital, each in their own single room with their own single special, maybe we could put them in a four bedded room and look after them together. (Mary – Nurse Manager)

Other participants suggested the need for modified ward environment, which would help the older person adapt to the ward and also protect the patient from harm:

The environment itself, ... we are certainly not keyed or set-up to manage confused elderly patients in our environment. ... [Such as] having an area where they can go outside and walk around ... [and] I think trying to manage each individual to their own set behaviour. (Betty – Nurse Manager)

Other modifications to the ward environment as suggested by the participants included alarms and shower chairs: ‘... *I think in bathrooms, you need to have shower chairs, that have an adjustable height*’ (Liz – Nurse Manager) and Debbie (Nurse Educator) felt that use of alarms were effective in monitoring these patients with challenging behaviours:

I think the chair alarms and the bed alarms actually work well because they reinforce the fact, it is re-orientating them every time they stand up, like don’t do it, so they sit back down, they realise once they sit back down, the alarm stops. (Debbie – Nurse Educator)

Some participants also felt that prudent use of restraints would alleviate the challenges faced by nurses caring for this group of patients: ‘*It is about safety, and about most effective use of resources. There is a role for safe and judicious restraint and we need to go back and look at that again*’ (Mary – Nurse Manager).

DISCUSSION

Findings from the study support the literature in relation to the challenges faced in the care of older people with behavioural disturbances in the acute setting (e.g., Borbasi et al., 2006; McCloskey, 2004; Poole & Mott, 2003). While ‘specialising’ provided relief to staff in the

ward, there is little data to reflect whether it improved the care outcomes of the patients. This is an important issue when minimal resources are available to provide care to all patients in a busy ward. The impact of a patient with behavioural disturbances is often not acknowledged in the literature and we need to acknowledge that other patients often do not tolerate patients who are noisy or displaying threatening behaviours (Schofield, 2008). It is clear from the data evident in this study that the incidence of need for patient 'special' was frequently at night, but this again may reflect the fact that fewer staff are available on the ward at this time (Zernike & Sharp, 1998).

Although there was anecdotal evidence to suggest that the forms used by 'specials' in the hospital where this study was conducted there was no research evidence that had confirmed the inadequacy of the forms. This study has therefore confirmed that the forms used by staff to request care and observe patients being specialled were inadequate. Observation forms need to be designed and structured efficiently so that they accurately reflect the patient's condition, behavioural disturbances observed, measures taken to control challenging behaviours and patient outcomes consequent to the measures implemented. As illustrated in Table 2, the observations recorded on the 'Special's Observation Form' were very minimal and would not be helpful if there was an incident. Despite the majority of the 'specials' indicating that their patient required close observation, most observations were recorded as the 'patient resting or sleeping'. This indicates that either the forms were not properly designed to portray behavioural care management of the confused older person or the patient was not assessed properly. It may also suggest that the mere presence of a companion ('special') was enough to calm the patient down, as there was no incidence of falls recorded on the observation forms that were analysed. Use of observation forms have been criticised in the past and there is a widespread consensus that monitoring patients through observation and observation forms fail to meet the needs of patients and/or health professionals (Bowles, Dodds, Hackney, Sunderland, & Thomas, 2002; Buchanan-Barker & Barker, 2005). If forms are to be used there is a need to design them efficiently and educate staff in how to use them effectively.

The study findings also suggest that caring for older people with behavioural challenges is seen as something that requires 'specialling' or one to one care, and is not a fundamental aspect of normal nursing care. This may be due to unpopularity of nursing older people and/or lack of time and resources (Courtney, Tong, & Walsh, 2000; Reed & Clarke, 1999) and this attitude towards caring for older patients is also reported amongst nursing students

(Dellasega & Curriero, 1991; Lusk, Williams, & Hsuing, 1995). Lack of knowledge amongst preceptor and student nurses about caring for older people with challenging behaviours (Fagerberg, Ekman, & Heyman, 1999) may add to the unpopularity of nursing in this area.

Clear assessment criteria based on research evidence should be utilised so that formal screening of patients is made and that the real patient needs are evaluated (Michaud et al., 2007; Schofield, 2008). A comprehensive assessment of the older person with behavioural disturbances in the ward setting is vital given the unique multiple challenges of providing care to this vulnerable patient group (Borbasi et al., 2006; Williams-Burgess et al., 1996). This reinforces Moyle et al.'s (2010) contention that individual assessment of this population is essential in order to maintain their personal dignity. In addition, nursing assessment of older patients with confusion needs to be routine and systematic with use of standard assessment protocols (Foreman, Mion, Tyrostad, & Fletcher, 1999). Although some participants in this study suggested judicious use of restraints in caring for older people who are behaviourally challenging, use of restraints has been long linked to higher mortality and morbidity (Bourbonniere, Strumpf, Evans, & Maislin, 2003; Frengley & Mion, 1986; Miles & Irvine, 1992; Mott, Poole, & Kenrick, 2005; Sullivan-Marx, 2000). Use of a modified environment to improve care provision for behaviourally challenging older persons has been advocated in previous research (Maas, Swanson, Specht, & Buckwalter, 1994; Marshall, 1997; Morgan & Stewart, 1997, 1999; Moyle et al., 2010). Use of alarms is considered as a pragmatic action to reduce fall among confused patients (Schofield, 2008; Sharma, 2006), where staff are alerted in situations such as when a vulnerable patient gets up from the bed or chair or leaves a ward (Schofield, 2008). Nonetheless, use of a modified environment or alarms largely depends on the resources available in health facilities given the limitations of health care systems in underresourced settings. The actual costs of using 'specials' depends on the time and degree to which the 'special' is used (Bowers & Park, 2001) and use of trained competent 'specials' may prove to be a cost-effective way to care for and enhance the safety of these patients. However, it is important to define the role of the 'special' and provide clear guidelines about the nature and level of care are expected from the 'specials'.

This study has shown that there is a place for 'specials' but as suggested by other authors and the nurses in this study they need to given training and education programmes supported by

management both at the ward level and above (Balas, Gale, & Kagan, 2004; Bradley, Webster, Schlesinger, Baker, & Inouye, 2006; Schofield, 2008).

Limitations of the study

One of the limitations of this study is that the analysis was retrospective. It would have been better if the strategy with better designed forms had been initiated. However, in the busy under-resourced health system this cannot always be the case. There were only a small number of staff interviewed and the number of forms reviewed were not significantly large. However, the findings have provided very useful feedback to help develop a better evidence-based strategy in the future.

CONCLUSION

This innovative initiative has shown that it has addressed a safety issue and staff issue in a busy urban hospital. The study has demonstrated that it is important to evaluate clinical practice in order to identify gaps in patient services. There is a need for more specific guidelines for the 'specials', better assessment of the patient condition and a review of the forms used during the use of 'specials', which will be achieved in a future study.

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Table 1: Request for special form specifications and summary of findings from audit

Specifications of form	Finding n(%)
Shifts covered	
Day only 1 (2)	1(2)
Night only 8 (16)	8(16)
Afternoon shift 3 (6)	3(6)
Full 24 h period 36 (72)	36 (72)
Level of care required by patient	
Level 1 (within 1 m of the patient: within easy reach)	17 (34)
Level 2 (Greater than 1 m from the patient: within line of vision)	9 (18)
Indications (43, i.e., 86% patients had more than one indication for specialling)	
A patient who is under a psychiatric schedule	2 (4)
Where a medical condition warrants 1:1 nursing and no HDU beds available	0
Patient/family requests private nursing	0
A patient who is assessed as being in danger of self-harm	22 (44)
A patient who is assessed as being in danger to staff/others without supervision	20 (40)
Patient who is exhibiting severe agitation or confusion	46 (92)
Wandering behaviour due to delirium or dementia	17 (34)
Falls risk where all strategies on falls risk action plan have been attempted	8 (16)

Table 1continued

Specifications of form (Continued)	Finding n(%)
Actions taken to manage patients exhibiting wandering behaviour	Continued patient observation
	Dose of valium
	Bedrails up
	Review of medication
	Adequate pain control
	Physical restraint
Actions taken to manage patients with high falls risk	Continued patient observation
	Bedrails up

Table 2: Special's Observation Form

Specifications of form	Finding n(%)
Time(s)	Observation (recorded every 20 mins)
Observed behaviour:	Observations recorded/ticked
(a) Actual self-harm	1
(b) Self harm ideas	0
(c) Psychomotor agitation	12
(d) Psychomotor retardation	4
(e) Resting/Sleeping	50
Did patient need specialling?	Yes: 42
	No: 9

Table 3: Demographics of Nurses

Demographic feature	Finding (N=10)
Gender	
Male	2
Female	8
Age	
21-30 yrs	2
31-40 yrs	2
41-50 yrs	5
51-60 yrs	1
Education	
Secondary	1
Tertiary	8
Occupation	
Nurse Manager	4
RN clinical co-ordinator	1
Clinical Nurse Educator	1
RN	1
EN	1
Undergrad Nursing Student	1
AIN	1
Number of yrs working in the field	
1-5 yrs	5
6-10 yrs	3
11-15 yrs	1
>15 yrs	1

