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Nursing students' learning about person-centred dementia care in a nursing home: A qualitative study

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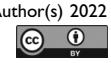

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Abstract

It is unclear to what extent nursing students are able to apply person-centred care in practice, despite a mixture of educational support approaches. The aim of this study was to explore nursing students' experiences of learning about person-centred dementia care after they participated in an adopted education programme in a nursing home. The education programme presented the main concepts of person-centred care. A qualitative explorative design was chosen where 32 bachelor-level nursing students participated in seven focus groups. The study is reported according to the COREQ checklist. Qualitative thematic content analysis revealed two main themes: care culture in the nursing home as joyful and inclusive, and the nursing student role as ambivalent and challenging. The nursing home management, staff members and patients, together with the programme, seemed to enhance students' learning about person-centred dementia care.

Keywords

content analysis, focus groups, nursing education, person-centred care

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Introduction

The prevalence of dementia, a group of conditions characterised by severe functional and cognitive decline and limited therapeutic options, is increasing around the globe.[1] As a direct consequence of this growth, more highly skilled professionals are critically needed to provide adequate dementia care in the future.[2,3] Alushi et al.[2] report that healthcare workers need more in-depth knowledge of dementia in this specialised field. Beyond this disease-specific knowledge, it is necessary to improve education for healthcare students concerning people living with dementia.[3–5] Studies have found a lack of innovative educational and learning strategies in nursing students' (NS') clinical practice settings, especially in aged care.[6,7]

A further concern is the person-centred approach in dementia care.[8–10] Some previous studies[8–10] build on the work of Kitwood,[11] one of the first authors to introduce the theoretical concept of personhood, that is, focusing on the person and not only on the patient's disease. Kitwood's definition of personhood aims to understand people's living situations both past and present; their life stories are central. Kitwood and Bredin,[12] somewhat contradictorily, point out that personhood must be seen from the social rather than the individual perspective, implying a focus on social dimensions in the care of persons with dementia, with environmental treatment frequently being used. The current study's approach to person-centred dementia care (PCDC) is frequently used in aged care in Norway.

PCDC emphasises understanding reality from the patient's perspective, facilitating a social environment that supports psychological needs and respect for the uniqueness and value of life.[11] According to Edvardsson,[13] 'person-centred care is holistic, flexible, creative, personal and unique'. Thus, a holistic view in nursing implies seeing the individual as a whole person in line with the holistic-existential view described elsewhere.[14] Lave and Wenger[15] argue for involving the unique individual in a 'community of practice', wherein teams or groups learn from one another.

Van Leeuwen and Jukema[16] found in their study that it remained unclear to what extent NS were able to apply person-centred care in practice, despite the mixture of educational support approaches used by experienced educators and clinical supervisors. This aligns with previous studies[2,17,18] suggesting the need for evidence-based best practices and quality models to improve dementia care education and student learning. Alushi et al.[2] suggest three domains for educational interventions: improvement in dementia education, attitude and comfort when working with persons with dementia disease. Robinson et al.,[17] in turn, point on dementia disease as a key clinical learning focus. Snoeren et al.[18] argue for care

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innovation units to promote workplace learning in nursing, where students can learn in a learning-centred culture, where the staff members offer responsible and independent learning tasks. Being valued as a team member and a person may enhance learning. Most of these studies have an inter-professional and inter-collaborative focus that may include at least 'healthcare students', highlighting the importance in NS' education of the quality of dementia care.

In our study, an adopted education programme for NS was applied in a nursing home (NH). The adopted education programme in aged care lasted from August 2018 to December 2019 and included lectures, supervision, seminars and reflection in groups. The theoretical underpinning of the programme was based on person-centred care as described by Kitwood[11] and Kitwood and Bredin,[12] and the pedagogical underpinning in turn, was based on Lave and Wenger's[15] view on practice as a community of learning practice. The core principles of PCDC were theoretically and practically conveyed to NS by lecturers and registered nurses, respectively. A few of the latter were geriatric nurses. Lectures in smaller groups described such central concepts as personhood, person-centeredness, holism, dementia as disease, constraints in dementia care, environmental treatment and communication. The NS also participated in ad hoc education initiatives arranged in plenum by the NH staff. Supervision was strengthened by collaboration between the lecturers and nurses so that the NS were more frequently supervised. Finally, the NS' written PCDC assignments describing the patients they had followed (for approximately one week) were presented in group seminars. The nurses and lecturers participated as well.

The NS requested a template for the written assignment due to the complexity of its construction, so a group of third-year NS created a template of instructions for the PCDC assignments. The template was returned to two subsequent first-year NS groups for comments. Some of the NS found it useful, while others preferred supervision and independent study. The NS thus experienced several learning methods, including one-on-one, pairs, teams and plenum methods, in sessions lasting two to three hours.

To conclude, universities and practice settings are being urged to educate increasingly competent and innovative NS,[19] implying a need for improvements in dementia care instruction. In this article, the NH as a setting for learning PCDC is studied from the NS' perspective to deepen the understanding of what may promote versus detract from the NS' learning experiences. Thus, the aim of this study was to explore nursing students' experiences of learning about person-centred dementia care after they participated in an adopted education programme in a nursing home.

Method

The study used a qualitative explorative design[20] and is reported in line with the Consolidated Criteria for Reporting Qualitative Research (COREQ) checklist.[21] Data were collected through focus groups based on Polit and Beck[20] and analysed using qualitative thematic content analysis inspired by Elo and Kyngäs[22] and Lindgren et al.[23] Focus groups with NS in research groups are judged to be appropriate for exploring the experiences of education programme participants.[20]

Settings

The aged care context in this study was a NH in northern Norway. The selected NH was known to have a capacity for innovation; the nurse management (nurse manager and ward managers) were eager and willing, and the staff members were involved in both negotiation and the implementation of changes, creating a workplace learning culture that involved all the personnel.[24] The NH aspired to be person-centred as described by Kitwood,[11] and Kitwood and Bredin[12] and to strengthen active-oriented care as a certified 'Joy-of-life nursing home'.[25]

Recruitment and participants

Thirty-five bachelor-level NS participated in clinical practice at the NH during the education programme period. Three NS dropped out due to mandatory duties with patients, so in total, 32 NS participated. They ranged from first- to third-year students, but most were in their second year of study. They were informed of the upcoming project by the first author in an email before they began an eight-week clinical practice. At the introductory practice seminar, they were given more specific details about the project and its central aim of exploring how they learned about PCDC in a particular NH. It was stressed that the intention was not to evaluate the practice. A description of the education programme was also shared with these NS. They were invited to participate in focus groups at the conclusion of their clinical practice.

Focus groups

Seven focus groups were jointly conducted in Norwegian by the first author (female), and another lecturer (male), from August 2018 to December 2019. Each group comprised three to six NS, as recommended by Polit and Beck.[20] Of the total number of participants 23 were female and nine male. The focus groups were carried out on campus in a meeting room due to a lack of room availability at the NH. The themes discussed in the semi-structured focus groups concerned the main concepts in the adjusted education programme: PCDC and holism and how the NS learnt about these concepts in practice; how they learnt about the older persons through the assignment; and how they participated in nursing changes and practice recommendations. The themes discussed were pilot tested with the first student group, whereafter they were found suitable to use for the next focus groups.

The first author made notes directly after each interview, describing the atmosphere of the interview situation. The NS were familiar with one another and their lecturers, which may have contributed to creating an active discussion atmosphere. Almost 10.5 hours (617 minuites) of material was audiotaped. The interviews lasted from 58 to 110 min, with a mean of 84 min. All the audiotaped material was transcribed verbatim by the first author, and the resulting transcripts amounted to 60 pages with single spacing, standard margins and Times New Romans font size 12. The NS did not receive the transcripts for control readings as no clarifications were needed.

Data analysis

According to qualitative thematic content analysis,[22,23] the transcripts were read through several times by the first author to obtain a sense of the content. The entire transcript text about NS' experience of learning about PCDC was divided into *meaning units*. Subsequently, the meaning units were *coded*, and the codes were abstracted and were compared to one another based on similarities and differences. Depending on their manifest or latent content, they were grouped into *subthemes*. The subthemes were discussed in a process of reflection and discussion among the authors that ended in agreement on how to divide the four emerging subthemes into groups. Finally, two main themes emerged that seemed to provide relevant headings that unified the subthemes. Examples of the analysis process are presented in Table 1.

Ethical considerations

Approval for the study and its data collection, correct storage and handling was given by the Norwegian Centre for Research Data (No. 49229). This study was exempted from the requirement for ethical approval from a regional research ethics committee according to Norwegian legislation, as it did not include research questions on health or patient information, and such information was omitted from the focus group discussions. The NS provided informed consent after receiving verbal and written information about the project. They were assured confidentiality and informed that participation was voluntary and included the right to withdraw.

Results

The thematic analysis yielded two main themes: (1) care culture in the NH as joyful and inclusive and (2) the NS role as ambivalent and challenging. The subthemes under the first main theme included (1) PCDC to include the individual person, and (2) Time and activity dimensions. The subthemes of the second main theme were (1) The NS' learning, and (2) Responsible and independent but challenging learning.

Care culture in the nursing home as joyful and inclusive

A care culture existed among the nurse management, staff members and patients. The NS related that they had been met with friendliness and an inclusive culture. The patient group, to the NS, seemed to be in the right place in relation to their needs and personalities. Everyone kept the patients in focus, and the staff had a positive attitude, so a unique work culture was fostered in which volunteerism was also welcome. The NS learned that nursing in a NH could be both exciting and challenging. The NS experienced that the patients were encountered in a dignified way.

> The patients themselves say that they are fine. Imagine if everyone in the world could be as well off as we are. The patient thrives because of the work the staff does. It's nice. (FG4, NS2)

The care culture in the NH was confirmed to the NS by the patients themselves.

PCDC to include the individual person. PCDC demands a high level of knowledge and expertise of the nurses, with high expectations on the nurses. The NS had good experiences of using methods with a PCDC approach that they had learned from staff members, for example, talking about memories and the importance of being honest with patients. In addition, the NS saw that music therapy was a part of PCDC. The staff members found music that the patients could relate to and used it to soothe the patients, for example, while they were receiving medical treatment. Initially, the NS focused on symptoms, while staff members were environmentally oriented. It transpired that the staff members had a different overall assessment of the patients' physical capacities, and the students

Table 1. Examples of the analysis process.

Meaning units	Codes	Subthemes	Main themes
PCDC means that you should truly see the person in front of you; you should write so that the person you are writing to can see the person in front of him. Then, you can't just write in a detached way because you have to find out who the person really is, and the patient thrives because of what the staff members do.	PCDC to focus on knowing the person and make the person feel included in a dignified care culture.	PCDC to include the individual person.	Care culture in the NH as joyful and inclusive.
First of all, you should learn to know the patient, which takes time. We do not always have this time.	It takes time to know the patient as a person.	Time and activity dimensions.	
That there is a Joy-of-life home and the activity during the day, the week. There is much fun.	Activity-oriented and joyful NH.		
It is much to focus on, both the education programme and the practice learning.	Focus on learning was ambivalent.	The NS' learning.	The NS' role as ambivalent and challenging.
They (the nurse management and staff members) let us work independently and be alone with the responsibility. Some of us need more support from supervising nurses.	Responsibility and independence could be too demanding and challenging.	Responsible and independent but challenging learning.	

Note: PCDC, person-centred dementia care; NH, nursing home; NS, nursing students.

began to understand the importance of obtaining holistic knowledge about the patients. Most significantly, after getting to know the patients better, the NS started seeing them as individuals. NS emphasised that writing about the patient enhanced learning about the person.

> PCDC means that you should truly see the person in front of you; you should write so that the person you are writing to can see the person in front of him. Then, you can't just write in a detached way, because you have to find out who the person really is. (FG6, NS4)

The NS learned about individual patients by listening to patients' stories while engaging in conversation with them. It was important that the NS showed initiative to converse with a patient, and that the patient had co-determination regarding starting and continuing a conversation.

The NS learned that the person the patient had been before arriving at the NH still existed. As their next of kin confirmed, these patients had neither changed nor developed another personality. This newfound acceptance meant that NS observed many more of the patients' dimensions as well as cues that they needed to recognise, such as the patients' non-verbal communication, socialisation and activation needs in addition to any needs beyond those which had previously been documented.

Time and activity dimensions. It takes time to get to know patients, but the NS found that they did not always have this time. The NS mentioned it made sense to spend time with the patients, for instance, sitting down with them, because they saw that patients would relate to fellow patients and NS at these times. This situation illuminated the patients' everyday lives, providing both NS and patients with a sense of accomplishment. However, the NS pointed out that the 'joyful NH' was activity oriented. Hence, these many activities were also pitfalls, as they did not suit every patient. Certification requirements meant that sick and bedridden patients were sometimes moved from the ward to another location because they no longer 'fit in' with the home's concept. Time and activity dimensions could cause ethical debate among the NS and required their increased involvement.

The NS' role as ambivalent and challenging

The NS said that PCDC would be an important approach in nursing regardless of where they practiced later in their education programme. The theory learned was put into practice at the NH. The NS had to choose theoretical literature based on their own interests and what they encountered in practice, finding a balance between their university assignments and working as NS. However, the NS' role was an ambivalent one, embracing several expectations about practice. It could be a challenge for them to find answers through their own studies, but the focus group discussions showed that some NS were reflective despite their uncertainty related to university expectations and practice settings.

The NS' learning. The NS learned from the staff, patients, volunteers of all ages, external visitors and lecturers outside our education programme. The NS emphasised that they had an inner motivation for learning this altruistic approach, as they wanted to perform well for the patient. This was a new way of working for the NS, and they learned from one another. The NS experienced the theoretical term 'holism' as meaningful and applicable in practice.

> Holism. It means that I take care of the main person now; previous nursing was mainly taking care of the older patients. (FG2, NS1)

The staff members expressed interest in the NS' tasks and the PCDC template with which they were working. Subsequently, the person-centred tasks led to the NS' improved learning, providing a thought process that forced them to carefully consider the task at hand. The NS experienced that their ideas and prejudices before they started their NH practice period had started to evolve in a more positive direction.

> Nursing in the NH is not only to sit with a group of people drinking coffee, with nothing much else going on. In case you should believe so, you are wrong. (FG4, NS1)

Responsible and independent but challenging learning. Responsibility and independence must be balanced by supervision. The NS were concerned with finding this balance and often discussed the topic in the focus group. The NS also pointed out that it was the nurse management's responsibility to give them the supervision they were entitled to and needed. However, they noted that the nurse management had responded to the criticism to a moderate extent. The NS had also enjoyed shared experiences, about which they emphasised that the nurse management had asked what they had learned the day before and what they were going to attend that same day.

Each student was responsible for proposing new ideas for care services. Several had experienced that many places were receptive to accepting NS' ideas; an openness that led to changes being made in the services provided to patients. Others endured a more combative experience when their well-founded proposals for new services were criticised and opposed for academic reasons.

Conversely, NS felt that the staff members and nurse management expressed trust by allowing them to work independently. When the NS were given group leader responsibility, they found it to be a positive experience. They felt that the staff members did not monitor them during the process but rather trusted them. All this made the NS reflect on being nurses in person-centred dementia care.

> Finally, I got the whole picture of what professional nursing is really like! (FG1, NS2)

The practice period had contributed to developing the NS' professional identity.

Discussion

The aim of this study was to explore NS' experiences of learning about PCDC after they participated in an adopted education programme in a NH. We discussed the results under the two main themes, 'Care culture in the NH as joyful and inclusive' and 'The NS' role as ambivalent and challenging', and

considered how these intertwined with the NS' overall learning experiences.

Our results show that the NS experienced a care culture by observing the manner in which the nurse management, staff members, patients and next of kin communicated with others. This culture also had an impact on the NS. The nurse management were held uniquely responsible for 'creating and keeping' the culture, which is confirmed by other studies describing nurse management as the cultural innovators.[26,27] Laugaland et al.[28] suggested in a recent study the need for nursing home managers' enhancement of learning environments for the NS, which the results in our study may exemplify, as the nurse management were highly appreciated by the NS.

PCDC, as experienced from the NS' perspective, permitted them to offer their own professional opinions and make suggestions for improvements in patients' daily care. However, unless the suggestions did not get approved by the staff members, the NS explained, the NS at least got the opportunities to have their voices heard. It transpired, however, that the care culture did not adequately support all the NS' individual learning experiences. Involving the whole of the person is in line with the holistic view in healthcare,[14] and failing to do so could create a weak link in the NS' learning process.

Hence, our findings suggest improving the individualisation of supervision for NS in clinical practice. This is in line with other studies[6,29] and with Lave and Wenger's[15] view, wherein learning should involve the unique individual as a member of the clinical practice learning community. However, several studies have emphasised the impact of a qualified supervisor on NS' learning.[4,7,10,30] In fact, the importance of the nurse supervisor seems to get even more attention, as Laugaland et al.[28] also stress in their study. This is supported in our study, as the NS described the supervising nurse as one important element in their overall learning, despite increased support from other participants in the adopted education programme. In fact, because of the education programme's multi-method learning approach, the importance of job shadowing and basic nursing skills supported by the nurse supervisor may not be fully appreciated.

Our study shows further that the NS appreciated being allowed to engage in responsible, independent learning with the patients, as they felt both more secure around the patients and trusted by the staff. The NS seemed to get the support at the NH for connecting with the older patients; a learning opportunity that should be more emphasised in aged care settings according to Keeping-Burke et al.[31] To learn from older persons is a learning experience mostly appreciated by the NS,[31] which the NS confirmed in this study.

On the one hand, the NS appreciated their independent position, yet, on the other, they needed more guidance and missed the opportunity to observe and enter into dialogue with nurses. However, our study found that the NS were guided to increased responsibility, including in PCDC, at an early stage of their practice studies. This could be interpreted as resulting from the nurse management in the NH, where all staff members were encouraged to challenge their limitations.[24] In addition, the nurse management may support the challenging responsibility and learner student role in a NH, which otherwise might be overwhelming for the NS, particularly in the case of the lack of full support from experienced nurse supervisors. The nurse management and nurse supervisors seemed to be preoccupied with the NS' learning about PCDC. However, it is suggested that nurse managers take responsibility for supporting the staff members to understand what supervision responsibilities are included in NH settings.[32] Due to the confusion with the roles of nurse supervisors among NS in our study, it should certainly not exclude the responsibility of the academia educators.

This aligns with the recommendation of Husebø et al.,[4] who propose an academic–clinical partnership in addition to criteria that include supervision by supportive mentors and high-quality nursing care to improve NS' learning in NHs. Smith and Dray[29] suggest collaborations between care homes and universities in which selected, trained nurse mentors supervise NS in a person-centred culture. Van Leeuwen and Jukema[16] in turn, emphasise that clinical teaching by a skilled supervisor may contribute to students' ability to offer person-centred care in practice. Consequently, the quality of the nurse supervisor is highlighted to improve NS learning in person-centred care.

Furthermore, the NS discussed the learning process, they prepared assignments and a template on PCDC for upcoming students. They also took part in seminars, and a number of NS made presentations. The education programme was active and learning-oriented due to the NH's Joy-of-Life[25] approach combined with multi-method learning, all of which were intended to increase NS' interest in participating in nursing education at the NH. Interestingly, the NS found that the focus on the patient as a person was a source of their learning about PCDC. This is supported by Moquin et al.,[30] who note that engagement with residents is crucial in learning about person-centred care in aged care. However, our results show that an overall education programme combined with activities may present challenges to NS' use of time with patients, which is the most important task.

The results reveal a discrepancy between theory, practice and learning objectives for basic nursing and PCDC in aged care. NHs having high-quality education implemented in a nursing curriculum is crucial to improving NS' learning outcomes.

This study, in which qualified nurses participated in the programme's development and performance, supports new approaches to educating NS in NHs. Berglund et al.[33] endorse nurses in practice education, suggesting a successful education programme in PCDC that is developed by nurses, in that case, in home-care settings.

Finally, our NS' participation in the programme and the manner in which they learned about PCDC may represent an example of innovative learning strategies applied to aged care. The fact that the NS found the NH to have a welcoming environment may, on the one hand, promote learning and, on the other, contribute to recruiting nurses in the future. At the very least, the students described how they learned PCDC and were ready to take their knowledge to the next level of study and practice.

Methodological considerations

Some factors may have impacted on the results. It may be a methodological limitation that the lecturers participated in the construction of the education programme and data collection,

which may have influenced the NS' decisions, but it was stressed that whether or not the NS participated would have no effect on their grades. Another limitation may be that we focused on NS' learning but have not evaluated the adopted education programme. The NS discussed a variety of learning situations, which may be a strength by contributing to achieve information power.[34] The NS described both positive and negative experiences, which we argue indicates that they felt free to express themselves in a manner they felt was most appropriate. The researchers (females) were both registered nurses with PhDs in health sciences and experience in qualitative research, both data collection and analysis. The second author did not participate in either the education programme or the focus group discussions, so the analysis was performed from both an insider and an outsider perspective. A limitation may be the pre-understanding within the bachelor programme and the knowledge of the field.[35]

Conclusion

The findings of the study support the following conclusions: a care culture in the NH as joyful and inclusive, supported by nurse management and staff members, is important in a NH, and an adopted education programme featuring nurses and lecturers in collaboration may contribute to NS' learning about PCDC. Due to the NS' ambivalent and challenging role, a nurse supervisor may be crucial for NS' overall learning experiences about aged care. Notably, the NS emphasised needing time to care for and learn from the patients as individuals, so alternating independent and active learning that takes into account the individuality of the NS is recommended. It could be useful to know more about individual students' learning styles, as this could prove crucial in planning worthwhile learning activities. For nursing in aged care, we suggest aiming to increase NS' involvement and learning experiences are further needed in healthcare. Consequently, our study suggests that aged care settings, which are shown to be practice communities of interest for learning, should be invited to develop and promote learning for NS.

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Author contributions

Study design: GK; data collection: GK; data analysis: GK, ÅS; drafting the manuscript: GK; manuscript development with critical intellectual content: GK, ÅS; and manuscript final approval: GK, ÅS.

Conflict of interest

The authors declare that there is no conflict of interest.

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