

EDITORIAL FOR: Hospital nurses' management of agitation in older cognitively impaired patients

TITLE: Hospitals, people with cognitive impairment, and agitation: how virtual reality could improve real world care

People with cognitive impairment, admitted to acute hospitals are an extremely vulnerable group. The combination of cognitive and physical frailty and a toxic environment increases harms including falls and prolonged hospital stay [1]. "Agitation" is a commonly used clinical term, often a shorthand for behaviour regarded as "problematic or disruptive" [2]. It has a profound impact on the person, staff and fellow patients. Agitation should be considered an indicator of distress secondary to unmet needs, [3] and pain is an important potential driver of this [4].

The paper by Graham et al. [ref] describes an innovative study on how nurses assess and manage agitation in acute hospital in patients with cognitive impairment. The project was underpinned by strong theory and used a novel virtual reality simulation. This enabled researchers to examine not only "what" happened during the simulation of an older person with agitation but "why". The findings are revealing. Hospital nurses predominantly managed agitation with antipsychotics, mostly after undertaking inadequate patient assessments. Pain was missed as a key driver of unmet needs and consequent behavioural distress.

Nurses do not work in isolation; they are part of a multidisciplinary team. However, care of people with agitation is almost entirely seen as a "nursing role". Doctors and other staff are less directly affected by the consequences of agitation and the distress it indicates, and do not actively contribute to day-to-day management [5]. Graham et al. found many nurses chose an antipsychotic as the primary intervention-but in most hospitals, this would be prescribed by a doctor. The study illustrates wider systemic issues around who takes "ownership" and supports the care of people with agitation in acute hospitals.

There are multiple layers of complexity, influence, and context. How hospital staff respond to agitation in people with cognitive impairment reflects the wider organisational culture.

Financial resources and staffing levels are important but there are broader drivers such as the value the organisation places on care of people with cognitive impairment and how well hospitals look after the needs of their staff, whose own personhood is often neglected [5].

Graham et al. highlight the importance of the 'clinical gaze' which reflects the 'discourse, norms and practices they (nurses) experience in their workplace and community of practice'. Providing high quality care to patients with cognitive impairment requires considerable knowledge and skill, which is often unrecognised. There is a lack of research and training

available on how to best care for patients with dementia. Nurses often can only rely on their collective experience to provide care, rather than evidence-based practice. Beaver [6], in her ethnographic study of care of patients with dementia who call out repetitively, identified that healthcare professionals communicate with each other to rationalise becoming unresponsive to calling out. She termed this “socialised care futility” and proposed that this resulted from two protective mechanisms of staff feeling they need to defend their: 1) professional identity and 2) competency by believing that there is nothing that can be done for a patient. These beliefs are a risk to high quality care, and to guard against this, staff must understand the importance of systematic assessment of patient need “assessment as an intervention”, whilst acknowledging that some needs are very difficult to determine or may not be meetable by the healthcare professionals caring for them.

To redirect their clinical gaze, nurses need to feel they have the capacity, capability, and authority to provide good quality care and to positively influence the situation [7]. Knowledge acquired through education and practical training contributes to healthcare professionals developing confidence in their competence [8]. But clinical care is complex and messy. Theoretical learning through didactic training can result in healthcare professionals understanding what they *should* be doing, but *unable* to apply this knowledge in practice. Graham et al. found that whilst there was a good theoretical knowledge of how pain can result in agitation, this was not translated into appropriate action in the simulated exercise.

The skill of applying theoretical knowledge into practice requires experiential learning such as through simulation or reflection. Simulation workshops provide healthcare professionals with a safe learning environment to practice new skills, reflect and receive immediate feedback. The VOICE study [9] successfully used actors who simulated patients with dementia in simulation workshops to teach healthcare professionals dementia communication skills. The multidisciplinary simulation workshops were considered the most valuable part of the training, but when implementing this training, following the research, the cost of retraining and using actors was prohibitively expensive. The use of online simulation training using an avatar and film appears a promising and affordable way to provide experiential learning at scale. This may prove even more potent if an inter professional approach is taken [10].

It is commonly argued that acute hospital wards are not an “appropriate” environment for people with cognitive impairment or dementia. However, if a person with needs hospital care and treatment, that cannot be provided in the community, good quality care should be accessible to them and not cause further harm. Obviously, staff want to provide person centred care, but institutional drivers of “routines, efficiency and risk reduction” [11] are ever

present barriers. Multidisciplinary simulation provides a promising strategy to deliver experiential learning that normalises a more holistic approach.

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