UNDERSTANDING NURSES' USE OF ACTIVITY-BASED INTERVENTIONS FOR PEOPLE LIVING WITH DEMENTIA IN ACUTE CARE

A Thesis Submitted to the Committee on Graduate Studies in Partial Fulfillment of the Requirements for the Degree of Master of Science in the Faculty of Arts and Science

TRENT UNIVERSITY

Peterborough, Ontario, Canada

Nursing, Professional Practice Leadership MScN Graduate Program

January 2026

ABSTRACT

UNDERSTANDING NURSES' USE OF ACTIVITY-BASED INTERVENTIONS FOR PEOPLE LIVING WITH DEMENTIA IN ACUTE CARE

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Older adults with dementia experience higher rates of hospitalization than those without dementia, yet nurses in acute care frequently feel unprepared to support patients with responsive behaviours using non-pharmacological approaches. The aim of this study was to explore the experiences of nurses' using activity-based interventions, such as colouring, word games, therapeutic dolls, and mechanical pets, with patients with dementia in a small community hospital. Using a qualitative interpretive descriptive method, face-to-face semi-structured interviews were conducted with ten nurses (five Registered Practical Nurses, two Registered Nurses, and two Nurse Practitioners). Data were analysed using Braun and Clarke's reflexive thematic analysis. Five major themes and multiple sub-themes were identified: (1) enhancing safety, stability, and emotional well-being, (2) facilitating engagement through practical and adaptive strategies, (3) collective responsibility and collaboration, (4) opportunity for deeper understanding and connection, and (5) challenges implementing activity interventions. The findings highlight how activity-based interventions enhance relational, person-centred care while revealing barriers related to resources, time, and knowledge. These results can inform the Canadian Gerontological Nurses' Association's aesthetic/artful standard and reinforce the need for enhanced dementia education for nurses and evaluation of activity-based interventions.

Keywords: dementia care, responsive behaviours, non-pharmacological interventions, activity, acute care nursing, hospital, relational care, person-centred care, gerontological nursing.

ACKNOWLEDGEMENTS

I would like to start by thanking my co-supervisors Dr. Kirsten Woodend and Dr. Beryl Cable-Williams. Throughout the past few years, you have shared with me your wisdom regarding the research process and provided some much-needed encouragement. I am grateful for your thoughtful responses, constructive feedback, and firm deadlines to help get me through this journey. I appreciated our conversations about older adults living with dementia. Thank you for believing in the importance of this work and encouraging me to continue.

Thank you to the nurses who took the time out of their busy work and personal lives to share their voices to this research project. Your work does not go unnoticed, and I hope that you continue to provide compassionate care to your patients. To the ward clerks who reached out to be part of this study, but were not included for various reasons, I see you and the work you do. You provide exceptional support to patients and their families every shift.

I want to thank my family because this has been a long and arduous journey! Thank you to my dad, Don Peddar, for routinely checking in on me and always waiting to hear my next steps. Your encouragement has meant more than you will ever know. Thank you to my mom, Debbie Savage, who stood in my kitchen many mornings, afternoons, and evenings chatting about my latest readings, insights into my data, and struggles with motivation. Our conversations helped me to keep going, mull over ideas, and get my thoughts in order.

Lastly, I am forever grateful to my husband, Tim Brown, for his dedication to me and getting our family through this journey. You have cooked many dinners and did more than your fair share of bedtimes. Your gentle encouragement and sometimes swift kick-in-the-pants to get through this thesis is forever appreciated! To my children, Linnea, Dawson, and Mallory – I hope that you carry with you a love of learning and exploration. Never cease to be curious!

LIST OF ABBREVIATIONS AND DEFINITIONS

ASC	Alzheimer Society of Canada
ALC	Alternate Level of Care
BPSD	Behavioural and Psychological Symptoms of Dementia
BSO	Behavioural Supports Ontario
DPC	Delirium Prevention Cart
GAT	Geriatric Activation Team
GPA	Gentle Persuasive Approaches
PLWD	People Living with Dementia
PCC	Person Centred Care
PSW	Personal Support Worker
LTC	Long Term Care
NPI	Non-pharmacological Interventions
NP	Nurse Practitioner
RN	Registered Nurse
RPN	Registered Practical Nurse

Definitions

Activity-based Interventions

Activity-based interventions refer to structured or unstructured tasks designed to stimulate physical, cognitive, emotional, or social engagement. Examples include listening to music, colouring, completing jigsaw puzzles, or sensory stimulation (Davis et al., 2023).

Acute Care

Acute care is a branch of healthcare focused on the short-term treatment of patients with severe, urgent, or episodic medical conditions. Services are typically delivered in hospitals and include emergency and intensive care, and inpatient medical or surgical treatment (Hirshon et al., 2013).

Responsive Behaviours

Responsive behaviours are actions, words, or gestures exhibited by people living with dementia. They may be a response to unmet needs, environmental stimuli, or discomfort. These behaviours may include aggression, wandering, resistance to care, or repetitive actions. They are understood not as deliberate acts but as a form of communication or way for a PLWD to cope with a situation that they may find confusing, frightening, or frustrating (Alzheimer Society of Canada [ASC], n.d.).

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CHAPTER 1: INTRODUCTION

Those with dementia are still people, and they still have stories, and they still have character, and they're all individuals, and they're all unique. And they just need to be interacted with on a human level.
— Carey Mulligan

Meet Marie

As a behaviour support nurse in an acute care hospital, I am asked to consult on patient cases when the individual may be expressing challenging behaviours related to dementia. The following story concerns a patient I was asked to assess because of complex and sometimes risky behaviours.

Marie[1] *was hospitalized after a fall at her retirement residence. Previously diagnosed with dementia, she faced challenges with word-finding and short-term memory loss. Physical assessments and labs revealed that Marie had a urinary tract infection, and consequently, she developed delirium during her hospital stay. Marie shared a room with three other patients but struggled to engage with them due to her cognitive impairment and communication difficulties. Marie frequently exhibited distress, often becoming tearful and calling out for help or searching for her mother, who had long- since passed away. When staff assisted her with personal care or attempted to provide other medical treatments, Marie would become agitated, occasionally resulting in her yelling and striking or grabbing staff.*

As the behaviour support nurse, I was consulted to address Marie's frequent vocal outbursts and physical expressions, such as hitting and yelling during care. Upon my initial assessment, Marie was alone in her room and spoke in brief sentences about a drawing on her table from her granddaughter. She became emotional and tearful, expressing a sense of missing her mom and wanting to go home. She did not understand or remember why she had been

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[1] Marie is a pseudonym.

admitted to the hospital. However, during my assessment, she began crying and shared her feelings of boredom and loneliness. Her need for social connection was evident; loneliness often can precipitate behavioural responses (Cohen-Mansfield et al., 2015).

I spoke with Marie's primary nurse as part of my clinical assessment. From this nurse, I learned that Marie often spent her nights at the nursing station colouring or working on puzzles. The nurse also mentioned Marie's interest in knitting, a past hobby, and requested yarn for her. The nurse shared that she would spend time chatting with Marie and using the activity items provided on the unit to reduce Marie's sadness. This conversation highlighted that Marie found comfort in spending time with the nurse and engaging in activities. To address her psychosocial needs and alleviate her boredom and loneliness, the nurse shared that she and other nurses on the unit chatted with Marie, got to know her, and described her as a pleasant and humorous woman. I used these aspects of nursing care to develop a non-pharmacological behaviour care plan for Marie. The plan was implemented, and after a week, Marie's behaviour was stable enough for her to move to the post-acute unit within the hospital.

This story highlights the aspects of nursing care that are not initially obvious when one thinks of nursing care. These aspects of nursing care include mindfulness of psychosocial needs as well as physical needs, and they reflect person-centred care (PCC) and relational caring (Tieu & Matthews, 2024) which are often invisible nursing work (Novy et al., 2023). After spending time in the hospital, one might recognize these specialized nursing skills. However, they often go unnoticed or unrecognized when contrasted with the fast-paced medical model of care that our hospital systems have become known for.

This case study reflects my own experience as a nurse, working with patients with dementia in acute care and trying to find non-pharmacological interventions to reduce their boredom and responsive behaviours. I was encouraged by the conversation with Marie’s nurse to learn that they also sought to implement person-centred non-pharmacological interventions. The story of Marie and her nurse highlights a nurse's ability to improve the quality of care for a person living with dementia and has been admitted to acute care. Marie's case underscores the value of non-pharmacological interventions (NPI), such as robotic pets and activity interventions, in improving the quality of care for patients with dementia. This case study supports further exploration and implementation of similar interventions to manage responsive behaviours in acute care settings. It is how Marie's nurse supported her in a non-pharmacological manner during a hospital admission and my awareness to this work that is the catalyst for this research project.

Background

In the coming decade and beyond, the population in Canada and around the globe will age significantly (World Health Organization [WHO], 2024). Nearly one in five Canadians has reached 65 or older (Government of Canada, 2022), and after the age of 65, the prevalence of dementia doubles every five years (CIHI, n.d.). While aging does not inherently equate with dementia, its prevalence does rise with advanced age (Alzheimer Society of Canada [ASC], 2022). Presently, approximately 750,000 individuals in Canada are living with dementia, and the ASC (2022), projects this figure to rise to over one million in the next decade. Worldwide, the number of people living with dementia (PLWD) is estimated at more than 55 million (WHO, n.d.). In Canada, dementia is the seventh leading cause of death (Government of Canada, 2021) and the fifth leading cause worldwide (Alzheimer's Association, 2024). As the number of people living with dementia increases, so too does the need for healthcare.

Dementia is an umbrella term for numerous neurocognitive disorders, including vascular dementia, Lewy Body dementia, frontotemporal dementia, and Alzheimer's disease (ASC, n.d.). Of these conditions, approximately 60% to 80% of cases are attributed to Alzheimer's disease (Alzheimer Society of Canada, n.d.-a; Lindeza et al., 2020; World Health Organization [WHO], n.d.). There is no one identified pathological cause of dementia, and it is irreversible. Dementia manifests through a range of cognitive symptoms that deeply impact an individual's daily functioning and autonomy. Dementia symptoms vary from person to person but comprise several prominent features, including memory loss, changes in judgement, reasoning, and personality. As dementia progresses, PLWD are likely to experience behavioural and psychological symptoms (BPSD). BPSD encompasses non-cognitive symptoms of dementia, categorized into psychological symptoms like anxiety and depression and behavioural symptoms such as aggression, shouting, and wandering (Behaviour Supports Ontario, n.d.). Roughly 70% to 90% of community-dwelling PLWD develop one or more symptoms (Freeman & Joska, 2012; Kales et al., 2015; Lyketsos et al., 2011).

BPSD, *behavioural expressions*, *behaviours that challenge*, and *challenging* or *inappropriate behaviour* are terms used in various countries (such as the UK) by the public, in academic literature, and in healthcare to describe behaviours that PLWD may express in response to their personal or social needs or physical environment (Behavioural Supports Ontario, n.d.; Legere et al., 2018; Wolverson et al., 2019). However, terms such as those previously listed can be perceived as offensive and derogatory and often imply blaming the PLWD for the problem (Wolverson et al., 2019). Language, particularly words, influences how people think about dementia and how the person living with dementia feels about themselves. Language is also geographical, and different countries use other terms to describe dementia related behaviours.

Therefore, in this paper, I will utilize the term *responsive behaviours* to describe the range of actions and reactions that a PLWD may express in response to various stimuli or as a form of communication. This term reflects common Canadian nomenclature for behavioural expressions. Furthermore, not all behavioural expressions are symptoms of dementia. Instead, they may be appropriate human emotions in response to boredom, frustration, loss of autonomy, or uncertainty, especially in clinical settings (Legere et al., 2018).

Responsive behaviours can be further understood through the *Need-Driven Dementia-Compromised Behaviour* (NDB) model developed by Algase et al. (1996). In this model, responsive behaviours are described as a way for PLWD to express their needs or goals relating to their personality and life history. Algase et al. (1996) identified that behavioural expressions are an embodied way for a PLWD to pursue a goal or express a need and are, therefore, meaningful for nurses to attend to in a person-centred way. Further aligned with the NDB is *The Unmet Needs Model,* developed by Cohen-Mansfield and Werner (1995), which offers a theoretical framework for interpreting responsive behaviours not as random symptoms of dementia but as meaningful attempts to communicate. From this perspective, behaviours such as agitation, wandering, or resistance to care may stem from underlying issues such as boredom, loneliness, pain, or overstimulation. In the behaviour support community, it is widely recognized that all behaviour communicates an unmet need (Cohen-Mansfield et al., 2015; Kovach et al., 2005) and should be acknowledged as having meaning. Using the term responsive behaviour (see definitions) throughout this paper, I plan to reflect a person-centred care approach as it concedes that PLWD are responsive to their environment and others.

Significance of the Problem: Dementia in Acute Care

The progressive nature of dementia often makes individuals more susceptible to medical complications, increasing the likelihood of hospitalization. Canadian statistics indicate that older adults with dementia face hospitalization rates approximately 65% higher than those without dementia (CIHI, n.d.). In Canada, 20% to 25% of all hospital beds are occupied by a person living with dementia (Hynninen et al., 2016). A comparable situation is seen in the UK, where one in four hospital beds is occupied by a patient with dementia (Torjesen, 2020).

Hospital admission can be disorienting and frightening for PLWD. While multiple factors contribute to this, the challenging environment of acute care settings exacerbates the situation for individuals with dementia (Røsvik & Rokstad, 2020). Hospitals are characterized by a fast-paced and often chaotic atmosphere, with bright lights, loud and constant noises, and unfamiliar surroundings, which can be particularly distressing for individuals with dementia (Abbott et al., 2022; Dewing & Dijk, 2016; Røsvik & Rokstad, 2020). Additionally, the underlying medical conditions that necessitate hospitalization, such as infections, injuries, or surgical procedures, can further contribute to confusion, anxiety, and agitation in patients with dementia (Sampson et al., 2014).

Furthermore, acute care hospitals are ill-prepared to provide optimal care to older adults with dementia, especially those who exhibit responsive behaviours (Abbott et al., 2022). PLWD face heightened risks of receiving poorer care and experiencing adverse outcomes in the hospital, such as urinary tract infections, malnutrition and dehydration, pneumonia, delirium, and mortality (Fogg et al., 2018). The challenges faced by PLWD during hospitalization are multifaceted and can have serious consequences. Adverse sequelae such as functional decline, falls, prolonged hospital stays, discharge to long-term care (LTC) facilities, and even death are unfortunately common occurrences (Fogg et al., 2018; Sampson et al., 2014; Zhu et al., 2015). Moreover, PLWD may receive fewer services in hospital, including suboptimal pain management and fewer referrals to palliative care (Fogg et al., 2018).

In acute care settings, healthcare providers find responsive behaviours among the most challenging aspects of dementia care (Yous et al., 2019). Managing responsive behaviours in acute care settings is challenging because of the unfamiliar and unpredictable environment (Røsvik & Rokstad, 2020). The sudden change in surroundings, routine, and the presence of unfamiliar faces can heighten anxiety and confusion in PLWD, often triggering responsive behaviours. These behaviours may present as wandering, day-night disturbances, kicking, hitting, yelling or threatening (Sampson et al., 2014). The prevalence of these behaviours increases during hospitalization, with over 75% of patients with dementia exhibiting responsive behaviours while in the hospital (Sampson et al., 2014). Responsive behaviours can compromise the safety of individuals with dementia, as well as the safety of other patients and caregivers (Sampson et al., 2014).

Healthcare providers should seek to identify and modify the contextual factors contributing to the behaviours of a PLWD before utilizing restraints and pharmaceuticals. Nurses recognized that using restraints could escalate behaviours and was not considered the best practice for caring for patients with responsive behaviours (Soun et al., 2023). Despite this, physical and chemical restraints are used in acute care to manage and prevent responsive behaviours, especially aggression (Walsh et al., 2022; Yous et al., 2019). Moreover, an integrative review of nursing care management of responsive behaviours in PLWD in acute care revealed that nurses perceived that chemical restraints are more acceptable to manage behaviours than physical restraints, and they will use them prophylactically to reduce potential responsive behaviours (Soun et al., 2023).

Pharmaceuticals, particularly psychotropic medications like antipsychotics, antidepressants, and benzodiazepines, are used to address responsive behaviours. These drugs are not recommended for PLWD and pose significant risks, including sedation, increased falls, cognitive decline, and a higher risk of mortality, especially with antipsychotics (White et al., 2017). In some circumstances, such as aggression and psychosis, psychotropic drugs are prescribed as treatment (Centre for Effective Practice, 2016). However, research in hospital settings indicates that after admission, PLWD often experience a significant increase in the use of psychotropic medications, including antidepressants, antipsychotics and benzodiazepines, with approximately 70% receiving new prescriptions during their stay (White et al., 2017). This rise is likely due to the challenges of managing responsive behaviours due to healthcare providers lack of time, knowledge, and resources to implement non-pharmacological interventions (Dookhy & Daly, 2021; Pinkert et al., 2018; Soun et al., 2023; Turner et al., 2017; Yous et al., 2019).

Problem Statement

Considering the well-documented risks of antipsychotics, including increased mortality (Steinberg & Lyketsos, 2012; White et al., 2017), it is essential to prioritize non-pharmacological interventions (NPIs) to address the psychosocial needs of PLWD in hospital settings. Non-pharmacological approaches, such as personalized care plans, environmental adjustments, and behavioural interventions, are considered safer and more effective in many cases than pharmacologic strategies for managing BPSD (de Oliveira et al., 2015). Furthermore, recent clinical practice guidelines from the Canadian Coalition for Seniors Mental Health (CCSMH, 2024) highlight the importance of NPIs, recommending interventions such as music therapy, reminiscence therapy, multisensory environments, massage, touch therapy, and robot-assisted therapy for mitigating responsive behaviours.

Given the challenges hospital environments present for PLWD and the limitations of pharmacological treatments, it is crucial to examine how nurses use NPIs, as these offer alternatives to medication for managing responsive behaviours. By tailoring meaningful and engaging activities, nurses can help alleviate the distress associated with BPSD (Goonan et al., 2019). Despite the potential benefits of these interventions, few studies have investigated how nurses can facilitate activities and meaningful engagement for PLWD in acute care settings. It is essential to understand how nurses implement and utilize NPIs, given the constraints they experience in the acute care setting.

Study Aim and Research Question

With the increasing number of PLWD entering acute care, there is a need to understand how nurses utilize NPIs to support patients with responsive behaviours in this setting. The aim of this study is to explore the experiences of Registered Nurses (RNs), Registered Practical Nurses (RPNs) and Personal Support Workers (PSWs) regarding their use of activity interventions to support patients with dementia in an acute care environment. In this study, activity interventions are identified as a diverse range of resources, including puzzles, dolls, watercolour paints, sorting items, music, and fidgets (see definitions). The research question that drives this study is: *What is the understanding and practice of nurses and PSWs regarding the use of activity-based interventions to support patients with dementia in acute care settings?*

Study Objectives

The following objectives guide this study:

1. To elucidate the perspective of nurses and PSWs caring for PLWD in acute care regarding their use of non-pharmacological activity-based interventions,
2. To identify barriers and facilitators to implementing activity-based interventions in hospital settings.

Contributions to Practice

The rationale for this study is to develop knowledge about how nurses in acute care use activity interventions in an in-patient acute care setting. The results of this study may contribute to nursing knowledge and improve the care of patients with dementia in acute care by providing NPIs for managing responsive behaviours. Additionally, the findings may enhance nursing knowledge through training program development or improving existing dementia training for nurses.

Overview of Thesis

Thorne (2016) describes a structured approach to scaffolding a research study, emphasizing the importance of personal reflection, a critical examination of the literature, and selection of an appropriate theoretical framework. This structured approach ensures a thorough and methodical exploration of the research topic. This thesis is organized similarly. In the first chapter, the topic of dementia in Canada is introduced along with a background on what is known about dementia and responsive behaviours in acute care. The study is further contextualized and my positionality and perspective on using NPIs in dementia care is highlighted in the second chapter. The literature review in Chapter Three consists of a discussion of the relevant literature related to nurses' work with PLWD in acute care and NPIs and a review of theoretical models that apply to the use of activities with older adults. The methodology, including study design, sample and sampling, data collection and analysis, and rigour, will be discussed in Chapter Four. Chapter Five includes the findings section and a thorough data review and thematic analysis. In Chapter Six, the findings are discussed in relation to existing literature. Chapter Seven contains the concluding discussion of this thesis.

CHAPTER 2: SITUATING THE RESEARCH STUDY

In this chapter, I will describe the context of this research study, highlighting my professional experience and the dementia immersion exercise that became the catalyst for the meaningful engagement project and, ultimately, this thesis. I will also reflect on my background and how that contributes to my interest in this research topic.

Dementia Immersion Training

Before the idea for this research study arose, I co-facilitated dementia training with the Geriatric Assessment Team (GAT) Supervisor at a small community hospital in central east Ontario. This training focused on an immersive dementia experience, like the Virtual Dementia Tour® programme (Beville, 2002). We replicated the sensory impairments associated with dementia and aging using simple, cost-effective items. Participants were assigned tasks to complete in a dimly lit room while a speaker played hospital sound recordings, recreating an acute care unit's noisy and hectic environment. This setup was intended to reflect the disorienting mental state characteristic of dementia. This training method was selected based on evidence suggesting that virtual reality can enhance participants' understanding of the dementia experience by provoking emotions such as fear, frustration, and helplessness. These emotions help cultivate a more profound sense of empathy and understanding towards individuals with dementia (Slater et al., 2019). After the immersive exercise, we conducted a debrief and an educational discussion about dementia and responsive behaviours.

During the debrief, the nurse participants expressed frustration with caring for PLWD who exhibit responsive behaviours. They expressed concerns about the limited spaces available for social interactions and the insufficient time to connect meaningfully with patients. Many nurses reported a lack of appropriate activity items to engage or stimulate PLWD, and some highlighted the need for more time to involve patients in meaningful activities. Additionally, the nurses emphasized the necessity for easily accessible and implementable activity items on the units. They believed that having resources, such as manipulatives and activities, for patients to use and interact with would enable them to provide better dementia care. These sentiments are consistent with findings from previous studies on nurses' experiences caring for individuals with dementia in acute care settings (Clissett et al., 2014; Dookhy & Daly, 2021; Yous et al., 2019).

Inspired by the nurses' feedback, I collaborated with the nursing staff, GAT supervisor, and recreation therapist to develop a list of items that could enhance social interaction and engagement for PLWD. The hospital's foundation funded the purchase of activity items to be utilized with patients across the hospital. The activity items were rooted in Montessori-based activities (Camp, 2010; Gitlin et al., 2017; Sheppard et al., 2016), and informed by evidence suggesting their practicality for acute care (Dasgupta et al., 2021). Activity kits, such as the water painting activity (Figure 1) magnetic tiles and others (Appendix A), were stored in Delirium Prevention Carts (DPC) (Figure 2). The DPC, which includes delirium prevention strategies and activity kits, were distributed to the four units within the hospital. The aim of purchasing the items was that nurses might quickly implement these resources to provide an engaging activity for the patient.

Notably, delirium and dementia are separate conditions which often co-occur in acute care. Dementia is a progressive, chronic neurocognitive condition. On the other hand, delirium is an acute change in cognitive function, including attention deficits and disorganized thinking. The prominent feature of delirium is that it comes on suddenly and fluctuates while dementia has a gradual and insidious onset. Delirium superimposed on dementia is quite challenging. In older adults admitted to the hospital, delirium is one of the primary hospital-acquired injuries (Fong & Inouye, 2022). The DPC were designed to support key delirium prevention strategies including optimizing hearing, vision, nutrition, and sleep (Fong & Inouye, 2022). The meaningful engagement items were provided to offer patients opportunities for engagement during wakeful hours. Although the meaningful engagement items were stored in the DPC, this research project was focused on examining nurses' use of the items for patients with dementia. A program evaluation of the DPC was considered, but not the focus of this thesis project.

Figure 1

Water Painting Activity

Water Painting Ideas-Easy

1. Provide the patient with reusable water painting sheets (2 in the package), a cup of water and the paint brush
2. Cue the patient to add water to the brush
3. Cue the patient to place the wet brush on the reusable water pain sheet, covering the sheet entirely to reveal the hidden painting
4. Repeat with the second water painting sheet

To note, the painting will start to fade and eventually disappear after 20 minutes

Note: (a) activity instruction sheet, and (b) the items in the kit, including the painting paper, paintbrush and instructions.

Figure 2

Delirium Prevention Carts

The meaningful engagement program is situated within the context of the challenges faced in acute care nursing and the needs of PLWD who require acute healthcare services. Organizational constraints, such as staff shortages and time limitations, hinder the ability of nursing staff to establish meaningful connections with PLWD while in the hospital (Dookhy & Daly, 2021; Handley et al., 2017; Turner et al., 2017; Yous et al., 2019). Additionally, environmental challenges further impede the delivery of high-quality dementia care (Dookhy & Daly, 2021; Handley et al., 2017; Reilly & Houghton, 2019). Recognizing these challenges, the activity items were strategically purchased for ease of use, familiarity, and cleanability to limit the operational burden for the nursing staff.

Reflective Summary

Research is often shaped by the researcher's own experiences and interests in a particular phenomenon, making it crucial for researchers to acknowledge their pre-existing knowledge and experiences related to the topic (Holmes, 2020). Thorne (2016) advocates for researchers to reflect on their lived experiences and personal insights, as these can significantly influence the research process. I recognize that my perspective, informed by prior interdisciplinary experience, provides a unique understanding of and approach to PLWD experiencing responsive behaviours. In the following section, I will explore my positioning within the topic of interest and its implications for the study.

This study is rooted in my extensive background in dementia care, encompassing roles as both a nurse and a recreation therapist across various settings. My journey into dementia care started during my studies in gerontology. After graduating, I served as an activity aide in LTC facilities, offering recreational and psychosocial support to older adults, many of whom were living with dementia. Subsequently, I managed programs and support services in several LTC homes. I then expanded my horizons by working with Alzheimer Society chapters in the community before advancing my expertise with a bachelor's degree in nursing. This academic pursuit complemented my practical experience, leading me to a role in an in-patient general internal medicine unit and, presently, as a Behavioural Supports Ontario (BSO) Registered Nurse in a rural community hospital.

In my current capacity as a BSO Nurse, I am keenly aware that hospitalized older adults with dementia-related responsive behaviours appear to be an interruption to nurses' more critical role of caring for acutely ill individuals. Furthermore, I have noticed that patients with dementia often receive insufficient attention amidst the demands of acute medical care, a phenomenon supported by literature (Turner et al., 2017; Yous et al., 2019). In my current role, I aim to identify each patient's unique needs and develop behaviour care plans, based on specialized strategies developed through dementia training programs like Gentle Persuasive Approaches (GPA) and Dementiability. The goal of this role is to educate and empower bedside nurses to implement non-pharmacological strategies to manage responsive behaviours. My curiosity about how nurses interact with patients with dementia, and their use of activity interventions sparked the idea for this study.

CHAPTER 3: LITERATURE REVIEW

Dementia does not rob someone of their dignity; it's our reaction to them that does.
— Teepa Snow

Theoretical Frameworks

Theoretical frameworks such as the Need-Driven Compromised Behaviour (NDB) model, the Unmet Needs Model and Activity Theory help to shape our understanding of the behavioural and psychosocial needs of PLWD. These frameworks offer conceptual guidance for our understanding of using activity interventions to support PLWD with responsive behaviours in acute care settings. They also provide a theoretical scaffold for this study (Thorne, 2016). The NDB and unmet-needs model were described in Chapter 1. The Activity Theory, discussed in this section, supports a deeper analysis of how and why nurses use activity-based interventions to support PLWD in clinical practice. In the section that follows, I will discuss the literature examining nurses' experiences of caring for PLWD and NPIs that have been used to support them.

Complementing the NDB and unmet-needs models of responsive behaviours, is activity theory, a model originally proposed by Robert Havighurst (1961). This theory highlights the importance of maintaining meaningful roles and activity engagement in later life to promote well-being. As individuals age, they often lose opportunities for social participation through retirement or changes in family dynamics. This loss can be especially pronounced when older adults are hospitalized. Institutional settings often lack daily routines and personal roles that once gave structure to life, which can exacerbate feelings of isolation, boredom, and confusion, especially for PLWD.

Research supports the view that meaningful engagement in social and leisure activities promotes psychosocial well-being, health, and life satisfaction (Adams et al., 2011). Older adults who are more engaged with staff through everyday activities and relationships are socially integrated and emotionally content in residential care settings (Park, 2009). However, most hospitalized older adults experience significant physical inactivity during their hospital stay, contributing to functional decline (Meesters et al., 2019). This loss of activity can contribute to feelings of boredom and loneliness, both of which are needs associated with responsive behaviours (Cohen-Mansfield et al., 2015). In this study, activity theory offers a lens to understand how nurses' use of activities, such as music, puzzles, and colouring, can support PLWD in hospital. Nurses implementing activity-based interventions may mitigate or counteract responsive behaviours by facilitating activities that align with the patient's interests and abilities, thereby promoting engagement and well-being.

Review of Relevant Literature

I carried out two literature searches to identify pertinent studies. Initially, I met with a health services librarian to develop an effective search strategy. Subsequently, I performed a search specifically targeting literature on nurses' experiences with using NPI to support PLWD who exhibit responsive behaviours in acute care. The aim of this focused search was to gather insights from the nursing perspective, which is relevant to the study. I conducted an independent second search to find relevant documents on NPI for managing responsive behaviours in acute care settings. In this section, I aim to provide a thorough evaluation of the literature covering two relevant areas: nurses' experiences caring for PLWD in acute care and the use of NPIs and activity interventions in hospital. The goal of this review was to enhance my understanding of nursing care practices relevant to PLWD, including barriers and facilitators to optimal dementia care, and the types of NPIs utilized by nurses in acute care. Additionally, I sought to identify gaps in current knowledge regarding nurses' use of activity interventions in acute care.

Nurses' Experiences of Caring for PLWD in Acute Care

Search strategy. The literature search was conducted in CINAHL and PubMed, two electronic databases. The search utilized the key terms *nurs*, perspectives or experiences or attitudes, hospital or acute care, dementia, or Alzheimer*,* NOT *long-term care or LTC or nursing home.* The search was limited to articles published from January 2010 to April 2024. Inclusion criteria required studies to be peer-reviewed, published in English, and focused on acute care or hospital inpatient units, and nursing staff specifically. An additional search of Google Scholar was conducted to find other relevant articles. A total of 1299 articles were revealed, 893 from PubMed and 386 from CINAHL. After removing duplicates and excluding articles that focused solely on education, knowledge and beliefs, and non-nursing or general hospital staff, a total of 11 articles were identified for review. The overarching themes that arose in the literature were providing person-centred care and challenges implementing NPIs.

Person-Centred Care. The person-centred care (PCC) framework is foundational to dementia care and to good nursing care overall. Rooted in the work of Carl Rogers, PCC emphasizes recognizing individual differences and tailoring care to meet each person's unique needs and preferences (Rogers, 1961). Tom Kitwood expanded on PCC, particularly in its application to PLWD (Kitwood, 1993). Before Kitwood's theory of personhood in dementia care, PLWD were often viewed through a biomedical lens, seen as lacking insight and capacity, and treated as having lost their personhood. From this perspective individuals with dementia were regarded as less-than persons because they had lost the ability to remember their history and lived experiences.

Kitwood's work has been pivotal in reshaping our understanding of dementia care and was highlighted by Turner et al. (2017) as an important aspect of the care of people with dementia in general hospitals. Moreover, Goonan et al., (2019) suggested that PCC “requires the clinician to place an emphasis on the individual’s abilities, interests, and values, to foster meaningful engagement in relevant activities within their social and physical environments” (p. 172). The discourse of PCC is prevalent in the literature on nurses caring for patients with dementia in acute care through themes of getting to know them and attending to perceived needs.

Getting to Know Them. Nurses expressed a strong interest in learning about the patient, getting to know them, and "seeing the patient beyond the dementia" (Osuoha et al., 2021, p.39). Nurses in several studies expressed that “knowing the person with dementia” (Houghton et al., 2016, p. 112) and their personhood was important in providing personalized care (Dookhy et al., 2021). Yous et al. (2019), identified that nurses who may not know a patient with dementia collaborated with others to meet their needs more holistically. Furthermore, nurses recognized the benefit of care continuity as patients with dementia get to know them and they recognize the “person’s preferences, needs, and routines” (Yous et al., 2019, p. 9).

Nurses play a key role in shifting from a biomedical model of care to PCC (Clissett et al., 2014). This transition is enhanced when nurses develop relationships with their patients and their care partners, allowing them to understand each person’s preferences, triggers, and needs (Yous et al., 2019). Through this person-centered approach, nurses can recognize triggers for responsive behaviours and apply appropriate non-pharmacological strategies, such as providing the PLWD their favourite activities (Osuoha et al., 2021; Yous et al., 2019). Recognizing the personhood, routines, and past interests of PLWD plays a crucial role in delivering effective dementia care. Yous et al. (2019) identified that nurses set patients up with their preferred activities such as a favourite television show or song choice, enabling them to carry on with their duties. This approach enables nurses to promote a sense of normalcy for patients with dementia while still attending to the other responsibilities that they face on an acute care unit (Pinkert et al., 2018).

PCC recognizes the individual's lived experience, considering their occupational, social, and emotional contexts (Abbott et al., 2022; Dookhy & Daly, 2021). Nurses identified that seeing the patient beyond the dementia, is foundational to delivering care and providing interventions for responsive behaviours (Osuoha et al., 2021). Nurses can implement NPIs more effectively, by understanding each patient's unique background and tailoring activities to meet the specific needs of PLWD in acute care settings (Pinkert et al., 2018; Yous et al., 2020). This personalized care helps maintain patients' dignity and supports better outcomes in managing responsive behaviours. Establishing positive social connections plays a key role in care planning and allows nurses to adjust care through interventions like modifying routines or providing calming activities (Pinkert et al., 2018).

Attending to Perceived Need. While it is common for nursing staff to prioritize bodily care and functions, emotional and psychosocial needs are often overlooked because of more pressing needs of acutely ill patients (Dookhy & Daly, 2021). However, in several studies it was found that nurses attend to perceived needs in an attempt to find meaning to the behaviour (Soun et al., 2023; Walsh et al., 2022). Keuning-Plantinga et al., (2022) identified that nurses primarily respond to a patient's responsive behaviours with care, by being present, asking what was wrong, and organizing activities. Furthermore, Walsh et al. (2022) identified that before administering as-needed (PRN) medications, nurses first assessed and addressed the patient's psychosocial and physical needs to identify the cause of the responsive behaviour. In an integrative review to understand how acute care nurses manage responsive behaviours, Soun et al., (2023) identified that nurses attempt to address perceived needs by toileting, changing the environment, and offering food.

The most frequent needs associated with responsive behaviours included feelings of loneliness, insufficient social interaction, boredom or a lack of sensory stimulation, a desire for meaningful engagement, and physical discomfort (Cohen-Mansfield et al., 2015). In a qualitative study examining nurses' experiences in caring for PLWD, nurses identified that under-stimulation and lack of activities and social interactions contribute to responsive behaviours (Yous et al., 2019). PLWD may become isolated due to communication barriers or the physical limitations of their environment, which is particularly evident in hospital where nurses are busy and the built environment is unfamiliar and sometimes inappropriate for patients with dementia (Houghton et al., 2016; Yous et al., 2019).

Nurses collaborated closely with allied health professionals and families to provide holistic care and ensure that a wide range of needs were met (Dookhy et al., 2020; Yous et al., 2019). Furthermore, Soun et al. (2023) identified that nurses collaborated with families and other healthcare providers to gain insight into the patients' needs and to assist with managing responsive behaviours through music or art therapy. Moreover, in a qualitative evidence synthesis of nine studies, Houghton et al. (2016) found that staff involved family to support patients with dementia. This collaborative approach supports the patient's well-being and contributes to more effective, person-centered care. Nurses emphasized the importance of engaging patients in individualized activities that align with their interests and routines, reinforcing the commitment to meeting the patient's needs beyond just the medical aspects of care.

Challenges of the Acute Care Environment. Nurses work amidst a culture of routine care practices that are challenging to modify (Dewing & Dijk, 2016) and the strict routine and task-oriented nature of acute care nursing often impacts the relationships nurses build with their patients with dementia (Pinkert et al., 2018; Houghton et al., 2016). Furthermore, the acute care environment, staffing levels, time-constraints, competing priorities, and inadequate dementia education are barriers to providing optimal care to PLWD in acute care settings (Digby et al., 2016; Dookhy & Daly, 2021; Pinkert et al., 2018; Turner et al., 2017; Walsh et al., 2022; Yous et al., 2019). Although nurses recognize the importance of PCC and forming relationships with patients (Dookhy & Daly, 2021) they are not always able to build relationships with patients with dementia because of these challenges. The following is a discussion of the challenges impacting the nursing experience of caring for PLWD and the implementation of NPIs.

Fitting Routines. In acute care settings, the structured and fast-paced environment often prioritizes efficiency, with routines designed to address immediate health concerns. The rigid routine of acute care units can be challenging to navigate for patients, especially those with dementia (Dookhy & Daly, 2021; Hartung et al., 2021; Walsh et al., 2022). PLWD often struggle with confusion and disorientation which can be exacerbated in unfamiliar, chaotic settings like hospitals. The pressure for these patients to conform to the typical acute care routine can lead to increased anxiety, agitation, and responsive behaviours such as aggression. Forcing them to fit into this system, “making the patient fit” (Walsh et al., 2022, p. 2029), rather than adapting care to their unique needs, can negatively impact their overall well-being.

Lack of Time. Acute care environments are often fast-paced and focused on treating immediate, often physical, health issues, which can sometimes clash with the slower, more deliberate care dementia patients require (Yous et al., 2019). Caring for PLWD in acute care settings requires significantly more time and attention than is often allocated. The complexity of dementia, combined with the routinized nature of acute care creates a challenge for nurses who strive to provide high-quality, person-centered care (Dookhy & Daly, 2021; Hartung et al., 2021; Keuning-Plantinga et al., 2022; Pinkert et al., 2018;). Nurses reported that time pressures and staffing shortages contribute to responsive behaviours (Dookhy & Daly, 2021; Soun et al., 2023). PLWD typically need more time for almost every aspect of their care, from communication to daily tasks, and this can be difficult to achieve within the time constraints of acute care environments. Due to the circumstances in this setting that impede nurses' ability to provide optimal person-centred care (Hartung et al., 2021), nurses feel dissatisfaction (Keuning-Plantinga et al., 2022) and experience emotional challenges (Dookhy & Daly, 2021).

Managing Risks. Caring for patients with dementia in acute care settings presents unique challenges for nurses to maintain their safety and prevent risks. Both client safety and nurse safety arose as concerns in the literature. Nurses often used physical and chemical restraints to manage responsive behaviours to prevent risk of harm related to aggression and agitation (Soun & Dahlke, 2023; Walsh et al., 2022; Yous et al., 2019). However, nurses recognized that the use of restraints could escalate behaviours and were not considered best practice for the care of patients with responsive behaviours (Soun et al., 2023). An integrative review of nursing care management of responsive behaviours in PLWD in acute care, revealed that nurses use chemical restraints prophylactically to reduce potential behaviours (Soun et al., 2023). Hynninen et al. (2016) found that nurses who had longer work experience were less likely to use physical restraints and identified as having increased understanding of dementia and responsive behaviours.

Dementia Education. Pinkert et al. (2018) identify that nurses feel uncertainty when working with a patient with dementia. This uncertainty can manifest in various ways, from difficulty recognizing and managing dementia symptoms to challenges in addressing BPSD. The lack of education and specialized training on dementia care is a significant issue in acute care settings where nurses often feel ill-equipped to manage the unique needs of patients with dementia, especially psychosocial care needs (Hartung et al., 2021; Yous et al., 2019). Nurses frequently experience uncertainty when caring for dementia patients, largely due to a gap in formal education and training specific to dementia care (Soun et al., 2023).

The Use of NPI to Manage Behaviours in PLWD in Acute Care

Search Strategy. I conducted a second literature search focused on finding literature examining the use of NPI in acute care. The literature search was conducted across several electronic databases: Cumulative Index to Nursing and Allied Health Literature (CINAHL), PsycINFO via Ovid, and PubMed. The search utilized key terms such as *dementia, Alzheimer*, hospital, acute care, acute, inpatients, non#pharm*, non-pharma*,* and *activity.* Search terms were combined using and/or as appropriate. The search was limited to articles published from January 2010 to April 2024. Inclusion criteria required studies to be peer-reviewed, published in English, and focused on acute care or hospital inpatient units. An additional search of Google Scholar was conducted to find other relevant articles.

Initially, the search was aimed at finding articles specifically about nursing use of non-pharmacological activity interventions. However, due to limited results, only one paper (Jesto et al., 2023), the search parameters were expanded to include any type of NPI used in acute care settings for supporting PLWD; from these articles, only those focusing on tactile, or activity interventions, were reviewed as the use of music and multi-sensory environments were outside the scope of this research project. Both quantitative and qualitative studies were considered, provided they involved samples of nurses. Some studies also included social workers, recreation therapists, and occupational therapists, but articles focusing solely on the experiences of these non-nursing healthcare providers were excluded. Additionally, studies set in long-term care or community settings were not included in this review. The initial search revealed a total of 769 articles. After removing duplicates and reviewing each article’s title and abstract a total of seven articles were identified for review.

Non-Pharmacological Interventions for Patients with Dementia. There is evidence supporting a wide range of NPIs to reduce BPSD including sensory-based modalities like aromatherapy, massage, multisensory stimulation and bright light therapy, exercise, validation therapy, reminiscence therapy, music and pet therapy, and meaningful activities (Legere et al., 2018; de Oliveira et al., 2015; Regier & Gitlin, 2017; Scales et al., 2018) The use of psychosocial and environmental treatment approaches are reported to be useful interventions to reduce responsive behaviours (Feast et al., 2020; Legere et al., 2018; Scales et al., 2018). Further knowledge of NPIs applicability stems from LTC and community and highlights the need for interventions that support a caring environment, individualized care, and ongoing education and skill development (Caspar et al., 2018). However, this review focuses on NPIs in acute care, therefore, NPIs focusing on acute care will receive greater attention.

Feast et al. (2020) conducted a thorough analysis of interventions to support PLWD in general hospitals and identified two interventions, multi-sensory behaviour therapy (Staal et al., 2007, as cited in Feast et al., 2020) and robot-assisted therapy (Rouaix et al., 2017, as cited in Feast et al., 2020) as significantly reducing BPSD. In their systematic review of 24 articles, Feast et al. (2020) found that NPIs interventions improved the care and management of PLWD, however, evidence was rated as low- to very low-quality. Moody et al., (2024) further identified that NPIs to support the care of PLWD in acute care have focused on improving nurses' knowledge and skills, and interventions targeting the physical environment and use of technology.

Nursing Specific Interventions. Jesto et al., (2023) conducted a systematic review examining nursing interventions for PLWD and found only two studies that focused solely on the interventions used by nurses. In this review, nurses were shown to have used sensory approaches, such as massage and multisensory stimulation (e.g., dimming lights, aromatherapy, and soothing music) to decrease agitation in patients with dementia (Jesto et al., 2023). Notably, the studies included in this systematic review were set in specialized geriatric psychiatry units within acute care and psychiatric hospitals, highlighting a need for evidence in general hospitals. In a systematic review of the literature, Moody et al. (2024) found that interventions primarily focused on educating nurses on person-centred care or tailored dementia training, such as Gentle Persuasive Approach. Furthermore, nurses identified the interventions helped them improve their knowledge, attitudes, and self-efficacy in caring for PLWD (Moody et al., 2024).

Using the Tools-at-Hand. Nurses are central to shaping the hospital experience for PLWD (Digby et al., 2016; Reilly & Houghton, 2019). Despite challenges in providing optimal dementia care, such as rigid and busy routines, nurses utilize simple, low cost NPIs when caring for patients with dementia (Jesto et al., 2023; Yous et al., 2020). Hartung et al. (2021), Hynninen et al. (2016), and Yous et al. (2020) identified that nurses utilize the tools-at-hand, such as television, folding towels, or walking, to create a diversion to the behaviours related to boredom and overstimulation. In a secondary analysis of qualitative data, Yous et al. (2020) found that nurses routinely utilized sensory activities, such as music and television, and physical activity such as face cloth folding to support the needs of PLWD. The nurses reported that these activities required little of their time and supervision so that they could continue to attend to other duties (Yous et al., 2020).

Using a questionnaire survey, Hynninen et al. (2016) similarly found that nurses would organize activities such as “switching on the TV in the patient room” (p. 5) to reduce behaviours. Other nurses indicated that they would sing or reminisce with patients as diversionary tactics (Hynninen et al., 2016) a finding that was also identified by Yous et al. (2020). Furthermore, Dookhy et al. (2020) also identified that nurses use perfunctory interventions such as conversation and reminiscence, such as learning more about the patient’s past experiences to help reduce responsive behaviours.

Nurses’ Use of Activity Interventions. Nurses were found to utilize activity interventions to help structure patients’ days and reduce boredom, such as reading newspapers together, playing with a ball or balloon, or doing exercise (Pinkert et al., 2018). Nurses took it upon themselves to set up activities such as puzzles with large pieces and colouring pages to give patients experiencing agitation something to do (Osuoha et al., 2021). Nurses also engaged in social activities including singing, conversing, or engaging in “arts and crafts” (Yous et al., 2020, p. 6). Moody et al. (2024) also identified that nurses would utilize hand massage, offer baby dolls, and use robotic animals as NPIs with patients. Though there were several systematic reviews addressing nonpharmacological practices to manage responsive behaviours in PLWD in acute care, there were few mentions of activity interventions specifically.

Activity Interventions to Improve Care of PLWD in Acute Care. Only four articles were identified that focused solely on activity interventions to reduce responsive behaviours and improve outcomes for PLWD in acute care (Dasgupta et al., 2021; Davis et al., 2023; Gitlin et al., 2017; Lourida et al., 2020). Davis et al. (2023) utilized an integrative review approach to analyse seven articles focusing on the use of tactile activity interventions for reducing responsive behaviours in hospital. They classified tactile activity interventions as a subset of NPI that focus on “the sense of touch, providing pleasant or familiar textures and encouraging fine motor function” (Davis et al., 2023, p. 7972). They further described these interventions as providing emotional and physical comfort, and social connection. The focus of the study was on identifying whether tactile activity interventions reduced responsive behaviours in an acute care setting. The outcomes of these interventions included positive behavioural changes such as a reduction in agitation and aggression, and improved engagement with an improvement in apathetic behaviour. Positive benefits were identified during the activity implementation, while only limited benefit was found post-intervention.

One study focused on the feasibility of implementing NPIs to manage responsive behaviours in hospitalized older adults using a pre-post, case-series methodology (Dasgupta et al., 2021). Interventions were tailored to meet patients' needs, focusing on their current sense of identity, sensory abilities, and needs. This study highlighted the importance of individualized activity prescriptions in acute care settings. These authors found that the engagement of PLWD in meaningful activities could mitigate the occurrence of BPSD and improve the overall care experience. Interventions included, but were not limited to, sorting crayons and drawing, playing cards, building blocks, music, cutlery sorting, wood sanding, activity aprons, looking at books or magazines, and stuffed animals.

Primarily, activities were utilized independently, while others required staff and family assistance to implement. The pilot findings suggested that NPIs are potentially feasible in acute care settings, particularly when activities are engaging and when families are involved in both delivery and companionship. However, several barriers to implementation were identified, including limited education for patients and families, skepticism regarding the effectiveness of NPIs, challenges engaging patients during episodes of responsive behaviour, and time constraints.

Gitlin et al. (2017) further explored activity interventions through a tailored activity program specifically designed for hospitalized patients with dementia. In this study, the researchers prescribed two to three activities to patients based on their cognitive functioning and interests. Occupational therapy staff implemented activities for 10 to 30 minutes. The benefits of the tailored activity program included improvements in positive gestures and reduction in anxiety, anger and negative verbalizations. Furthermore, patients showed increases in pleasure and positive gestures, and a decrease in negative nonverbal behaviours. The researchers also identified that it was feasible to implement an activity-based intervention in the acute care setting. Gitlin et al. (2017) highlighted the potential for activity interventions to support PLWD in acute care settings, even though the role of nursing staff in facilitating these interventions was not fully explored.

Lourida et al. (2020) conducted a systematic review of activity-based interventions aimed at improving care for hospitalized patients with dementia. They reviewed six studies, which featured activities such as music, art, board games, card games, crocheting, towel folding, and exercise. Other interventions included "movement therapy and sociotherapy within a psychodynamic therapeutic community program" (Lourida et al., 2020, p. 7). The setting of the studies in this review included acute care and psychiatric day hospital. The authors found that activity interventions effectively improved mood and responsive behaviour, including agitation and anxiety, for PLWD in hospital. The quality of the studies in the review was questioned and

Lourida et al. (2020) suggest that the studies were under powered and of low methodological quality.

Gap in the Literature

Activity-based interventions tailored to the interests and abilities of PLWD have shown considerable potential in improving care outcomes, particularly in reducing responsive behaviours and enhancing overall well-being (Dasgupta et al., 2021; Davis et al., 2023; Goonan et al., 2019; Lourida et al., 2020). Approaches such as Montessori-based activities (Sheppard et al., 2016) and personalized activity programs (Gitlin et al., 2017) provide meaningful engagement that meets the psychological, emotional, intellectual, and social needs of PLWD, especially in acute care settings.

Despite evidence supporting the effectiveness of these interventions, there is a noticeable gap in the literature concerning the role of nurses in the implementation of these activity-based strategies within acute care environments. While studies have examined nurses’ experiences with non-pharmacological interventions (Dookhy & Daly, 2021; Hartung et al., 2021; Keuning-Plantinga et al., 2022b; Pinkert et al., 2018), activity interventions are often underrepresented or not fully explored. There is also a lack of focused research on how nurses and PSWs use activity-based interventions, and how these strategies can be optimized within the constraints of acute care (Yous et al., 2020). Further investigation is needed to better understand nurses' perspectives regarding the use of activity-based interventions and to identify barriers and facilitators to the successful implementation of these non-pharmacological strategies.

CHAPTER 4: METHODOLOGY

While no one can change the outcome of dementia or Alzheimer's, with the right support you can change the journey.

— Tara Reed

In this section, I will discuss the rationale for qualitative investigation and the suitability of interpretive description as the study design, including its usefulness in nursing research (Dolan et al., 2022; Thorne, 2016). Following this discussion, I will outline the recruitment, sampling and data collection strategies. These methods are based on the principles of interpretive description outlined by Thorne (2016). Lastly, I will discuss the data analysis strategy, which is rooted in the reflexive thematic analysis approach developed by Braun and Clarke (2006, 2022).

Philosophical Paradigm

This study is grounded in a constructivist paradigm, a philosophical perspective positing that how we perceive the world significantly influences our understanding of reality (LoBiondo-Wood et al., 2018). Constructivism emphasizes that individuals construct their understanding and knowledge of the world through experiences and reflections on those experiences. The constructivist paradigm is relevant to this study as the knowledge has been gained from the nurses' perspective as research participants. Nurses bring many personal and professional experiences that influence their understanding of health, illness, and patient care. By recognizing the subjective nature `of these experiences, the constructivist approach allows researchers to explore how nurses' perceptions and interpretations shape their practice and interactions with patients.

Engaging nurses in research through a constructivist lens provides valuable insights into the complexities of nursing practice. It acknowledges the importance of their lived experiences and the contextual factors that influence their decision-making and caregiving approaches. Understanding the nurses’ perspective helps to uncover the diverse and nuanced realities that they encounter in their daily work, leading to a richer understanding of the challenges and opportunities within the healthcare environment (Thorne, 2016). By situating this study within the constructivist paradigm, I aim to explore how nurses' perceptions and interpretations influence their practices and responses to the available tools, such as activity-based interventions, and their relationships with patients.

Methodology: Interpretive Description

I chose Thorne's (2016) interpretive description (ID) approach as the methodology for this research study to better understand how nurses experience their clinical practice and use of activity-based interventions with patients with dementia. ID is aligned with the philosophical assumptions of constructivism and helps the researcher explore and interpret issues related to clinical practice. Thorne et al. (1997) identify that ID is intended for small-scale qualitative investigations, such as this one, to capture themes and patterns within subjective perceptions. ID methodology helps researchers generate knowledge that has a practical application, which is particularly relevant for applied disciplines such as nursing (Thorne et al., 1997).

Thorne et al. (2016) acknowledge that as an applied discipline, nursing scholars should seek to pursue data or evidence that can be put into practice rather than solely build theoretical knowledge. ID is less prescriptive than traditional qualitative research models and is well suited to nursing scholars pursuing "credible and meaningful disciplinary knowledge" (Thorne et al., 2004). This methodology enables nurse researchers to adopt approaches from various qualitative methods, such as ethnography, grounded theory, and phenomenology, without the constraints of adhering strictly to any single method when it may not be applicable. By embracing ID, nurse researchers can go beyond merely describing the phenomenon and instead use the most appropriate methods to answer applied research questions and derive new nursing knowledge.

Hence, ID is an applicable form of inquiry for this study as I am pursuing knowledge drawn from nurses to inform future clinical practice in the care of PLWD in acute care settings.

Study Design

Setting

Recruitment for this study occurred in a small community hospital in southeastern Ontario. The number of acute care in-patient beds at this hospital is approximately 60. The hospital has one recreation therapist who primarily supports patients designated as alternate level of care. Additionally, the hospital has a part-time BSO Registered Nurse, a provincially mandated role, to support older adult patients who have responsive behaviours related to dementia, neurological conditions, mental health, and substance use.

Sampling

Recruitment was conducted through convenience, purposive, and snowball sampling (Lobiondo-Wood et al., 2018). According to Lobiondo-Wood and colleagues (2018), convenience sampling is used to "access participants of a particular phenomenon" (p. 272). Thorne (2016) suggests that purposive and theoretical sampling are viable options in ID research. A purposeful sample was sought from PSWs and nurses within the healthcare setting. The targeted sample size for this study was eight to twelve participants. A sample of this size was considered enough to elucidate varied experiences. Previous research examining nurses' perspectives on caring for PLWD in acute care has drawn samples of fifteen (Yous et al., 2019) and eleven (Hartung, 2021). Thorne (2016) suggests that aiming for data saturation is not always relevant in applied qualitative studies because there is always more to be studied, as human experiences are intricately complex. Sampling ceased when it appeared that the collected data was sufficient to capture the complexity of the issue, and I felt confident that the research question had been sufficiently addressed.

The sample was drawn from Registered Nurses (RNs), Registered Practical Nurses (RPNs), and Personal Support Workers (PSWs) working primarily in an acute care unit. RNs, RPNs and PSWs work in tandem to care for patients in the acute care unit. PSWs play a primary role in supporting the personal care needs of patients. Nurses and PSWs who met the following inclusion criteria were recruited:

1. English speaking
2. Hold a professional designation of RN or RPN, or are PSWs
3. Currently, working in an acute care unit at the study site
4. Has been working in the acute care unit at the study site for at least 3 months
5. Has been exposed to the Delirium Prevention Carts and the meaningful engagement activity items

Justification for the criteria set out above is as follows:

English speaking. Participants needed to speak English as the researcher only speaks English.

Registered Nurses, Registered Practical Nurses or personal support workers. These three staffing groups have varying responsibilities and scopes of practice. However, all work together in the acute setting where the phenomenon of interest occurs. These individuals are key informants regarding the phenomenon under study and, therefore, are the best equipped to answer the research question. As a nurse myself, I was particularly interested in learning about nursing practice, however, I chose to include PSWs to broaden the perspective on using activity interventions for the care of patients with dementia. While other health professionals work with

PLWD in this setting, their perspective is beyond the scope of this study. Therefore, occupational therapists, physiotherapists, rehab assistants, and recreation therapists were excluded.

Employed for at least three months and exposed to the Delirium Prevention Carts. DPCs, which house the meaningful engagement activity items, were launched in June 2024. Study participants needed to have the opportunity to be aware of these items and the opportunity to use them. Therefore, staff were recruited if they had three months of job experience in the acute care unit so that they had been exposed to the activity items in the DPCs through the hospital's general clinical orientation and on-the-job training.

Participant Recruitment

Study participants were recruited over several weeks from December 20, 2024, to February 28, 2025, following approval by Trent University's Research Ethics Board on December 17, 2024. I utilized a combination of recruitment methods to maximize reach and engagement among potential participants, ensuring a diverse and representative sample of nurses in the acute care units. Recruitment posters (Appendix B) were placed in highly visible areas within the acute care units of the hospital and in other highly frequented areas. These locations included the staff lunchroom, bathrooms, locker room, and medication rooms. The posters provided key information about the study, including the purpose, eligibility criteria, and contact information for those interested in participating. A quick-response (QR) code was embedded on the poster so interested participants could provide their name, email address, and phone number to the researcher via a Microsoft Form.

In addition to physical posters, the nursing unit manager sent an email (Appendix C) to inform all nursing staff and key informants about the intended study. The email included detailed information about the study, including its purpose, significance, and how to participate. The nursing manager included a feature about the study (Appendix D) in the hospital's acute care weekly newsletter. This brief article included an overview of the research, the aim of the study, the importance of participation, and contact information for the researcher. The newsletter was emailed to the acute care nursing staff and posted in the unit bathrooms. This multifaceted approach aimed to ensure that potential participants were well-informed about the study and had various opportunities to learn about and express interest in participating.

Initially, five participants, two RNs and three RPNs, filled out the form by scanning the QR code. The nursing manager further supported recruitment by sending out an additional email outlining the time commitment and rationale for the study on her own accord. One PSW followed up on this email, expressing interest. I emailed each participant to thank them for their interest and outline the next steps for booking the interview. I also included a copy of the study information and consent form for participants to review. Unfortunately, three participants did not respond to my initial contact email, and I could not book an interview.

Recruitment continued throughout the data collection process. I sought permission from the unit manager to promote the study face-to-face. After speaking to nurses in huddles and small groups, two nurse practitioners, one RN, and four more RPNs reached out via verbal expression of interest or by using the QR code on the poster. One RN and RPN from this group did not continue the interview process as they did not respond to my email. An interview date and time were agreed upon via email, and upon confirmation of the interview date four days in advance, the interview guide was sent to participants for review and familiarization. In most instances, completed consent forms were received prior to the interviews. If participants had not returned a completed consent form before the interview, they were allowed to read and sign it before the interview started.

Bias and Influence. As an insider in this workplace with access to the field and potential study participants, my biases and enthusiasm about the study might have unintentionally influenced potential participants, affecting their decision to participate. To mitigate this, I sought key informants, such as the unit manager, GAT supervisor, and team leads (charge nurses), to assist with recruitment. They were asked to share information about the study during regular huddles on the units and through other means, such as email. In this way, I attempted to reduce the risk that nursing staff participated out of a sense of obligation rather than voluntarily. I struggled with recruitment in this manner. I requested and received permission from the unit manager to meet face-to-face with the acute care staff to introduce my study and allow nurses to ask me questions, facilitating further interest in the study and aiding recruitment.

Data Collection

Face-to-Face Semi-Structured Interviews

Face-to-face semi-structured interviews are widely used in qualitative research (Holloway & Fulbrook, 2001). Interviews allowed for exploring participants' experiences in depth and offered an opportunity for clarification and further probing of areas of interest. I conducted face-to-face semi-structured interviews with study participants, prioritizing in-person interviews whenever possible. In-person meetings were held with eight participants. All interviews occurred in a private location in the hospital. When interviews could not be conducted in person, Zoom^{TM} meetings were arranged. Only two interviews were held via Zoom^{TM} due to the participants' schedule or preference.

At the beginning of the interview, participants were asked to review and sign the informed consent form if they had not returned a signed copy. If copies of the informed consent form had been received earlier, their verbal consent was received again before initiating the recording. The interviews were recorded using Zoom™ on a laptop, and a cell phone was used as a secondary recording device to capture audio data. This dual recording ensured that a backup was available in case of technology failure or error in capturing audio recordings. Each device was password-protected to ensure data security. The interviews ranged from 16 to 55 minutes in length. The shortest interview was with a participant who had not used the activity items. All interview recording files and transcripts were saved using unique anonymized identifiers on a password-protected cloud server and cell phone.

Interview Guide

This interview guide (Appendix E) was developed to include closed-ended and open-ended questions in collaboration with committee members and the GAT supervisor. In developing the guide, I used questions intended to facilitate discussion and attempted to avoid using value-laden prompts. During the interviews, I attempted to maintain a neutral and non-judgmental stance. I used prompts or probing questions to delve deeper into the topics brought up by the study participants. The nature of using a semi-structured interview allowed for the participant to lead the interview beyond the structure of the interview guide. The interview guide was altered as I analyzed the data and unearthed further areas of exploration related to the research question. These additional questions can be found at the bottom of the interview guide.

Transcription

I utilized artificial intelligence (AI) via Zoom™ to transcribe each interview. In two interviews, I forgot to press transcribe on Zoom™ and utilized Otter.ai to transcribe the Zoom™ recordings. Otter.ai is a web-based, password-protected platform that offers free transcription services. Following digital transcription by these AI platforms, I reviewed each interview recording and corrected the transcripts to ensure accuracy. All transcripts were anonymized and saved using unique identifiers, such as NP1 or RPN2, on a password-protected cloud server (Microsoft OneDrive).

Field Notes

Phillippi and Lauderdale (2018) recommend the use of field notes as they assist the researcher in contextualizing the data by providing non-verbal cues and other details of the interview interaction that may not be decipherable from the audio or video recordings alone. The use of field notes allowed me, the research instrument, to capture my thoughts, biases, and reactions during the research process, enabling a process of reflexivity during the data collection and analysis process.

In addition, field notes complement coding and increase rigour and trustworthiness (Phillippi & Lauderdale, 2018). As per Phillippi and Lauderdale's (2018) suggested method of collecting field notes about interviews, I took small scratch notes during the interview process of the participant's behaviours and non-verbal cues. I also captured details regarding my participation as the interviewer, such as questions that I asked that were not in the interview guide. Following each interview, I wrote more thorough notes while my memory was fresh in reflection of my experience as a novice researcher and interviewer. These notes were beneficial in aiding my recall of specific details during the data analysis process.

Data Analysis

Descriptive Statistics

Demographic information, including participants' age, gender, years of nursing experience, education level, and number of years worked in the acute care unit, was collected from them using Microsoft Forms survey questionnaires prior to the interviews (Appendix H).

Thematic Analysis

I used Braun and Clarke's (2006, 2022) six-phase approach to reflexive thematic analysis (TA) to analyze the data. The phases of this process are outlined in Table 1. This method of data analysis is not tied to any philosophical underpinning or qualitative methodology (Braun & Clarke, 2006). Instead, it is a flexible method for data analysis across different qualitative methodologies and is appropriate for ID (Thorne, 2016).

Table 1

Braun and Clarke's Six-Phase Method for TA

Phase 1: Become familiar with the data	Phase 4: Review themes
Phase 2: Generate initial codes	Phase 5: Define themes
Phase 3: Search for themes	Phase 6: Write-up

I began going through the data analysis phases after completing the first five interviews by listening to the audio recordings and reviewing the interview transcripts. Through this process, I generated initial patterns and themes. Using insights from earlier interviews created a more iterative data analysis and allowed for adjustments and deeper exploration of emerging themes as the study progressed.

Phase One: Becoming Familiar with the Data

Following the six phases of this approach, I listened to each recording several times while editing the transcripts to ensure accuracy. I captured my initial thoughts, questions, and reflections on my process as a novice researcher in a journal during transcription. To further achieve familiarization with the data, I read and re-read the transcripts, making notes of emerging codes in a notebook. As someone who learns best through audio experiences, I listened to the audio recordings while reading the data multiple times. Braun and Clarke (2006, 2022) suggest immersing oneself in the written data, however, listening to the audio recordings multiple times was incredibly beneficial to my ability to make sense of the data.

In this phase, I immersed myself in the data, capturing my initial observations and perceptions of the nurses' experiences in a paper journal, sticky notes, and through mind maps. Thorne (2016) suggests that meaningful statements in the data should be set aside at this initial stage to prevent one from fixating on these dominant elements of the discourse. Instead of ruminating on participants' particularly vivid descriptions of using activity interventions, I set any particularly dominant sentiments or compelling quotes aside in the notebook to come back to in the thematic analysis process and write-up.

Phase Two: Generating Initial Codes and Coding

Braun and Clarke (2022) suggest going through the data in a fine-grained way. However, Thorne (2016) suggests that this way of doing coding can cause the researcher to become "derailed by excessive precision in [their] early coding" (p.160). Therefore, I reviewed the data and coded sections relevant to the research question. Initially, the generated codes were semantic labels. However, as I proceeded to immerse myself in the data, I added latent codes to the code list (Appendix F) by focusing on the deeper, more implicit meaning of the data content (Braun & Clarke, 2022). Data was managed using Delve, a web-based qualitative analysis software program. All transcripts were uploaded, stored in the password-protected cloud-based program, and analyzed individually. Initial thoughts and code labels were shared through several meetings with my supervisors and further reflected on before proceeding with the analysis phase.

Phase Three: Generating Initial Themes

I searched for themes in the third phase by collating the initial codes and quotes into an Excel spreadsheet. From there, I collapsed similar codes into categories and generated several themes. Initial themes were focused on the experience of patient engagement, nurse adaptation and creativity, the logistical and staffing challenges in acute care settings, and the emotional satisfaction staff derive from seeing positive patient outcomes. These initial themes were discussed with my supervisors and subsequently refined.

Phase Four: Refining Themes

The fourth phase was a complex phase that involved returning to the coded data extracts in the Excel sheet to ensure internal consistency and external variation of initial themes. Through this iterative approach, I ensured that each theme shared a central meaning and that the themes were distinct (Braun & Clarke, 2006). During this phase, several subthemes were collapsed or reorganized, and some initial themes were either redefined or discarded due to a lack of supporting data or relevancy to the research question. I paid particular attention to how themes related to one another and the overall dataset. I completed this process in Excel, reviewing the extracted data, code labels, and categories to ensure the themes remained grounded in participants' accounts and aligned with the research question. A code tree example is provided in Table 2 (Appendix G). By the end of this phase, I had developed themes that captured the key patterns in the data and supported a coherent, nuanced interpretation of nurses' experiences with activity-based interventions in acute care.

Phase Five: Defining and Naming Themes

In this phase, each theme was conveyed in an overarching title that captured the meaning of the data and the relevance to the research question. As I wrote the report, the theme names were refined and crafted to reflect the thematic analysis taking shape, ensuring they reflected the data and experiences the nurses conveyed. Sub-themes offered a more detailed understanding of the nuanced perspectives of the participants. Using sub-themes, I highlighted specific aspects of the nurses' use of activity interventions within the broader themes. In this stage, I engaged analytically and interpretively with the data to ensure that the findings remained grounded in the participants' voices. The final phase of Braun and Clarke's (2022) analysis is the write-up, where findings are presented with supporting data. In Chapter 5, the themes are described in relation to the research question.

Ethical Considerations

Ethics Approval

The hospital's Chief Nursing Executive (CNE) was approached for consent to conduct the study. The CNE agreed that ethical approval from Trent University's REB would be sufficient to meet the hospital's research requirements in a letter to the research student (Appendix I). Prior to recruitment, ethical approval was sought from Trent University's Research Ethics Board (REB #29345).

Informed Consent

All participants were fully informed about the study's purpose, procedures, and their rights before participating. All participants received written information about the study (Appendix J) when they expressed interest. Signed informed consent forms were obtained from each participant prior to data collection. All consent forms were scanned into a password-protected file folder on the researcher's computer. Original signed consent forms were shredded.

Data Storage, Anonymity, and Confidentiality

Ensuring the confidentiality and security of participant data was a priority throughout this study. To maintain anonymity and confidentiality, interviews were conducted in a private setting and audio-recorded with participants' consent. All recordings were stored on the researcher's password-protected Zoom^{TM} account and cell phone. The transcripts were saved in a password-protected, multifactor-authenticated cloud server provided by the university (Microsoft OneDrive). Transcripts were also stored on Delve, a password-protected cloud-based server. Access to the data was restricted to members of the research team, all of whom were trained in data protection protocols.

To ensure accuracy, transcripts were emailed to participants for member checking. Only one participant responded, confirming the accuracy of the transcript, stating, "I think the transcript looks great!! I don't have anything to add to it" (RPN1). All personal identifiers were removed during transcription and replaced with non-identifying codes such as RN1 or RPN2. No identifying information will appear in any reports, presentations, or publications arising from the study.

All transcripts and recordings will be retained for five years in accordance with institutional and legislative requirements, after which they will be securely destroyed. Digital files will be erased using secure deletion methods, and physical documents will be shredded. Participants were informed of their right to withdraw at any time without penalty. In such cases, their data would have been destroyed unless already anonymized and included in the analysis; however, no participants withdrew. These measures were implemented to maintain the highest standard of data security, confidentiality, and ethical integrity.

Zoom™ Meeting Protocols

Zoom™ is a cloud-based videoconferencing platform that allows users to host online meetings and record sessions securely (Zoom Video Communications Inc., 2016). This platform was used to conduct real-time interviews with participants when face-to-face meetings could not be arranged. Zoom™ sessions were scheduled at mutually agreed-upon times. While Zoom™ offers benefits such as convenience, time efficiency, cost-effectiveness, and ease of use, it also presents potential drawbacks, including connectivity issues, poor call quality, and interruptions such as dropped calls (Archibald et al., 2019).

To support a positive participant experience, several precautions were taken. Invitations and direct Zoom™ links were emailed to participants, and confirmation of receipt was obtained in advance. Before each meeting, I tested my equipment to ensure that audio and video functioned correctly and confirmed that sufficient storage space was available to save the recording. I conducted each interview from a quiet, private space in my home to maintain confidentiality. At the start of each session, I reviewed the purpose of the research and the informed consent form and confirmed that the participants agreed to be recorded before beginning. If internet connectivity was unstable on either end, the interview was to be rescheduled, however, this was unnecessary. At the conclusion of each interview, participants were offered time to debrief and ask questions. Audio-visual recordings were automatically saved to the password-protected cloud server.

Ensuring Rigour, Trustworthiness, and Credibility

In qualitative research, the researcher's subjective lens inevitably influences the study design, data collection and analysis (Braun & Clarke, 2022). Therefore, establishing rigour was essential to demonstrate that the findings were valid and meaningful. In alignment with Thorne's (2016) framework for rigour in interpretive descriptive studies, I ensured methodological integrity by applying four key principles: epistemological integrity, representative credibility, analytic knowledge, and interpretive authority (Thorne, 2016). I maintained epistemological integrity by ensuring that all aspects of the research process were aligned. From my research question to the findings, I ensured that this study was grounded in a constructivist paradigm. I recognized that my experience as the researcher and that of the participants was socially constructed and context dependent. I maintained integrity by recognizing my biases, acknowledging my assumptions through conversations with my supervisors, and keeping a reflexive journal.

To enhance representative credibility, I used member checking by seeking participant feedback to ensure data and interpretation accuracy. Transcripts were emailed to participants for review, allowing them to verify their statements and clarify or amend their responses. Additionally, a summary of the data analysis was shared, allowing participants to identify any errors or discrepancies in my interpretation. Braun and Clarke (2022) note that member checking is only meaningful in reflexive thematic analysis when participants recognize the interpretation as a credible account of their experience. They caution that more critical or abstract interpretations may not be recognizable to participants. In this study, no participants responded to the request for clarification or feedback about the analysis.

To support representative credibility, I sought a sample sufficient to illicit data to support answering the research question. Triangulation was conducted by seeking variability in the sample by recruiting RPNs, RNs, and PSWs. Transcripts were sent to my supervisors to review and discuss my analytic findings. Consensus coding, which is critiqued by Braun and Clarke (2022) as being somewhat problematic to TA, was not used in this study. However, I used peer debriefing by meeting weekly with my supervisors during the data collection and analysis phase to discuss and reflect upon my ideas and assumptions.

To ensure analytic logic, I reflected on what is already known about the topic in a literature review and provided theoretical scaffolding for this study. An audit trail was maintained through a reflexive journal throughout the research process. During the coding and analysis phases, evidence of my analytic reasoning was captured in comments using Delve, Microsoft Word, and Microsoft Excel workbooks. Additionally, I used multiple direct quotations from the research participants to support the claims I was making and to ensure the credibility of my interpretation of the data.

Regarding Thorne's (2016) concept of interpretive authority, I sought to be transparent about my positionality and situatedness. Thorne (2016) emphasized researcher reflection as an approach to rigour in ID. Reflexivity is an important element of qualitative research as it involves a continuous self-examination and reflection on the researcher's biases, assumptions, and influence on the research process (Berger, 2015). Given that I was the primary instrument through which data was collected and analyzed, I reflected on what I already knew about the topic to "better understand the role of the self in the creation of knowledge" (Berger, 2015, p. 220). This reflection occurred at the outset of the study, as described in Chapter Two. This self-awareness helped inform the reader of my knowledge and assumptions regarding the use of activity-based interventions for PLWD and presented a background regarding my interest in the phenomenon under study.

A knowledgeable researcher strives to embrace their personal and theoretical perspectives (Elliott et al., 1999 as cited in Braun & Clarke, 2022) by being deliberate in their decision-making processes and maintaining reflexivity throughout their practice. When I found myself writing from my perspective in the write-up of the findings, I reflected upon this in a reflexive journal and through discussions with my supervisors. I then proceeded cautiously to remove my voice from the written findings and stayed as true to the data as possible using verbatim quotations. I then thoughtfully integrated these reflections into the analysis and discussion, enhancing the depth and validity of the interpretive description.

CHAPTER FIVE: FINDINGS

In this chapter, I will discuss nurses' perceptions of facilitating activity-based interventions for patients with dementia in acute care. Firstly, I will include a description of the study participants, including demographic, employment, and education characteristics to contextualize the sample of nurses that chose to participate. Following this, I will present the thematic analysis which includes five major themes and numerous other subthemes. Throughout this chapter, I will refer to the study participants as *nurses* encompassing all three classes of nurses who participated in this study: RPNs, RNs, and Nurse Practitioners (NPs).

Participant Characteristics

A total of three RNs, seven RPNs, and one PSW contacted the researcher to express interest in participating in the study. Additionally, two NPs who work on the acute care units contacted the researcher and expressed interest in participating in the study. Of these, two RNs, six RPNs, two NPs, and no PSWs participated in interviews. The demographic characteristics of the participants is presented in Table 3. The study included ten participants, of whom 90% identified as female and 10% as male. The average age of participants was 33.5 years, with the majority falling within the 20-25 age range (30%). The sample included individuals across a range of ages, with smaller proportions in older age categories. Half of participants (50%) had less than five of experience as nurses. Half of the participants (50%) were employed at the hospital for 1 to 2 years; three participants (30%) were employed for more than five years. Regarding employment specifically on the acute care units, 30% of participants had been working in acute care for 1 to 2 years, while 20% had between 3 and 5 years of experience. A small portion of the sample (10%) had more than 15 years of experience.

Many of the activity interventions were stored in the DPCs, thus it was important to know whether participants were aware of the carts and the items stored in them. All the participants were aware of the DPCs. The majority (90%) had learned about the DPCs through huddles on the unit, while one participant (10%) had learned from a colleague. Only 30% of the participants had additional dementia training. Two participants had received training in GPA and BSO. Only one nurse had geriatric education through a Canadian Gerontological Nurses Association workshop. Although the focus of this study was not to determine whether nurses with additional training used activity materials more with patients, the nurses did perceive that additional training was valuable in aiding their work with PLWD, as will be discussed in the following section.

Table 3

Demographic Characteristics of Participants

Demographic Variables	**Number**	**Percent**
Gender		
Male	1	10
Female	9	90
Age in years	33.5 (mean)	
20-25	3	30
26-30	1	10
31-35	2	20
36-40	2	20
41-45	1	10
46-50	1	10
Highest Level of Education Completed		
College Diploma	5	50
Bachelor’s Degree	3	30
Master’s Degree	2	20
Discipline		
Registered Nurse	2	20
Registered Practical Nurse	6	60
Nurse Practitioner	2	20
Personal Support Worker	0	0
Years of Experience		
4 to 6 months	0	0
6 months to 1 year	1	10
1 to 2 years	2	20

3 to 5 years	2	30
More than 5 years	5	50
Length of Employment at Hospital		
3 to 6 months	1	10
6 months to 1 year	0	0
1 to 2 years	5	50
3 to 5 years	1	10
More than 5 years	3	30
Years Working on Acute Care Unit		
3 to 6 months	1	10
6 months to 1 year	2	20
1 to 2 years	3	30
3 to 5 years	2	20
6 to 10 years	1	10
11 to 15 years	0	0
More than 15 years	1	10
Awareness of the Delirium Prevention Carts	10	100
How Staff Learned About the DPCs		
Huddles	9	90
Colleague	1	10
Additional Dementia Training		
Yes	3	30
No	7	70
What Additional Training?		
BSO	1	10
GPA	2	20
Other	1	10

Overview of Themes

Nurses' use of activity-based interventions with patients with dementia is intricately woven into the complex environment of acute care, which presents its own unique challenges. Nurses shared their experiences working with patients with dementia, utilizing both practical activities (e.g., towel folding) and toy-like items (e.g., magnetic tiles) to engage them. Their perspectives shed light on why they choose to use activity-based interventions and provided insight into how these activities are used in practice. They highlighted not only the practicality of the interventions, but how these tools supported the psychosocial and emotional well-being of both the patients and themselves. Furthermore, nurses identified barriers and facilitators that influenced the use of activity-based interventions for patients with dementia in the acute care setting, illustrating the complexities of integrating these approaches into daily nursing practice. Their experience is demonstrated in five major themes: (1) enhancing safety, stability, and emotional well-being, (2) facilitating engagement through practical and adaptive strategies, (3) collective responsibility and collaboration, (4) opportunity for deeper understanding and connection, and (5) challenges implementing activity interventions (Figure 5).

Figure 5

Themes and Subthemes of Nurses Use of Activity Interventions

Enhancing safety, stability, and emotional well-being

- Managing responsive behaviour through engagement
- Enhancing visibility and monitoring at the nurses' station
- Providing a sense of normalcy through tailored activity
- Reducing stress and worry for the nurse

Facilitating engagement through practical and adaptive strategies

- Trial-and-error approach to engagement
- Adapting to patient capabilities.
- Personalizing activities based on preferences and history
- Facilitating familiar activities with easy to use items
- Utilizing items that are readily available

Collective responsibility and collaboration

- Collective responsibility in patient care
- Family involvement in supporting care
- Learning from colleagues

Opportunity for deeper understanding and connection

- Building relationships through curiosity
- Developing empathy and understanding
- Humanizing care and fostering respect
- Enhancing professional fulfillment

Challenges Implementing Activity Interventions

- Competing priorities and time constraints
- Uncertainty in selecting and implementing activities
- Reactive approach to implementation
- Resource limitations and availability
- Varied patient engagement and response

Why Nurses Use Activity-Based Interventions

Enhancing Safety, Stability and Emotional Well-Being. Nurses shared considerable concern for patient safety and well-being. They described using activity-based interventions to maintain a safe and stable care environment for patients with dementia. By using these interventions, nurses identified that they could redirect patients' responsive behaviours and reduce the need for physical or chemical restraints. Through engaging patients in activities, nurses supported their safety and well-being by enhancing daily routines, providing a sense of normalcy, and creating social and relational benefits. While most of the data related to the stability these interventions offered one subtheme was identified where activity interventions benefited the nurses and reduced their stress and worry. The following subthemes illustrate how the use of activity-based interventions provides safety and stability for patients and nurses in acute care and describes why nurses are drawn to use these interventions: (a) managing responsive behaviour through engagement, (b) enhancing visibility and monitoring at the nurses' station, (c) providing a sense of normalcy, and (d) reducing stress and worry for the nurse.

Managing Responsive Behaviours and Promoting Safety Through Engagement. A recurring theme across the data was the value of activity-based interventions as a non-pharmacological strategy to manage responsive behaviours, wandering, and falls. Nurses acknowledged that the hospital environment is not ideal for people living with dementia, identifying that fear, confusion, and especially boredom can contribute to responsive behaviours. Several nurses described how patients often spend their time doing nothing but *"staring at the same four walls everyday"* (RPN6). Nurses reported that there are limited recreational therapy activities on the unit to help patients pass the time. They reflected that few opportunities existed for patients to attend structured programs off the unit and the days can be long and drawn out, especially for patients waiting for long-term care.

Nurses identified that the monotony of the hospital setting may drive behavioural expressions such as agitation, wandering, and restlessness. Activity-based interventions play a critical role in addressing this boredom and engaging patients in meaningful and stimulating tasks that provide a sense of purpose and normalcy. Nurses were motivated *"to introduce [activities] in a way that it's just something to do, something to keep the time"* (RPN3). One nurse described how a patient who was "*bored and stuff*" (RPN5) became much more animated and joyful when provided with a cd player and music, even dancing in his room while in isolation. Nurses reported using interventions such as colouring, fidget tools, puzzles, and tactile items to redirect boredom. As one nurse stated, *"[activity engagement] entertains them, right? A lot of the times they're not that acutely unwell. But they get really bored on the unit. So, it helps"* (NP1).

Nurses emphasized that activity engagement would alleviate some of the restlessness patients experienced. By addressing boredom and idleness, nurses offered distraction and provided the patient with *"something to focus on"* (NP1), keeping them "*occupied and happy…not just sitting and watching four white walls all day"* (RPN6). Nurses identified that responding to responsive behaviours included attending to unmet needs, such as hunger or needing to toilet. However, once physical needs were reduced activity engagement helped the patient pass the time:

> *...they're [the patient] agitated and wanting something... you've just got to find what it is and then it deescalates them. Until something else comes up, if they're hungry, or has to pee, stuff like that. But if you eliminate all those things, then you provide the activity and then time goes by.* (RPN5).

Many nurses described restlessness and agitation as behaviours that needed their attention. While nurses did not reveal in their narratives what this behaviour looked like, it became apparent to that restlessness and distress required nursing intervention. For example, one nurse shared that they "*use some of the activities for patients that are very, very restless [and]in need of some support"* (RPN1). Motivation to use activities stemmed from seeing a patient's anxiety and trying to ameliorate that distress:

> *Usually, the patient is stressed out they're upset there's something going on that's disrupting their routine. So, I want to try to solve that problem. So, for me, it's trying to relieve that stress, that anxiety…engaging with them, with these activities, is really about trying to improve…to relieve the stress of whatever's bothering them in that moment. I would say that's the majority of times that I initiate those activities.* (RPN4)

Nurses described using items such as colouring, crosswords, and puzzles to help alleviate a patient's distress before resorting to as needed medications, except where behaviours posed risk.

By using activity-based interventions nurses are offered an alternative to pharmacological approaches. Nurses utilized these strategies to support positive outcomes for patients resulting in decreased agitation and restlessness. Nurses expressed awareness of using these interventions as a first line of defense for responsive behaviours, prior to giving an as needed medication:

> *…we want to use the activity items first…it does influence my decision to use a PRN. If I can use this activity at first, if really, it's just that…it's not an excessive behaviour where I would have to use a PRN, but it's still a behaviour.* (RPN2)

The effect that these resources have on patient behaviour can lead to a decreased need for antipsychotic medications and consequently foster overall patient safety and well-being:

> *For many patients, it's been night and day. They've required less medications. It gives them a sense of safety. It gives them a focus because now they have something to occupy their time. If it's a baby [doll] and it's someone that's always loved being a caregiver, they now spend that time that they were anxious and fretting and crying, now focused on caring for this little baby. Or if it's a [robotic] dog and they're playing with the dog in their capacity, they're petting the dog or they're doing puzzles, and you can see an actual physical calming effect on the patient. They have less agitation.* (NP2)

These quotes illustrate a key dimension of activity interventions as not just tools for distraction, but as clinical strategies embedded in nursing care. Engaging patients in meaningful tasks was seen as a valuable strategy to reduce the use of sedating PRN medications for managing responsive behaviours. One nurse shared,

> *I always try to practice least restraint and if I can get a patient to stay on task and direct their behaviour in a positive way without giving a PRN medication, that's always the desired effect. I would say that engagement with the activities, especially things like colouring… you can avoid… [PRN medications].* (RPN4)

This quote underscores how purposeful engagement can promote emotional regulation and reduce the need for reactive or restrictive measures.

Nurses noted that activity engagement may serve as an effective tool, helping patients "*kind of regulate again*" (RN2). Structured activities can provide the necessary distraction to help patients regain a sense of calm. However, nurses did not identify these resources as nursing interventions. They reported no formal assessment to monitor them as behaviour management strategies. However, a nurse indicated that "*if we can prevent aggressive behaviour or redirect those behaviours, I think that's a really good gauge of success*" of the activity-based interventions. Furthermore, the effectiveness of the intervention was reported as an observable decline in the patient's challenging behaviour and agitation, as indicated in this statement:

> *For me, if this is a person that say spent eight hours fretting and anxious and calling out at the desk a week ago, and the only changes that we've brought in were these [activity] interventions…and they're now sitting at the desk for an hour and they're just playing with the blocks or they're doing whatever. That's a significant success because now they've had an hour where they've not had the fear and the agitation or the responsiveness that they had before.* (NP2)

Success was also measured beyond emotional and behavioural changes and could be assessed physically:

> *You could see like the joy and the concentration… you can see demeanor change, shoulders relax. We can actually see it vitally too sometimes, it they're finally calm. They might be escalated. We can't get vitals. Where the vitals are really elevated and we've got them doing their*

> *activity, listening to their music, watching their show, petting the cat and they're back to baseline.* (RN2)

Furthermore, positive outcomes of the activity-based intervention were identified as a reduction in risk: *"well, they stayed in their seat…"* (RPN2). Aside from managing responsive behaviours, the use of activities as a fall prevention strategy was evident in the data. Most participants identified that maintaining patients' safety was a factor in offering activity-based interventions. The prevention of falls and wandering was particularly important and was a key driver in nurses' reasoning for choosing to engage a patient in an activity:

> *It allows me to be able to ensure that the patient's needs are being met so that they're not, you know…I go back to safety concerns, right? If a patient's left completely unattended, bored, and with no direction at the nursing station, even if they have, like, a seatbelt on with their wheelchair, they could take it off and try to stand up, wander and fall, right? Whereas if they have a task to focus on, they're sitting at the nursing station, even though maybe it's just the clerk there hanging out them and there aren't any nurses there, but they're quietly working on a word search or colouring page, it takes away that element of wandering and no direction.* (RPN4)

The prevention of falls was a prominent factor in nurses setting a patient up with an activity. They identified that the activities provided a therapeutic alternative to manage restless behaviour that could contribute to fall risk. When they did offer an activity, it was often to reduce the need to redirect the patient to sit down repeatedly. Patients may not recognize that they *"can't stand and walk on their own but still are trying to. So, it's a safety concern and we want to distract them from that behaviour. It's a good distraction"* (RPN2). Nurses described that the acute care setting they were employed in did not utilize physical restraints as much as in other facilities. These interventions supported their adherence to least restraint practices, as one nurse noted:

> *We don't really use restraints here, if at all, it's extremely minimal, and it's only in extreme situations, and it's only a lap belt. But, if we can ensure the patient is safe and perhaps, they're engaging in an activity or with one of therapeutic dolls or something and we know where they are and they're doing something safe and enjoyable it's that one less stress and worry for their safety, it's keeping them safe, which is always our priority.* (RN2)

Activity-based interventions not only align with least restraint policies but also foster a more supportive and therapeutic care environment for both patients and staff.

Tied closely to the subtheme of managing responsive behaviours was the idea of emotional well-being and support. Nurses identified that activities not only helped to reduce responsive behaviours but also provided comfort to patients, which was outside the bounds of managing responsive behaviours. Nurses reflected that items such as therapeutic dolls and robotic pets were soothing for patients:

> *I will say though, the dolls that we use on the unit, they are very much like the patient doesn't want to give them back because they love them so much. I think they think it's like a part of their identity now. So I would say that's a positive, for sure.* (RPN1)

Not only did nurses recognize that activity interventions helped to stabilize a patient's mood and behaviour, but they also observed that this contributed to a more peaceful nursing environment. For example, the provision of a simple colouring activity had a noticeable calming effect on a restless patient:

> *They [the patient] were scooting around and very restless, like, 'I got to get out of here. I got to get out of here.' And then we kind of handed them the colouring sheet. And they settled a little. They stopped with the 'I got to get out of here, and I got to go to my room, and I got to do this.' They were just chill.* (RPN6)

Reducing one patient's behavioural expressions effected the whole unit, as one nurse described: "*when you get them [the patient] an activity that they're actually happy with, you find the unit has calmed down. It's quieter, it's less busy, stressful"* (RPN1). These quotes are pivotal as they reveal how activity engagement contributes to behaviour management in a non-pharmacological way, extending beyond the patient to improving the environment within the unit.

Enhancing Visibility and Monitoring at the Nurses' Station. Nurses were motivated to use activities to enhance visibility and monitoring. In this acute care setting, nurses identified the patients they cared for could be dispersed across the unit and visibility was a significant safety concern. Nurses described not having "*time to be closely monitoring the patient in their room if they're all the way down at the end of the hallway*" (RPN3). To address these concerns, nurses reported bringing patients to common areas, or to *"a room that everyone can see them"* (RPN1). Patients in need of frequent monitoring and redirection due to perceived risk of harm related to falls and responsive behaviours were routinely brought out of their rooms for supervision. As one nurse stated:

> *You know, at the nursing station I can still keep an eye on them. Other people can keep an eye on them, but they're engaged in the activity. So, they're not trying to get up on their own. They're not yelling and screaming.* (RPN2)

With the limited space on the acute care unit to engage in structured activities, the nurses' station was illustrated as a central space for activity engagement and socialization. Nurses described setting patients up in this space because it was the only accessible area on the unit for activity. For instance, one nurse shared, "*They don't really have a spot where they can just go, because it's acute right? There's no spot"* (RPN5). They indicated there was one family room, but they did not want to use that for activities because it was not easily supervised. One participant described how a patient would sit at the desk "*for an hour and they're just playing with the blocks or they're doing whatever*" (NP2), highlighting how this space was reimagined as a therapeutic zone.

Nurses identified that they used the opportunity to engage a patient in activity at the nurses' station to ensure that someone on the unit could keep an eye on them: "*...at the nursing station I can still keep an eye on them. Other people can keep an eye on them, but they're engaged in the activity"* (RPN2). This fostered security and provided the nurse with an opportunity to complete other duties, as described by this participant:

> *You can actually get some work done. Not to minimize them [the patient with dementia], but sometimes, if they're wandering and you're worried they're going to get out…you can set them up…at the nurses' station, sometimes it's too loud, but…then I know that they're safe and I know I can get stuff done and they're doing an activity and I can, you know, continue on with checking on them.* (RPN1)

This quote illustrates how engaging patients in activities in a common area, despite the potential drawback of overstimulation, allows the nurse to manage their workload effectively while maintaining patient safety. The nursing station served as both a practical space for enhancing patient safety and supervision and as a therapeutic environment. Hence nurses were enabled to support patient safety while attending to competing responsibilities.

Providing a Sense of Normalcy. Nurses expressed concern that acute care settings are not appropriate places for patients with dementia, although some individuals with dementia may also require acute medical attention. One participant described that they observe the nurses using activity items with patients when they no longer need acute medical care: "*…the time I see the activities being used the most is typically with like the ones [patients] that are ALC [alternate level of care] waiting for home. So, they're not acute anymore. They're just like stuck up here"* (NP1). In acute care settings, nurses identified that patients living with dementia may experience responsive behaviours because of the lack of daily routine and boredom. Nurses noted that involving patients in familiar activities provided cognitive stimulation and helped to establish structure and routine. One nurse described, "*So if they [the patient] can read a book at the same time that they would read the newspaper every day then it gives them a sense of routine. Building a routine, daily routine"* (RPN3).

Nurses also expressed that once patients developed a routine, they expressed a sense of anticipation for various activities, positively influencing their mood. For instance, one nurse described a time when a patient looked forward to sitting at the nurses' station and engaging in tactile stimulation by using a fidget board:

> *He was really interested in that [fidget] board. And prior to that introduction to the board, he would not sit still, and he was, you know, frustrated and just…not calm. And then he would look forward to coming to the nursing station to sit and do the board. So, it kept his attention, right? For a long period of time. So, I think it definitely did affect his mood on a regular basis.* (RPN2)

Activity-based interventions can help nurses provide patients with familiarity, purpose, and identity, allowing them to feel more comfortable in the acute care environment. Nurses described how engaging patients in familiar activities provides a sense of normalcy while in hospital. One nurse expressed, "*it just creates normalcy for them, or a new normalcy, that actually gives them a sense of purpose and allows them to be a person again"* (NP2).

Activity-based interventions enabled nurses to provide an opportunity for patients with dementia to reconnect with past interests. Patients' personal interests and preferences often dictated which items nurses provided, as depicted in this statement:

> *…I can remember a patient that like always loved to play euchre or cards or whatever. So that's when we were utilizing, I think there was a deck of cards for them to do or even just to play solitaire. I do find that… a lot of the times people have like their go-to things, right?* (RN1)

When activity interventions matched a patients' preferences the impact was far greater than activity interventions that did not reflect interests. Nurses described the importance of finding activities that personally reflected the patient's past roles and hobbies. Nurses conjectured that this familiarity offered an opportunity for patients to reconnect with past experiences, offering comfort and emotional stability during an acute care admission.

***Reduces* Stress and Worry for the Nurse.** Nurses indicated that activity-based interventions offered meaningful support to them as well. These interventions provided benefit to the nurses and helped to alleviate their own stress and worry. The ability of the nurse to set a patient up with an engaging, independent activity created a sense of relief, and ease in the context of demanding workloads. For instance, one nurse described the use of activity interventions in relation to her workload and emotional state this way:

> *It [activity intervention] works, like so well. I know it works. So, it's great. I mean, if we didn't have these activities, I think it would be very hard to do everyday life as a nurse, because they are distraction activities for the patient, but they're also helpful for us too, because we know that they're safe doing an activity and we can continue on, but we also know it helps them and their behaviour.* (RPN1)

This quote highlights the dual benefit of activity-based interventions. Nurses could set a patient up with an independent activity and they would calmly engage, allowing the nurse to experience reduced emotional strain while attending to other clinical responsibilities. Nurses acknowledged that when they set a patient up with an activity in a location with enhanced supervision they could *"go off and finish my med pass, or… answer my call bells"* (RPN4).

Nurses acknowledged that the activity-based intervention items offered practical ease when the patient could do the activity relatively independently and without direct nurse-and-patient engagement. Interestingly, one nurse reflected with surprise about the benefit the interventions offered her and her workload:

> *I think it was a lot easier for me, like selfishly, because they were very preoccupied with that [colouring], and I was able to get things done without them following me around to other patients' rooms, telling me they need to go home.* (RPN6)

By setting the patient up with something to do, the engagement "*definitely helps me do my job"* (RPN2), reflected one nurse. This sub-theme illustrates how activity-based intervention not only benefits patients with dementia but also plays an important role in supporting the emotional well-being of nurses.

How Nurses Use Activity Interventions

Facilitating Engagement Through Practical and Adaptive Strategies. Nurses embraced dynamic and multifaceted approaches to promote patients' meaningful engagement in activity. Given the complexity of dementia care, nurses often relied on flexible patient-centered methods to determine the most suitable activities. This theme is broken down into the following subthemes: (a) trial and error approach to engagement, (b) adapting to patient capabilities, (c) personalizing activities based on preferences and history, (d) facilitating activities with easy-to-use items, and e) utilizing what is readily available.

Trial and Error Approach to Engagement. Nurses shared stories of their willingness to try the activity resources, expressing an attitude of experimentation when learning what worked best for patients. Through trial-and-error, adaptation, and creativity, nurses worked to identify interventions that best supported patients' needs. Nurses learned how to use the items through trying and adapting their practice, much like the way they learned about dementia care strategies. One nurse explained that her ability and confidence in engaging patients with dementia in activities gradually developed through experience and repeated practice:

> *I think from trial and error… I've not been a nurse forever, but like with experience, I feel like…When I was a new nurse, having someone with dementia was almost like a nerve-wracking thing, right? Because you don't know until you know, right? Like you don't know how to properly deal with someone…cognitively impaired…*(RN1)

Nurses' skills in engaging patients in activities developed from using the items, rather than through training.

Without any formal instruction on how to introduce the activities, nurses relied on their prior experiences, knowledge of the patient, and nursing intuition. Although the activity kits came with instructions, nurses often did not use them initially. Only when the patient struggled with the activity did the nurse try to use the instructions to improve the patient's engagement. As one participant stated,

> *I don't know if this patient's going to sit for very long. I'll just kind of be like, let's do something I know is going to work for the first time, and then I can go back to actually doing the real instructions…*(RPN1)

Nurses were responsive to patients' interests and spent time trying to figure out the best item to use. One nurse mentioned, *"it takes a while to figure out what works for them [patient]*" (RN1), indicating that ongoing assessment is necessary to refine activity choices. Another nurse expressed how she adjusted her approach to find a suitable item:

> *I just take away that one, go back to the bin, find something else. Well, maybe this will work. And I just keep going through it until I've gone through the whole bin, and then I'm all out of ideas. You know, then I got to really, you know, get creative right.* (RPN2).

This approach is underscored by the nurse's interest in finding the most meaningful activity for the patient and highlights the reflexivity involved in nursing care.

Nurses emphasized that providing activities based on a patient's preferences was important. They identified that trying to find an enjoyable activity for the patient took time and effort. Reflecting on their approach to introducing activities, one nurse expressed, "*it really depends on the person, right? Trying to find the right activity for the right person. You know, so it's trial and error"* (RPN2). Some nurses described using their own instinct to choose activities and then adjusting their approach. This was necessary when patients could not express themselves. One nurse stated,

> *I find I'll just like, for factors [influencing use], I just like will pick myself sometimes. If they don't tell me their likes, I'll just do like. I'll just, let's try. Let's try this. If it doesn't work, let's try something else.* (RPN1)

This iterative approach enabled nurses to personalize the activities and tailor the interventions to suit the patients' unique abilities and interests.

Adapting to Patient Capabilities. Nurses modified the activity interventions based on patients' physical and cognitive capabilities. Adaptations to the activities were made to ensure they were accessible to patients with varying cognitive ability. One of the most frequently described modifications was the simplification of tasks, or as one nurse put it, *"making it easier for the patient"* (RPN1). Nurses adjusted materials such as puzzles, colouring sheets, and word searches to match the patient's cognitive function. They identified that patients with more advanced dementia required more creative adaptations. One nurse described,

> *I think they [patients with more advanced dementia], benefit from more simpler activities. Sometimes, if it's just a smaller activity. Their attention span is shorter, too. So, having something that's still like catches the eye and makes them want to do it, but also is not as difficult.* (RPN1)

Others described modifying activities to accommodate patients who struggled with more complex tasks or had a limited *"ability to keep focus"* (RPN2).

Nurses reported reducing the number of puzzle pieces or swapping small-pieced puzzles for ones with large pieces. Another nurse described placing puzzle pieces out of sight to make the task less challenging: "*If they [the patient] are doing like a puzzle, and there's a lot of pieces, sometimes I'll take a few away so they feel like they're getting closer to the end of the challenge. It just helps them"* (RPN1). Similarly, nurses described making colouring materials and word games simpler. They described printing off colouring activities that were less intricate making it easier for patients to use without feeling overwhelmed: "*I might print off a colouring activity that's a little less advance, like not as many lines that they have to…You know, not as many different spaces to colour in or a more simple word search"* (RPN3).

Other nurses considered patients' physical dexterity and modified activities to support those with limited fine motor skills. One nurse described taking into consideration a patient's physical function, cognition, and safety when offering a colouring activity:

> *There are some patients that would benefit more from like a thicker marker than a pencil crayon… for dexterity. But also, if they are in a bit of a delirium. The pencils can be a little dangerous. So, like a fatter Crayola marker is sometimes simpler and easier than like the thinner stuff. Or there's been colouring pages that are just a little bit small…those are the easiest ones to modify.* (RPN2)

By reducing the task complexity, nurses made the activity more appropriate for the patient. This helped to reduce patients' frustration and enabled them to participate meaningfully.

Nurses utilized creative problem-solving skills to adjust activities when the patient was not meaningfully engaged. Nurses described moments when they adapted their approach in response to a patients' immediate concerns or preferences. By modifying the activity, nurses facilitated better patient engagement and enhanced emotional connection. One nurse reflected on adapting the activity to support a patient who was distressed and not able to complete the activity that was initially presented:

> *[I] present[ed] …the colouring activity for example and [the patient said]…, 'oh, I don't, I don't want to do that.' And I'll say, oh, like. 'What do you want to do?'… They were focused on like having to pick up like a grocery list, for example. So, I said OK, [and] I flipped the page over and I said write out your list and maybe we can go look for those things. I'll, I'll go look for those things for you. You just give me the list of things you need, and that was really helpful.* (RPN4)

This creative modification occurred when patients' cognitive function impaired their engagement with a particular task, such as word games. Nurses needed to think quickly to maintain a patient's interest. Instead of focusing on the structured activity, nurses reframed the activity entirely. They described turning the time together into a storytelling or reminiscing session, or they spent time doing an entirely different activity with the patient. One nurse reflected,

> *There are patients that sometimes they can't do the word search puzzles…So I'm like, okay, let's close your eyes, see where your finger lands. If their finger lands on the letter O, like it's like 'How many objects, or what starts with the letter O?' and then we use the dry erase markers and we start drawing out pictures or writing out the words that they can say. Or I'll start writing the note for them. And then sometimes if they can write I'll get them starting to write it out and I'll write it at the same time so I can acknowledge, oh, that's a good one. They might have only squiggles, but in their mind, they've written out the word ostrich, right?* (NP2)

These creative adaptations allowed the activity to retain its therapeutic value, even if it no longer resembled the original intention. By shifting their approach nurses were able to support patients with dementia, reduce their frustration and maintain their engagement.

Personalizing activities based on preferences and history. Nurses recognized the importance of personalizing activities for patients with dementia. Nurses tailored the activities to a patient's personal history, interests, and preferences. Rather than taking a one-size fits all approach, nurses identified that to make activities meaningful and engaging they needed to be personalized. One nurse explained, *"you can't just do what you have… you have to make it personal, because some patients aren't going to do it, like it's just not going to work"* (RPN1).

Nurses described starting with general activities like colouring and then refining the activity based on what resonated with the patient. Other times, nurses read information sheets posted in patients' rooms to identify interests and adapt activity interventions. For example, one nurse described providing specific colouring sheets based on what she knew about the patient's interests:

> *Some of the patients have like, a Get To Know Me [information sheet], especially like the ones with dementia…Sometimes I'll read that they really like horses or whatever, so I'm going to print off a colouring sheet with horses, and that's kind of like getting their interest in it, or, like someone who really likes trucks, or whatever.* (RPN6)

In other cases, activity interventions were based on patients' past roles and occupations. Nurses described selecting items that tapped into patients' familiar skills and memory. They offered building sets, lock puzzles, fidget boards, or sorting tasks to patients who were former tradespeople or carpenters. While others offered measuring cups to those who enjoyed baking. One nurse expressed, "*It's finding something that's relates to that person… If it relates to them, then it's something they can focus on"* (NP2). Nurses recognized the importance of understanding patients' backgrounds and interests to engage them effectively. One nurse noted, *"if you find something they are passionate about or still occupies their mind on a consistent basis…it is much, much easier to focus that kind of attention"* (RPN4). This suggests that knowledge of a patient's identity can enhance the quality of care and activity engagement.

Nurses also noted that they tailored activities according to specific gender-related factors. Gender norms and assumptions occasionally guided nurses' choice of activities for patients. For example, nurses described using domestic tasks for women, perhaps appealing to their past roles as caregiver or homemaker. Others described the ease of using baby-dolls to support the care of female patients: *"But the dolls are so nice for an elderly woman who is like, motherly, and they have this baby doll, I find it like, takes them back to their like, when they used to be a mom"*

(RPN1). Nurses identified that male patients liked to fix things and that activities with mechanical parts or fidget boards worked best for them. They identified that it was more challenging to engage male patients in activity in the acute care setting than women. This could be associated with the type of activities available, as one nurse explained:

> *I think the women care a little bit more about the activities…I find the men are just not as interested in it, so we have to find other things for them to do. But the women, like will sit down and will fold the towels and they'll colour. But men are a little bit more challenging.* (RPN6)

However, nurses tailored activities to men's previous occupation showing that personal history can often supersede generic gender assumptions.

Nurses' interactions with patients often revolved around recalling memories linked to their identity. Nurses initiated conversations to discover what patients enjoyed doing in their free time or for their career. For instance, one nurse mentioned, *"I always ask them, what they did for a career, what did you do for a living?"* (RPN1). Other nurses reported asking patients about music preferences or activities they enjoyed in the past to help guide activity engagement. When patients could not speak for themselves, nurses adapted the activity based on preferences. For example, one nurse shared,

> *There was one gentleman, and nothing seemed to settle him. A cup of tea would have him sit in one place for two minutes and he tried all the things [activities]. And then there was this like watercolor paint and I think it goes dry, and the colours go away…but he would sit there [at the nurses' station] for extended periods of time with a big smile on his face painting. And we weren't able to figure out maybe historically, because some patients can't communicate that they used to paint, but we think that was part of his enjoyment at home at one time just because of how focused he was and nothing else worked.* (RN2)

Nurses personalized activities by asking questions to uncover preferences, listening to patients, and adapting their approach based on patients' unique identity and history. These personalized efforts also depended on nurses' knowledge of the patient's background, which was not always available.

Facilitating Activities with Easy-to-Use Items. Nurses emphasized the importance of providing activities that were familiar and straightforward for patients. Although the initiation of familiar activities was associated with patients' preferences and interests it was also related to nurses' comfort with the activity itself. Nurses routinely offered activities that resembled housework and chores, taking advantage of readily available items on the unit. For example, nurses presented patients with tasks such as folding laundry or listening to music when some of the more structured activities were unsuccessful. One nurse explained,

> *Another kind of common activity I do, so I know a lot of patients with dementia, they like they're very task oriented…So folding is a is a big one. You give them towels or clothes and you'll ask them, hey, can you, you know, can you help me with this? You know, I would really appreciate your help folding up all these towels.* (RPN4)

Nurses also chose to implement activities that were familiar to them rather than learn how to use the structured activity resources, like sorting activities or matching games. Instead of providing activities that took time to set up and facilitate, they gravitated towards activities that required little prior knowledge for implementation, like word games and puzzles. These activities were more intuitive for staff and patients to use. One nurse emphasized the practical and accessible nature of word games:

> *I feel like a word search and a crossword, I'm always like gravitating to, because…I can always, if we don't have any, or we can't find it in the cart, or they all been used up, it's easy to find it online, right?* (RN1)

Nurses indicated that because of time constraints they preferred to offer items that were simple to implement and accessible. One nurse stated, *"I always use colouring because it's the easiest one to think about"* (RN2) a sentiment that was echoed by several other nurses. Using these practical activities freed up time and allowed nurses to focus on other duties. In this regard, the choice to implement activities was pragmatic rather than personalized and creative.

Nurses also described relying on default activity choices. Colouring and music were regularly mentioned as easy activities to facilitate. Several nurses referred to music as their "*go-to" (RN1, RN2)* activity. Nurses reported using their own phones or their portable workstations to play music for patients during their shifts. They indicated using platforms such as YouTube to provide personalized playlists and interactive activity. One nurse described the mutual enjoyment they received from music: "*I'm a music girl. So, I'll bring my phone out. I had patients doing karaoke with me"* (RN2). Music was also described as an engaging activity for patients with dementia who did not have the cognitive capacity for other intellectual activities.

Utilizing Items That are Readily Available. Nurses expressed that items readily available and visible were frequently used because they were easily accessible. Activities such as laundry folding were often presented to patients not only because of their simplicity, but because the items were easily accessible on the unit. Rather than looking through the storage carts, activities that were readily available and visible at the nurses' station were the go-to choice for staff, especially on busy shifts. Nurses indicated that having items close-at-hand and visible facilitated their use. They noted that items, like puzzles, that were consistently left out and *"just there"* (RPN6) tended to be used repeatedly. One nurse described,

> *I think also a lot of the times like the puzzles that get left on the front desk is like what continues to get used, right? Like, I don't know if people are as like ready to go hunting in the drawers [where other items are stored]…Because there's so much more like they're right there [at the nurses' station]. So, like the nurses are more willing to grab them, right?* (RN1)

Having activities available when patients were brought to the nurses' station allowed staff to easily settle a patient in a more public space. This nurse explains, *"A lot of times there's a lot of books and puzzles sitting out the nursing station already. So, if I bring the patient up to the nursing station, it's within a few feet of me"* (RPN3).

Other nurses described using activities that had already been provided to patients and were accessible in their rooms. One nurse stated they gravitated to "*things that have already been implemented [and] already in the room. Sometimes they'll have books, or the [robotic] cat or the [robotic] dog and stuff are in there [the patient's room]*" (RPN5). These insights suggest that the convenience and proximity of resources often influenced nurses' selection and use of activity-based interventions in practice.

Collective Responsibility and Collaboration. Nurses described that a culture of collaboration and teamwork existed in supporting activity engagement for patients with dementia. Nurses described how they collaborated with interdisciplinary team members and family members to promote meaningful engagement. This theme is underscored by the following sub-themes: (a) collective responsibility for patient care, (b) family involvement in supporting care, and (c) learning from colleagues.

Collective Responsibility in Patient Care. Nurses described relying on colleagues and the interdisciplinary team to support patients in activity engagement. They noted a collective responsibility in caring for patients, and described their reliance on colleagues, ward clerks and charge nurses to ensure patients are safe, supervised, and engaged in activities. As one nurse described, ‘f*or the most part, I think we do work as a team…If someone was to be wandering, they'd be like, ‘hey, do you want to go read? or do you want to go do this or whatever?’*’” (RN1). This quote illustrates how nurses, collectively, support one another in the care of patients with dementia.

The theme of collective responsibility is closely tied to visibility and monitoring but extends beyond ensuring safety. Nurses relied on colleagues to assist with engaging patients in activities when they were preoccupied with other duties. One nurse reflected,

> *Often these patients with dementia become the floor's patient…I mean, sometimes they're not, but often the whole floor kind of keeps eyes on them…and in so doing, they know what they like too. The floor starts to know what they like."* (RN2)

This insight demonstrates how patients with dementia, particularly those with extended lengths of stay, became the shared focus of the entire unit rather than being the sole responsibility of the assigned nurse.

A key aspect of fostering collective support was bringing patients to the nurses' station to enhance visibility and supervision from peers and other colleagues. One nurse described how situating a patient at the nurses' station increased the propensity for other staff, such as ward clerks or the charge nurse, to be involved in the patient's care:

> *I've seen [the charge nurse] play a puzzle just to keep the person sitting there, and then, then she'll come back make sure they're still engaged. And then even the ward clerks too. So those colleagues are involved. And then if there's somebody, obviously other nurses are walking by, they're not doing anything. And then they'll chime in too, because they really like the magnet one and try to teach them how to do it.* (RPN5)

This practice not only facilitated patient engagement but also increased psychosocial support through collaborative interaction.

Ward clerks played a pivotal role in supporting patients on the unit, particularly because of their consistent presence at the desk. Nurses indicated that the ward clerks provide support in getting the patient involved in a task and maintaining their interest in the provided activity. Several nurses described the support that the ward clerks gave in printing word searches or colouring pages for patients to complete:

> *I find the ward clerks are really good at it [activity engagement]. Because they're always just like, right at the desk. So, this patient might just be there all the time… they'll get to know the patient really well. They'll print off the colouring sheets, and they'll play the puzzles and with all the blocks or whatever. They really get into it too.* (RPN6)

Additionally, the involvement of ward clerks supported patient safety. Through their supervision, ward clerks were able to engage patients in activities at the desk and potentially reduce patient risk. As one nurse explained:

> *If they have a task to focus on, they're sitting, you know, at the nursing station, even though maybe it's just the clerk there hanging out with them and there aren't any nurses there, but they're quietly working on, you know, a word search or colouring page...It takes away that element of wandering and no direction.* (RPN4)

Occasionally, other staff members with free time joined patients in activities, working together on puzzles, and fostering relationships and socialization. Through collective responsibility and collaboration, nurses were able to provide a supportive environment that focused on patient engagement and emotional connection.

Family Involvement in Care. Families were instrumental in guiding the nurses' use of activity interventions. Family members provided key insights into patients' preferences, routines, and care needs. For instance, nurses reflected on one patient in particular who had advanced dementia and could not communicate noting that the patient's family members provided invaluable information about their history, likes, and dislikes, which helped nurses facilitate better engagement:

> *The family sometimes will write, like, massive amounts of stuff on the whiteboard…And the doll, they were like, if you need any help, make sure you use the doll. The doll always seems to help. Well, it does. If you use the doll and you kind of, you know, work with the patient…sometimes that helps, because sometimes with advance dementia and they can't really talk, say, right? So even just seeing, like, Oh, here's your baby, here's the doll, it works.* (RPN1)

This information, and the availability of the patient's familiar doll, offered nurses strategies to support patient care.

Others indicated that the activity-based inventions were beneficial in alleviating some families' anxiety related to the uncertainty during a hospital admission. Nurses described how families were pleased that staff were offering non-pharmacological interventions to support their loved-one with dementia. One nurse described, *"I think they're [family] happy to see their loved one up in a chair doing something rather than lying in bed and not, you know. I think it's an extra level of care"* (RPN3). This sentiment was echoed by other nurses who reported that families were *"just happy to see them interacting"* (RN2). When staff in acute care can find activity-interventions that work, the patient and the family are supported as well. One Nurse Practitioner reflected how these activity-based interventions may support the patient after discharge:

> *The person [patient] has a purposeful intention and activity that they can do, then that doesn't touch one person. It touches the entire family unit…So by helping the patient, you're helping the entire family unit to cope and develop a sense of coping and strategies that can then be used at home to prevent future admissions or even just to give that person some peace at that time.* (NP2)

Nurses recognized the value of having input from families. However, unless families were proactive in disclosing the information about the patient with dementia, nurses found that time barriers impacted their ability to gather this information. Though even gaining small insights from family members could enhance their ability to meaningfully engage patients.

Learning from Colleagues. Nurses relied on collaboration and sharing practices with colleagues in the context of caring for patients with dementia in acute care. Specific tools, such as whiteboards in patients' rooms and "sticky notes" in the electronic health record (EHR), were used to communicate patients' interests, preferences, and care strategies. As one nurse explained,

> *I think like the sticky notes is something that…most nurses, not everyone, but most nurses utilize…I feel like that having like a care planesque thing on the sticky notes has worked in the past and I've seen it worked well.* (RN1)

Sticky notes in the patient's chart were highlighted as an essential tool for passing along information to other members of the care team. For instance, one participant noted, *"It says on the sticky notes that they don't do this, don't do that. That's kind of helped us"* (RN1). Nurses emphasized that even small pieces of information, such as a patient's preference for sitting by a window, drinking apple juice, or avoiding early morning activities, were useful. Nurses also identified the usefulness of having information on the whiteboard in the patient's room or on an information sheet posted at the bedside.

In addition to written tools, nurses described learning how to use activity-based interventions by observing colleagues in action. Several nurses identified the BSO nurse as an important support for learning dementia care strategies. One nurse shared, *"I know we've touched base about de-escalation strategies and things like that"* (RN2). Nurses also reported that they found it beneficial to see this specialized nurse engage patients in activities. As one nurse expressed,

> *I know a lot of people find ideas when they see [the BSO nurse] at the nursing station doing things with the patient, as opposed to in the room. Because then the specific nurse, the primary nurse will know an activity or know how to approach the situation…or how to introduce something to the patient or which activities you should introduce.* (RPN3)

This quote illustrates the knowledge transfer that nurses gain from observing and learning from others. Seeing the BSO nurse demonstrate activity introductions, engagement strategies, and de-escalation techniques in real time provided opportunities for practical learning.

Learning from colleagues extended to learning how to adapt various activity items for patients' functional ability. One nurse described modifying activity approaches after seeing the BSO nurse simplify a puzzle: *"I've tried to modify, like [the BSO nurse] did yesterday"* (RPN3). Another nurse expressed the benefit of observing other nurses' techniques and *"adopting the ones that I saw that worked"* (RN1). These strategies helped nurses feel more prepared to introduce activities and engage patients meaningfully. Beyond the BSO nurse and other nurse colleagues, nurses identified other disciplines, such as social workers, physiotherapists, and occupational therapists as valuable sources of information.

Nurses learned about activity interventions informally through casual conversations, team huddles, and observations. Nurses identified communication and learning tips and tricks from others through verbal communication, because *"sometimes people [other nurses] just know people [patients] a little bit better*" *(RN1).* They indicated that due to their irregular schedules they sometimes were not familiar with patients' care needs. One nurse explained that they learn strategies by *"asking my peers, have you had this patient before? What worked last night? They were really exhibiting these behaviours last night, what did you do?"* (RPN6). Others indicated that they relied on PSWs to provide insight into the care needs of patients coming from long-term care: "*Sometimes PSWs too. Because sometimes they also know these patients if they have two jobs or have worked in other care facilities…"* (RPN5). Information sharing and learning from colleagues was central to fostering care for patients with dementia in the acute care setting.

What Activity-Based Interventions Offer Patients and Nurses

Opportunity for Deeper Understanding and Connection. This theme encapsulates the deeper understanding of the relational aspects of nursing care that develop through activity engagement. Nurses shared that the use of activity interventions with patients with dementia fostered a greater respect for them as human beings and promoted more dignified care. This theme is reinforced by the following sub-themes: (a) building relationships through curiosity and shared engagement, b) humanizing the patient and developing empathy and understanding, and (c) enhancing nurses' professional fulfillment.

Building Relationships Through Curiosity and Shared Engagement. Nurses described how activity-based interventions facilitated meaningful social interaction and connection with patients. The activities not only supported engagement but also provided opportunities for nurses to build rapport with patients. One nurse spoke about the enjoyment they received from spending time participating in activities with patients:

> *Oh, it's so nice! Like, if I have time in my day, which I try to, especially on an evening [shift]. If I can sit with them [the patient] and they're, you know, even if I'm not doing anything like an activity, and I'm just sitting there and they're doing a puzzle, I can just sit there and get to know them more. It's nice.* (RPN1)

Engaging in activities together led to nurses learning about patient's lives and preferences. This knowledge could then be shared with colleagues to facilitate future care. Nurses frequently completed activities alongside patients, such as painting nails or doing puzzles, which created opportunities for conversation and mutual enjoyment.

The activities became a catalyst for enhanced social interaction. Occasionally, other staff members with free time would join patients in activities, working together on puzzles, and fostering relationships and socialization. For instance, building puzzles became a shared experience that led to deeper connection, as one nurse reflected:

> *Sometimes our nursing scholars…if they had a free moment, would sit with her. She just wanted the socialization and the [jigsaw] puzzles…and she would sit there and talk about her life. And it was like dementia, again earlier [stage], but it was like the dementia was gone. So maybe that's just an activity she's always liked to do and that kind of triggered some normalcy for her, some peace for her, but… whenever she sat and did that, she was happy as a clam.* (RN2)

Nurses described sitting beside patients with negative behaviours and engaging with them in a way that reduced the nurse-patient hierarchy. As one nurse explained,

> *Then I sit down, I pull up a chair right beside them and sit down and just as if we were friends talking. Like hey what's going on? You know, and then I'll ask, what do you like to do? Do you like to paint?... I get a moment to see and hear from them, right? Not just from them talking at them and them yelling at me or whoever. It's just, it's a good moment to engage with them.* (RPN2)

In these moments of shared engagement, nurses moved beyond routine care to connect on a personal level. Nurses' curiosity about patients' lived experiences facilitated these meaningful interactions. Nurses expressed a genuine interest in learning who the patient was beyond their diagnosis. One participant reflected, *"Well, you spend time with the patients and it's amazing how when you sit at their level and just talk to a patient, how much you find out—and you do find out"* (NP2). These conversations often revealed meaningful aspects of the patient's identity.

In addition to deeper nurse-patient relationships, activities also fostered peer-to-peer connection between patients. Much of this interaction occurred at the nurses' station, where activities were commonly set up. One nurse recalled a time when two patients were engaged in an activity using wooden building blocks and how they started to engage together:

> *I've also had it with a male and a female [patient]. With doing like the blocks. And they're just kind of chatting. They were just building things together. I think at the start, it started on their own…then it turned into them kind of turning towards one another and building together.* (RPN3)

Activity engagement also created a passive shared experience for patients. They described patients *"colouring together on their own separate sheets, but they're sharing markers"* (RPN3). Activity engagement fostered a sense of connection and deepened the relationship between nurses and patients.

Humanizing the Patient and Developing Empathy and Understanding. The theme of humanity in caregiving was intricately woven throughout the nurses' accounts of using activities with patients living with dementia. Nurses emphasized the importance of empathy, individualized attention, and respect in their approach**.** These values appeared to shape their interactions with patients, and their understanding of the emotional and social needs of patients. For some nurses, activities were not simply used as diversionary intervention, but a pivotal tool for seeing and treating the patient as a whole person rather than just a medical diagnosis. One nurse expressed,

> *I find it [activity interventions] extremely valuable. I think art therapy and music therapy trying to figure out patients likes and comforts from home and things like that are extremely important. And they only help nursing care, like they only help the team; they only help the patient. It's only been good things. I don't see where it [activities] would ever be a negative part of their treatment. I think it humanizes our patients again and makes them more than their diagnosis and it makes them a whole person, which is the whole point of healthcare, should be the whole point.* (RN2)

This sentiment reflects a positive attitude towards the value of activity-based interventions in supporting patient care and nursing workloads.

By seeking to know more about the patient and engaging with them, nurses were drawn towards their humanity. Activity-based interventions such as music, art, or reminiscing created opportunities for connection that extended beyond clinical nursing tasks. One nurse noted, "*When they express that [reminiscing]…I feel like you see them more as a person and less of like a patient to take care of or a task to complete"* (RPN4). In taking time to sit down with patients and connect on their level, nurses reduced depersonalized care practices which can become habitual in acute care settings. One nurse reflected on the impact of physical positioning in fostering relational connection with patients, stating:

> *I see them as another person, not as just my patient, not as my job. But like to level with them as another human being I typically sit with them and try to get on their level. Like I don't stand over them and talk down to them.* (RPN3)

This comment reflects the embodied dimension of positioning and power and the importance of posturing in relational caring. Through these interactions, nurses were able to see patients with dementia in a new way.

Through using activities with patients, nurses expressed a mindset which shifted from task orientation toward more engaging, relational care practices. As one nurse shared:

> *I've had a scenario where a gentleman told me, well, I can't even go to the bathroom on my own. Like, I can't do anything. I can't do anything right. And so, I was saying 'Well, you're doing great with this puzzle and you're doing great with this and you can you can still do activities, you're just requiring some more assistance'. And then, and a lot of times kind of, even if just for a minute, like it brightens their day I try get a smile out of them.* (RPN3)

This shift from task-oriented to relational care was particularly evident in how nurses responded to patients' emotional needs. Nurses demonstrated empathy for individuals who experienced long hospital admissions or ones marked by transition from home to another care setting. One nurse reported:

> *Yeah, like kind of social and meaningful stimulation, right?… I'm somebody who I can't sit still for more than you know, a few minutes at a time sometimes. And I think about— you know, it's sad — to realize that a lot of these patients you have, they come from, you know nursing homes*

> *or were kind of home alone and now they're moving into a transition time in their life where they're going to need to kind of, you know, get some extra care after this hospital stay. So, you've got to try. We have to try harder to find out how we can provide meaningful interaction and stimulation for them on a kind of moment-to-moment basis throughout day.* (RPN4)

They reflected that the boredom and lack of purpose that patients experience while in hospital can be negatively impactful. Nurses expressed a sense of empathy for those that were hospitalized and how activities could offer some distraction to that boredom. As one nurse explained:

> *It [activities] just gives them something to do. I can't imagine sitting in the hospital bed all day. It could be very depressing. I can imagine why people go into delirium if you're just sitting in a hospital bed. So, it could just give them a sense of purpose, like that. If they're confused and they think that that puzzle is the one thing they have to do today, and that's their task, and they get that done, that might give them a sense of accomplishment.* (RPN6)

These findings demonstrate that activity-based interventions can facilitate relational care by fostering empathy. Through these interactions, nurses are better able to recognize and respond to the full personhood of individuals living with dementia in acute care settings.

Mutually Rewarding Interactions and Professional Fulfillment. Nurses described the tension between task-oriented care and the need for meaningful interactions with patients. One nurse reported, *"Something that I, at least, I have fallen victim to is when you're in the setting where your kind of in care mode, and you're doing your job, and you're task oriented"* (RPN4). Several nurses described the tendency for care in hospital settings to be reduced to checklist items, like giving medications, preventing falls, and maintaining hygiene. While these tasks are essential, nurses described the personal rewards that they experienced when they moved beyond task-oriented care to engage with patients using activities.

By engaging in activity with patients, nurses had the opportunity to witness patients' positive emotional responses including smiles, laughter, and reminiscing. These responses affirmed nurses' efforts and reinforced the value of engaging patients in activity. One nurse emphasized how meaningful it was to witness a patient's joy and pride after participating in colouring: "I*f they coloured or and then we're putting it up on the fridge and stuff, and they're getting all excited. It's just positive rewards"* (RPN5). In addition to benefiting patients, activity-based interventions were described as *"mutually rewarding"* (RPN4) and influenced nurses' own professional fulfillment and emotional well-being.

Nurses shared that witnessing patients' satisfaction during activities evoked positive emotions for both parties. Engaging patients in these ways prompted deeper social interaction and understanding. One nurse shared:

> *I've had good, really good, interactions with patients that have been rewarding for me. Even where it's like you sit down and engage with them in activity and then that prompts conversation and social interaction that you know. Like, I've had patients with dementia when they're talking about their career or the job they did for 50 years. Right? They'll teach you something and you'll learn something, right? Or you'll see them smile and get excited about something. From that social, you know aspect of the care, that's rewarding.* (RPN4)

This sentiment reflects a sense of accomplishment and emotional significance for the nurse. It also illustrates how activity-based care can foster not only patient engagement but also enhance nurses' sense of accomplishment and job satisfaction.

Professional fulfillment was deeply connected to opportunities for relational and meaningful care that were developed through activity engagement. Some nurses indicated having feelings of success at their job when they engaged a patient in activity. For instance, one nurse reflected, *"You feel like you've actually done something. You feel like, you know, like, I can go home because that one patient did a couple pieces in a puzzle today, and that made a huge difference in my day"* (RPN1). This quote illustrates that activity-based engagement can prompt nurses to feel more fulfilled in a task-driven environment.

What Prevents Nurses from Using Activity-Based Interventions

Challenges Implementing Activity Interventions. This theme encapsulates the multifaceted challenges that nurses face when implementing activity interventions for patients with dementia in acute care. Nurses shared that they face competing priorities, time constraints, and a reactive rather than proactive approach to using activity-based interventions. Uncertainty and variability in patient engagement further hinder nurses' effective implementation of activity interventions. Within this theme, several sub-themes were identified including: (a) uncertainty in selecting and implementing activities, (b) competing priorities and time constraints, (c) reactive approach to implementation, (d) resource availability and limitations, and (e) varied patient engagement and response.

Uncertainty in Selecting and Implementing Activities. Nurses consistently revealed a sense of uncertainty and lack of preparedness in dementia care. They also identified a general lack of confidence with how to utilize activity engagement as a non-pharmacological intervention for patients with dementia. For instance, one nurse expressed frustration, noting *"they expect us to just kind of figure it out"* (RPN6) when it came to implementing activity interventions. The ability of nurses to confidently implement activity-based interventions appeared closely tied to their prior experience and their general aptitude for caring for this population. One nurse reported feeling more equipped due to previous experience working in long-term care: *"…it [using non-pharmacological interventions] was ingrained in me because I was a PSW in long-term care"* (RN2).

Nurses expressed a need for further training in dementia care practices. While some nurses stated that they received GPA training, the majority did not have any formal education in dementia or any *"training…here [at the hospital] for any activities"* (RPN5). This paucity created uncertainty and a lack of confidence in "*how to approach the patient with a new activity. I think I try my best to do a good job of it, but I don't know that, you know, I have training to do so"* (RPN3). Another nurse identified that nursing school did not prepare them with practical dementia care strategies:

> *I would say surprisingly, I find that nursing school doesn't focus enough on it [dementia care] at all. It talks about the kind of pathophysiological mechanisms of dementia, but it really doesn't focus on the social elements of dementia and dementia care. Which, thinking about that now, just completing my BScN, I can't remember much of any content we covered that specifically focused on the social and the practical care side of dementia care.* (RPN4)

In addition to training deficits, several nurses described the awkwardness of trying *"to figure out when best to use them [activity items]"* (RPN2) and not knowing how to integrate an activity into the patient's day "*or which activity to introduce"* (RPN3). Uncertainty also came with not knowing how to engage patients with the activity items. One nurse identified that patients struggled to utilize and engage with the activities:

> *I've tried those [blocks] and I mean, they'll keep their attention for a very short period of time. They don't really know how to use them, especially the magnetic ones. I think it's just too, maybe it's too much for them. I don't know. You know, I just don't think they know how to use it.* (RPN2)

This may reflect a deeper lack of knowledge in how to structure or adapt the activities in a way to support the patient's cognitive capabilities and promote positive engagement. The activities may not be well suited to the patient's interests, but this could also highlight a lack of knowledge or training in how to introduce or modify activities that make it meaningful or successful for the patient. Without a clear understanding of how and when to use the activity resources, nurses may choose to implement items that they are familiar with or take a more reactive approach to implementation.

A Reactive Approach to Implementation. Nurses took a reactive approach to patient engagement, offering activities primarily as a strategy to manage restlessness and agitation rather than as a proactive means of fostering meaningful engagement and cognitive and emotional wellbeing. One nurse described how engagement is often initiated only when patients begin exhibiting wandering or other behavioural concerns:

> *So …if I was to see a patient like kind of in quotations, obviously, but like getting into trouble, like walking to other people's rooms, like obviously doing that like wandering behaviour or having difficult behaviours or not difficult, but you know what I mean. But I would like see if they were willing to sit down, broach the topic with them and see like oh, do you like word searches? Do you like crosswords?* (RN1).

Nurses acknowledged that their days are busy, and as a result, activity-based interventions often become an afterthought rather than a preventative or care-enhancing strategy. As another nurse noted, activities are rarely introduced unless a patient is already exhibiting distress:

> *Like we really, we have such a reactive approach, right? Like we don't try, we would never get people to do puzzles unless they started acting out. Like we could avoid some of the behaviours that happen if we had initiated that before. We're not very good at that.* (NP1)

Although nurses recognize that calm moments could provide valuable opportunities for engagement, they often do not act on them due to competing demands and systemic barriers. One nurse described the dilemma of wanting to introduce activities during periods of calm but being pulled away by other priorities:

> *[The patient is] kind of just sitting in the room looking out the window, right… that would be a great opportunity to bring an activity to them… and have them do something constructive and mentally stimulating. So, because… they're calm… there's no need to, you know, you got other priorities that come up aside from that. You don't. You know, you don't act on those opportunities as often because your day is so busy.* (RPN4).

Competing Priorities and Time Constraints. Nurses shared that they often deprioritize activity interventions due to the pressing demands of acute care. The high acuity level of other patients necessitates that nurses prioritize immediate medical concerns over psychosocial care, preventing them from engaging in meaningful activities with patients with dementia. One nurse explained:

> *You're focused on primarily, first and foremost dealing with that medical need. All of the other social and kind of relational needs that the patient has often do fall by the wayside in this setting specifically.* (RPN4)

Nurses acknowledged that the acute medical needs of other patients take precedence, making it challenging to dedicate time to engaging patients with dementia in activities. They described feeling overwhelmed and emphasized a need to identify how best to balance the needs of patients with dementia and support the medical needs of other acutely ill patients: *"Acute care is so busy. I come on, I try to figure out what's wrong with each person and what I can try to help fix… I'm always pulled all around"* (RPN5).

Nurses expressed a sense of moral distress in their inability to provide care that holistically supports the patients with dementia. One nurse reflected on the complexity of supporting patients with dementia who remain in acute care longer than necessary because of discharge delays of barriers to long-term care placement:

> *Some of these patients [with dementia] end up in stuck in this acute care phase way longer than they need to be for dealing with that acute medical issue. But then you've got other patients who are coming in with acute medical issues, right? So, then they're kind of falling down the priority list for, you know, how we're interacting with them, at kind of every shift. And it's, it's tough. It's something that I've observed…Often…and it, it's tough, right?* (RPN4).

This quote illustrates the tension nurses face when providing acute medical care and meeting the emotional and cognitive needs of people living with dementia in this setting.

Additionally, nurses often lack the opportunity to familiarize themselves with available activity resources, further limiting their ability to meaningfully engage patients. This lack of time contributes to a lack of knowledge about a patient's interests and impacts on the nurse's ability to become familiar with the activities and resources that are available to them to support patient care. For instance, nurses identified that they lacked *"time to really look into"* (RN2) the available resources. Moreover, nurses recognized that family members can provide insight into the patient's preferences and routines, but expressed that they do not have time to source this information:

> *…we need to have that conversation to know [the patient's routine]. Sometimes they [the patient] don't even know, they can't communicate that with us. So, to get the family involved if we can. I think it's just difficult because the floor is so busy. And when you have five or six patients you don't necessarily have the time to sit on the phone with a family member for half an hour to ask those questions.* (RPN3)

Even though setting up activities could ultimately make their shifts easier, nurses identified that the initial effort required is often perceived as an additional burden:

> *It's like two sides of the coin, right? … if we have things that work for someone, it does make things easier in the end, but I think… trying to figure those things out… is like a time-consuming thing* (RN1).

Nurses described how workload pressures create barriers to spending time with these patients: *"The last thing in your mind is to think like 'Oh, maybe an activity would help this person settle.' And your kind of focused on…resolving that problem quick and like fast, right?"* (NP1). Nurses shared that they facilitate a patient's use of the items: *"… if it's cards or colouring and stuff, you kind of have to get them into it by doing it with them.*" (RPN5). However, their implementation is hindered by a perceived lack of time: *"We don't have as much time to sit down with people, facilitate those activities"* (RN1) or "*get someone set up properly"* (RN1). This contributes to underlying feelings that the activities are not being used as the program was designed:

> *What is the value of any of these activities if they're not being used, right? We, like, clinical staff on the unit, often get pulled so short…our time is so short, it's hard to meaningfully engage using these activities in the way that they're intended to.* (RPN4)

Nurses indicated they used activities as diversionary tools to manage patient behaviour rather than as meaningful engagement strategies tailored to individual needs:

> *Some people, I mean, I know people are busy, but they do just kind of shove things at people like, 'Here, do a puzzle. I know you don't really care about it, but just pretend to play with it or whatever, just so they look busy.' And I know nurses are busy, and that happens, but I feel like that's just not doing anything*. (RPN6)

Activities, then, became a means of distracting the patient so that nurses could get other work completed rather than an essential part to relational caring: "*…they're kind of, like, distracted, and then they kind of get into it [the activity]…but it's so hard, you can't really sit with them for* *long as you're constantly doing other things on the floor"* (RPN6). However, nurses acknowledged that while identifying meaningful engagement strategies and setting up activities for patients requires time, the effort is ultimately beneficial. As one nurse explained*, "It takes some time out of [the] day to organize it… but in the long run, they [the patient] are comforted and calm" (RPN3).* Another noted, *"If you put the work in, it does make it easier. If we have a schedule and activities that work for someone, it makes things easier in the end"* (RN1).

Resource Limitations and Availability. Resource limitations and accessibility were significant barriers to nurses' effective use of activity interventions for patients within the acute care setting. Occasionally, the activity resource itself posed challenges. For example, one nurse shared her mixed feelings about robotic cats:

> *I like the dolls. The cats can sometimes be… I don't want to use the word pain, but when you can't turn them off from like two in the morning and the patient has been sleeping, I find that sometimes a problem because it will just meow out of nowhere.* (RPN1)

Another nurse humorously reflected that the *"robotic cats are definitely scary. When you walk in and you don't realize that they have one in there, and it meows at you. I have jumped a couple of times. But they like them, so it's fine"* (RPN6). These reflections reveal the benefits and limitations of certain activity items. Although dolls and robotic pets are often effective in engaging patients, issues such as their disruptive features, like unexpected noises, can diminish their utility in specific situations.

When it came to accessing resources, one nurse stated, *"I don't know if they are easily accessible"* (NP1). At times the activities that nurses identified as beneficial to patients were not available due to limited resources within the hospital. The limited supply of resources limited the number of patients who could be served at any given time. One nurse reflected that, *"there's often only one of them [particular item] in a cart, for a unit of 30 or 35 people"* (NP2). The nurses reported that the limited variety of items impacted patient engagement over time, especially when patients had a long length of stay.

Accessing available resources for activity engagement was often viewed as problematic by nurses, with barriers stemming from both logistical and systemic factors. For example, one nurse pointed out a practical difficulty, noting, *"The cart can be hard to get into"* (NP2). Resource availability appeared inconsistent due to limited staff time and funding constraints that impacted stock levels and accessibility. Items may also be stored in other areas of the hospital creating access barriers. One nurse explained that some resources are kept by particular staff members, such as the recreation therapist, and it can be cumbersome for nurses to obtain specific items:

> *I know we have limited resources for like the doll therapy. So, those aren't easily accessible. Which just kinds of adds more stress to the nurse having to… it's an extra step to get it, right? Like they have to now contact whoever has them to bring them up [to the acute care unit]. And they have a lot of… it's a busy unit.* (NP1)

Some nurses lamented the loss of the local newspaper, a once popular and enjoyable activity.

Due to availability of items, nurses found themselves taking on the burden of creating activity materials adding to their workloads. One nurse reflected, *"Sometimes we have to print off colouring pages because we don't have a generalized big colouring book section. We have markers, and we have stuff like that. But it would be nice to have a bit more"* (RPN1). The available resources may not meet the varied interests and needs of patients. This also highlighted nurses' reliance on makeshift solutions, such as hand-written games, for engaging patients in activity.

While nurses expressed appreciation for the items that were available, they identified many items they wished they had access to. One nurse questioned the variety of supplies, stating, *"Do we need more activities of different things?"* (RPN1). Nurses expressed a desire for a broader range of materials and resources to enhance their ability to implement engaging activity interventions for patients. One nurse mentioned, *"It would be nice to have a bit more [colouring books]"* (RN1) and suggested that having a *"whiteboard would be really good too"* (RN1) for engaging patients in creative activities. Others expressed a desire to have access to newspapers, magazines, and books, emphasizing that "*sometimes a patient will be like 'oh, I really want a newspaper. I'm bored"* (RPN1) and *"newspapers would be nice, or like a magazine"* (RPN3). Nurses also indicated a desire for items that would support emotional well-being and comfort. For example, one nurse stated, *"I think is we had more of like the muffs and things like that, that are easy to clean but that provide comfort but give some stimulation beyond rubbing a blanket"* (NP2). Nurses identified a variety of items that would provide opportunities for creative engagement and enhance comfort.

Varied Patient Engagement and Response. Nurses described patient disinterest as a barrier to engagement in activities. One nurse shared, *"I guess what would be a challenge is that you get the odd patient that's like, not interested in anything, and that's hard because you want to do something with them"* (RPN1). Another nurse described that sometimes patients are not interested in doing an activity at the time it is presented and finding something to do with them was challenging: "*They're like, No, I'm not interested, then you'll try to find another activity that they are interested in. Sometimes activities just don't, it's just not what they want to do"* (RPN5). This disinterest can fluctuate day-to-day or throughout the day, making it challenging for nurses to develop a consistent plan of care. Another nurse explained,

> *Depending on the time of day or just the patient in general. Like, I've had where you try and give them something like a puzzle or colouring book and they don't want to do it. But then in another moment, or maybe the following day, that that's all their want to do.* (RPN3)

Others described times when a patient's cognitive function impacted their engagement with items, such as robotic animals. One nurse described an experience with a patient with fluctuating cognition:

> *I had one patient with fluctuating cognition and they at some points throughout the day would be like, I know that that's a fake cat. And then other times throughout the day, they would be petting the cat and talking to the cat and it was just a comfort for them.* (RPN3)

Nurses also described times when they felt hesitation in offering certain activities due to previous negative experiences with patient responses. One nurse recounted her reluctance to use a painting activity because a patient threw the paint during a previous session. She reflected, *"sometimes I feel like… maybe I'm jaded because I've had enough stuff thrown at me or spilt or whatever, but I'm afraid of getting messy"* (RN1). This statement demonstrates that the unpredictable response of a patient to an activity can act as a barrier to implementation and engagement. Nurses also identified that some patients are challenged by the activities, resulting in frustration, as described by one nurse, *"I find some people… sometimes they get frustrated by it"* (RPN6). Patient interest in activities is further dependent on the length of their admission. One nurse reflected that the activities available become redundant, and the patient can become disinterested in using them:

> *If someone's here for a month, they get tired of doing it day after day after day. And many of them do it. And then once they become accustomed to it… there needs something a little bit more, not challenging, maybe more challenging, but they need something a little bit different to stimulate a different part of their brain because what worked on Monday might not work on Thursday.* (NP2)

Patient engagement with activities can be unpredictable and change depending on the day, time, or length of stay.

Summary of Findings

Nurses described incorporating a range of activity-based interventions, such as music, colouring, puzzles, and fidget boards, into care routines to address patients' psychosocial needs, alleviate boredom, and reduce responsive behaviours. These activities were used both proactively and reactively. Nurses used activity-based interventions proactively to mitigate boredom and create a sense of normalcy. They reactively used them in response to agitation and confusion. Nurses recognized activities as tools for promoting calm, reducing responsive behaviours, and preventing safety risks such as falls and wandering. By providing patients with structured activities, they were given an opportunity to attend to something meaningful and gain a sense of purpose and enhanced well-being. When patients were actively engaged in meaningful activities, primarily at the nurses' station and under supervision of colleagues, nurses were able to attend to other demands. Nurses expressed that families, other colleagues, and allied health professionals guided their understanding of activity engagement.

By using activities, nurses connected with patients beyond their clinical diagnosis and needs. Engaging patients in activities encouraged social interaction, which helped to foster relationships. This interaction deepened relational care practices and offered benefits to both patients and nurses. By incorporating activity-based interventions into daily routines, nurses were able to create an atmosphere of calm, safety, and dignity for patients. Nurses revealed several barriers to engaging patients in activities, such as time constraints, lack of knowledge, and limited resources. Nurses reported needing to frequently adjust their approach based on patient interest, mood, and cognitive ability. They also noted that activities could become repetitive for patients who had longer admissions, creating further disinterest in activity engagement. These challenges highlight the complexities of implementing non-pharmacological interventions for patients with dementia in acute care settings.

CHAPTER SIX: DISCUSSION

Overview

The aim of this study was to explore the experiences of Registered Nurses (RNs), Registered Practical Nurses (RPNs) and Personal Support Workers (PSWs) in using activity interventions to support patients with dementia in an acute care environment. The research question guiding this study was: *What is the understanding and practice of nurses and PSWs regarding the use of activity-based interventions to support patients with dementia in acute care settings?* Nurses in this study integrated a variety of activity-based interventions into the routine care of people living with dementia in the hospital. These interventions included music, colouring, jigsaw puzzles, and word games, and were used by nurses to address the psychosocial and behavioural needs of patients.

Five key themes, that offer insight into nurses' experiences using activity-based interventions for patients with dementia in acute care, were identified through thematic analysis: (1) enhancing safety, stability, and emotional well-being, (2) facilitating engagement through practical and adaptive strategies, (3) collective responsibility and collaboration, (4) opportunity for deeper understanding and connection, and (5) challenges implementing activity interventions These themes illustrate the dynamic and multifaceted role of nurses in supporting patients with dementia using non-pharmacological approaches amid the demands of acute care. The identified themes reveal much about how nurses utilize activity-based interventions and the facilitators and barriers to their implementation. They enhance our understanding of why nurses are motivated to use activity interventions, how they utilize them, and what benefits they derive from using them. Before engaging in a discussion of the findings, I will situate the study by examining several contextual factors, including sample characteristics and recruitment methods, that may have influenced the results. Finally, I will reflect on the strengths and limitations of the study and outline directions for future research.

Contextual Factors and Participants

This study was conducted in a small community hospital in Ontario, Canada. The participants were primarily female, which is representative of the broader demographic profile of the nursing workforce in Ontario (College of Nurses of Ontario [CNO], 2024). Notably, 90% of the participants had fewer than ten years of clinical experience. This aligns with the provincial data showing that younger nurses now make up the largest cohort, following significant attrition among older nurses during the COVID-19 pandemic (Baumann & Crea-Arsenio, 2023). Younger nurses may be more open to adopting new and creative approaches to dementia care, such as activity-based interventions. In contrast, more experienced nurses may feel confident in managing challenging behaviours but often adopt a more passive or avoidant strategy, such as reacting by doing nothing (Hynninen et al., 2016). In this study, the number of nurses with more experience may be limited because there are not many of them in hospital settings, and they are not inclined to utilize resources to respond to PLWD with responsive behaviours. However, it is difficult to say for sure why nurses with more than 10 years of experience did not participate in this study. They may be less inclined to use activity-based interventions, and instead, as Hynninen et al. (2016) suggest, may choose to ignore the person with responsive behaviours. More evidence is needed to fully understand the relationship between years of experience and nurses' care of patients with dementia.

Recruitment of Personal Support Workers

Although the intent was to include PSWs in this study, recruitment was unsuccessful. I sought to include the perspectives of PSWs in this study because they often interact with patients with dementia in this hospital setting. PSWs play a critical role in delivering direct, hands-on care to patients. It was anticipated that their insights would offer unique perspectives on the use of activity-based interventions within this environment. Despite efforts to recruit PSWs, participation from this group was not achieved. This lack of participation raises important questions and considerations regarding recruitment strategies, timing, and systemic factors that may affect PSW engagement in research. PSWs often work under conditions of high workload, low autonomy, and limited recognition (Zeytinoglu et al., 2017), which may impact their capacity or willingness to participate in research. For instance, the PSWs in this setting are often the only PSWs on the unit, supporting nurses in caring for up to 30 patients. Consequently, PSWs in this setting may have felt they had limited time to engage in research activities due to high workloads and the demanding nature of their role. Additionally, PSWs may also feel uncertain about whether their contributions will be valued within academic or professional discourses.

Themes in Relation to Existing Literature

This study contributes to and extends existing literature by, (a) highlighting the significance of relational care in fostering rapport and managing responsive behaviours, (b) drawing attention to the informal yet important role of interprofessional team members, such as ward clerks, (c) identifying facilitators for implementing activity-based interventions, (d) outlining barriers to their use, and (e) describing practical strategies for their use in acute care. These findings will be discussed relative to the existing literature and highlight implications for nursing practice, policy, and education.

Opportunities for Deeper Understanding

Relational caring is a philosophy of care grounded in human connection, recognizing that PLWD are not isolated or diminished by their diagnosis, but are relational beings who are shaped through connections with others (Dupuis et al., 2016). This concept deepens our understanding of person-centred care (PCC) by embedding it within relationships that support and sustain personhood (Dupuis et al., 2016a). According to Dupuis et al. (2016), relational caring involves connection, interdependence, collectivity and collaboration. Furthermore, Ryan (2021) highlighted that building therapeutic relationships, maintaining identity, and engaging with people in a holistic manner are key facilitators to relationship-centred nursing care. These elements were evident in the nurses' experiences, as they shared how they engaged with patients not only as care recipients but as individuals with personal histories, preferences, and identities. Nurses in this study emphasized aspects of relational care, such as empathy, individualized attention, and respect, as central to their approach (Dupuis et al., 2016). Thus, this concept provides a lens through which to examine nurses' experiences and the opportunity for deeper understanding offered by activity-based interventions.

Connection. In this study, the nurses' use of activity-based interventions disrupted the depersonalizing routines common in acute care settings, which often emphasize efficiency and risk reduction over relational care (Jensen et al., 2023; Keuning-Plantinga et al., 2023; Walsh et al., 2022). Nurses in this study enacted relational care by demonstrating curiosity about their patients during activity engagement, a factor of relational caring described by Dupuis et al. (2016). Rather than focusing solely on clinical care or behaviour management, nurses in this study used activity engagement as a mechanism to learn about patients' careers, hobbies, family, and other aspects of their personal histories. They nurtured relational caring through conversations that emerged over time spent on activities such as completing puzzles or word games. These shared moments enhanced nurses' understanding of the patient's personhood (Kitwood, 1997) and their capabilities. Nurses also used activities and conversation to build trusting relationships with patients, a finding that aligns with research by Pinkert et al. (2018) on nurses' experiences caring for patients with dementia.

Nurses' engagement in the relational care of patients with dementia through activity is an important finding because previous studies have identified both the stigmatization of people with dementia in acute care (Digby et al., 2016) and the frequent neglect of PCC in this setting (Clissett et al., 2013). Despite operating within the constraints of time pressures and staffing limitations, nurses in this study found ways to build rapport through physical presence and one-on-one engagement in activity. Their efforts to reach the person's level, both physically and interpersonally, align with the findings of Cowdell (2010). Nolan et al. (2004) emphasized that relational care develops from a shared understanding and mutual recognition between all parties involved in the care of older adults. The use of activity-based interventions created a space, or a milieu (Nolan et al., 2004), and an opportunity for informal yet meaningful exchanges, thereby promoting person-centred and relational nursing care.

A significant finding is how activity engagement prompted nurses to reframe their perceptions of patients with dementia. Some authors have highlighted that nurses may hold negative perceptions of caring for patients with dementia in acute care (Cowdell, 2010), including viewing them as disruptive or less deserving of attention (Turner et al., 2017). Furthermore, Dunkle et al. (2022) identified that nurses' focus on the medical needs of patients may prevent them from attending to the patient's basic human needs. This can contribute to the marginalization of patients with dementia (Digby et al., 2016) and reinforces the care of them as less important compared to more acutely ill patients within hospital settings (Baillie et al., 2012). Activity-based interventions served as “the medium for exchanging the information, feelings and concerns needed for a better understanding of the meaning of illness” (Nolan et al., 2004, p. 48). In this study, activity engagement helped nurses see patients as *“more than their diagnosis”* (RN2) and encouraged them to connect with patients on a more human level.

Interdependence. Relational care is not unilateral. It involves a reciprocal dynamic in which both individuals influence and respond to one another through shared experiences and emotional connection (Nolan et al., 2004). Relational care involves the mutual recognition of both patient and nurse as persons in the relationship (Dupuis et al., 2016). In this study, activity engagement became a mechanism for relational interdependence by deepening social interactions and creating space for reciprocal connections between nurses and patients with dementia. In their work on the Senses Framework and relational care, Nolan et al. (2004) described the importance of a sense of achievement, or the ability for staff to provide good care and feel satisfied with their efforts. In this study, nurses reported a sense of accomplishment derived from fostering positive emotional outcomes in patients through engagement in activities.

Furthermore, nurses in this study described the personal rewards they experienced when they transitioned from task-oriented care to forming more meaningful connections through activity-based interactions. Elements of PCC, such as getting to know the person, have been found to enhance job satisfaction (Van Diepen et al., 2020). When nurses in this study moved beyond routine tasks and connected meaningfully with patients through activities, they reported a greater sense of purpose and pride in their work. In the present study, joining patients in shared activities allowed nurses to form relational bonds that were mutually rewarding. Similarly, Gustavsson et al. (2023) highlighted that healthcare providers who spent more time with patients had stronger relationships, which in turn increased their job satisfaction.

Collectivity and collaboration. Both informal and formal communication are central to collaborative practice. Ryan (2021) highlighted that communication and interpersonal skills are central aspects of relationship-centred care. In this study, nurses described how conversations with colleagues and family members served as opportunities to exchange insights about patient preferences, behaviours, care strategies, and practical tips. These interactions often led to more personalized and responsive care, hallmarks of relational care practices (Dupuis et al., 2016). Previous research has shown that nurses in acute care settings rely on a range of staff, including recreation therapists (Dookhy & Daly, 2021), allied health professionals (Yous et al., 2019), volunteers, and nursing students (Baillie et al., 2012) to support patients with dementia. However, in this study, nurses reported a limited involvement from other health professionals, particularly recreation therapists, in facilitating activity engagement. Instead, they relied on one another to promote patient engagement and ensure patient safety.

Teamwork and collaborative approaches to caring for patients with dementia have been highlighted in other studies (Moody et al., 2024; Yous et al., 2020). Similarly, Hung et al. (2019) found that nurses often seek to support one another when providing care for individuals with dementia, especially in challenging hospital environments. In this study, one nurse noted, "*patients with dementia become the floor's patient*" (RN2), reflecting a collective sense of responsibility and flexibility that supports relational care (Dupuis et al., 2016). In this context, engaging patients with dementia in acute care is not viewed as an individual nursing task, but rather as a shared responsibility among the care team.

This ethos of shared responsibility was evident in how nurses approached activity engagement. Their accounts contrasted with findings from earlier studies that highlighted a lack of compassion in dementia care, where patients with dementia were often subjected to labelling (Cowdell, 2010), neglect (Pinkert et al., 2018), and other negative attitudes (Keuning-Plantinga et al., 2022; Turner et al., 2017). In contrast, nurses in this study demonstrated relational and person-centred care practices by engaging patients in meaningful activities and fostering a sense of community.

Bringing patients to a shared space, such as the nurses' station, was described as a strategy to enhance visibility, promote safety, and foster collective involvement among staff. These shared spaces enabled individual nurse-patient interactions and facilitated broader participation from the care team, including ward clerks and other nurses. This approach overcame some of the contextual barriers, including a lack of space, resources, and social connection, that prevented familiarization, social interaction, and occupation, as outlined by Gwernan-Jones et al. (2020). Furthermore, staff reported that peer-to-peer patient relationships were enhanced through joint engagement in activities in shared spaces. Sharing moments and place (Edvardsson et al., 2012) through activity engagement reinforced the importance of social inclusion and reciprocity in dementia care. In this regard, activities served to support the patient's need for belonging, as described in Scerri et al. (2018). These shared experiences fostered a sense of community among patients, promoting social connections that extended beyond nurse-patient relationships and contributed to a more relational model of care.

An unexpected insight from this study was the role of ward clerks in supporting nurses' use of activity-based interventions for patients with dementia. While not traditionally considered part of the direct care team, ward clerks offer crucial frontline care in acute care environments.

They manage patient information, coordinate administrative tasks, and facilitate resources for the care team. The nurses mentioned that ward clerks assist patients with dementia in staying engaged in activities. This interaction benefited the patient by redirecting them and keeping them safe. Much consideration has been given to the interprofessional team in the care of patients with dementia in acute care, including nurses' collaboration with art and music therapists, occupational therapists, physiotherapists, dementia specialists, and social workers (Davis et al., 2023; Goldberg et al., 2014; Pinkert et al., 2018; Reilly & Houghton, 2019).

Gwernan-Jones et al. (2020) and Cowdell (2010) described the hierarchies of care that impede the sharing of knowledge. They suggest that workers in the hospital unit, such as cleaners, porters, and personal support staff, have valuable information about patients that can facilitate better PCC, but that it is not sought out. Ward clerks represent a group with potential knowledge to shape PCC practices in acute care settings. Thus, future research could be conducted to explore ward clerks' knowledge, beliefs, and practices related to dementia care in acute care settings. Understanding their perspectives might inform the development of interprofessional education initiatives, including non-clinical staff as key contributors to dementia-friendly care settings.

Additionally, the nurses in this study identified the BSO nurse as a key figure in supporting the use of non-pharmacological strategies to manage responsive behaviours, including activity-based interventions. Other researchers have described nurses' reliance on specialty teams to support patients with responsive behaviours (Yous et al., 2019). Handley et al. (2017) reported that access to staff with dementia expertise was helpful for role modelling appropriate dementia care strategies. However, they caution that staff may defer the care of patients with dementia to those with clinical expertise rather than developing a culture of collaborative practice. On the other hand, Yous et al. (2019) have described the benefits of shared care practices and interprofessional collaboration as a facilitator for the use of NPIs in hospitals. In this study, learning from one another and specialists enabled nurses to use activity-based interventions, particularly when the nurse was less familiar with the resources and how to utilize them.

Facilitators for Implementing Activity-Based Interventions

The management of responsive behaviours emerged as a key driver for the use of activity-based interventions. Nurses in this study reported that the acute care environment was ill-suited to the needs of PLWD and marked by high levels of boredom, contributing to expressions of agitation, restlessness, and wandering, findings also identified by other researchers (Dookhy & Daly, 2021; Hartung et al., 2021; Reilly & Houghton, 2019; Røsvik & Rokstad, 2020; Walsh et al., 2022; Yous et al., 2019). This finding aligns with previous research by Yous et al. (2020) and Hynninen et al. (2016), who also reported that nurses recognized the role of unmet psychosocial needs in the expression of responsive behaviours. Nurses in this study engaged patients with dementia in meaningful activity to help alleviate boredom and loneliness, factors known to contribute to responsive behaviours (Cohen-Mansfield et al., 2015).

Previous researchers have indicated that nurses use simple activities, such as music, television, conversation, towel folding, walking, and distributing newspapers, to support patients with responsive behaviours in acute care (Walsh et al., 2022; Yous et al., 2020). Nurses in the present study similarly used colouring, word games, puzzles, and tactile activities, such as fidget boards, to redirect and calm patients, thereby reducing distress and restlessness, and minimizing the need for sedating antipsychotic medications. Nurses emphasized a preference for least-restraint pathways, in line with gerontological best practices, while also acknowledging that medications were occasionally necessary to ensure patient and staff safety (Registered Nurses Association of Ontario [RNAO], 2012). These findings are consistent with broader evidence indicating that nurses often employ low-cost, non-pharmacological strategies to manage responsive behaviours in acute care settings (Lourida et al., 2020; Walsh et al., 2022; Yous et al., 2019, 2020).

Providing non-pharmacological care to manage responsive behaviours in this setting can be challenging. Nurses in this study reported that patients in their care could be dispersed across large units, making observation and ensuring safety difficult. Environmental structure and visibility play important roles in enabling or disrupting activity use within acute care environments (Dookhy & Daly, 2020; Moody et al., 2024; Goldberg et al., 2014; Gwernan-Jones et al., 2020). To mitigate safety risks, nurses brought patients out of their rooms and engaged them with activity at the nurses' station to enhance monitoring. Goonan et al. (2019) also described how nurses situated activities in highly visible areas to enhance patient monitoring and engagement with other patients and staff members. The dual benefit of safety and engagement makes this practice appealing in an acute care environment where staffing may be limited and workloads are high (Thériault et al., 2019). Visibility and proximity were thus seen as crucial enablers to nurses' use of activity interventions with patients and their integration into nurses' workflow.

Unlike other previous findings that suggest nurses' focus on safety dominates person-centred care (Digby et al., 2016), in this study nurses described using activities to address fall risks, agitation, or wandering, while simultaneously enhancing patient dignity and emotional comfort. Rather than prioritizing risk aversion over engagement, they found ways to integrate both, aligning safety goals with the therapeutic use of activity to address psychosocial needs.

Similarly, Ryan (2021), identified that attending to a person's psychosocial needs as part of a complex approach to relationship-centred care has positive outcomes such as reduced agitation and restraint use. In the context of this study, the use of activities as a safety strategy to mitigate falls could be due to the limited use of restraints in this hospital, or it may be characteristic of the nurses who participated in this study. Jensen et al. (2019) indicated that nurses with personality traits, such as a calm demeanour, were more routinely assigned to care for patients with dementia. Thus, it is possible that nurses who are more prone to using activity-based interventions also possess these characteristics, which prompts them to promote person-centred and relational care.

Facilitating Engagement Through Practical and Adaptive Strategies

Due to the complexity of acute care, nurses were drawn to items that required little effort to implement, such as colouring pages, word games, and puzzles. Nurses emphasized that activities were most effective when patients were familiar with them, as they may be unable to understand how to use some toy-like activity items, such as wooden building blocks, without assistance from a nurse. Similarly, in a feasibility study on the implementation of non-pharmacological interventions, Dasgupta et al. (2021) found that one-on-one support was a barrier to the implementation of activities. Furthermore, Yous et al. (2020) described how nurses use activities, such as music and television, to keep patients occupied without requiring a significant investment of their time. Previous studies have highlighted the use of activities, such as towel folding, as a simple distraction and redirection for responsive behaviours (Soun et al., 2023). Nurses prefer interventions that are straightforward to use as they are most feasible to implement (Moody et al., 2024; Yous et al., 2020).

The proximity of activity items emerged as a key facilitator for implementing activity-based interventions in acute care. The nearness of activity items allowed for spontaneous engagement, especially in moments when patients were restless or displaying early signs of agitation. In contrast, when materials were stored in distant supply rooms or required effort to locate, they were often overlooked due to competing demands and limited time. This finding aligns with Yous et al. (2020), who also observed that nurses were more likely to use non-pharmacological strategies, including activity-based interventions, when materials were readily available and within reach.

Barriers to Implementation in Practice

Nurses in this study identified multiple barriers to implementing activity-based interventions, including competing priorities, limited time, and a lack of training specific to dementia care. Similar barriers have been documented by other scholars examining the implementation of non-pharmacological interventions for patients with responsive behaviours in acute care (Houghton et al., 2016; Yous et al., 2019).

Competing Priorities and Time Constraints. Nurses in this study reported that they did not have sufficient time to engage patients in meaningful ways and often used activities that could be accomplished independently. However, they also acknowledged using a trial-and-error approach and described spending time with the patient to identify the activities that best suited this patient. The use of trial-and-error has been identified in other studies (Dasgupta et al., 2023; Soun et al., 2023). Other studies identified that nurses' lack of time impacts the delivery of person-centred care (Soun et al., 2023; Yevchak et al., 2017) and contributes to nurses using activities that require little effort to implement, as discussed previously.

Despite acknowledging the benefits of engaging patients with dementia in activity, nurses in this study expressed prioritizing the acute medical needs of other patients, a finding that has been documented in other studies (Digby et al., 2016; Jensen et al., 2020; Yous et al., 2019). This prioritization, while understandable in high acuity settings, lowers the priority of patients' psychosocial and emotional needs and impacts person-centred care. As highlighted in previous studies (Digby et al., 2016; Houghton et al., 2016; Reilly & Houghton, 2019), the multiple demands placed on nursing staff in acute care may result in the marginalization of the social and emotional needs of patients, even when these needs can contribute to increased responsive behaviours related to anxiety, fear, and boredom. Therefore, nurses' lack of knowledge about the contributing factors of responsive behaviours, such as boredom and loneliness (Cohen-Mansfield et al., 2015), is a barrier to the facilitation of activity-based interventions.

Nurses in this study described using activities as a reactive approach to behaviour management rather than as part of a structured or preventative approach to care. This aligns with previous research acknowledging the downgrading of care of patients with dementia in acute care (Turner et al., 2017) and the use of activities in response to challenging behaviours (Hynninen et al., 2016; Yous et al., 2019). Nurses' use of activity items was often shaped by situational demands, such as maintaining unit safety, rather than a proactive approach to reduce delirium or prevent responsive behaviours in patients with dementia. This reflects broader trends in acute care, where high workload volumes, inconsistent staff-patient interactions, and organizational pressures impede opportunities for relational and individualized care for PLWD (Keuning-Plantinga et al., 2020; Moody et al., 2024; Pinkert et al., 2018; Ryan, 2021; Walsh et al., 2020; Yous et al., 2019). Notably, while nurses in this study did not explicitly describe staff shortages, human resource shortages have been presented as barriers to implementing tactile activity interventions (Davis et al., 2023).

Resource Limitations and Availability. Resource limitations and accessibility emerged as significant barriers to nurses' effective implementation of activities in this setting. Nurses in this study expressed a desire for a broader range of resources, including newspapers, fidget muffs, and whiteboards. Nurses also reported that the limited variety of available resources made it difficult to sustain patient engagement, particularly for those with more extended hospital stays. A patient's lack of interest or knowledge in the activity was also perceived as a barrier, aligning with previous findings by Dasgupta et al. (2023). These findings align with previous research that documents the impact of a lack of resources (Dasgupta et al., 2021) and funding on the implementation of optimal dementia care (Tropea et al., 2017).

In response to limited access to formal materials, nurses in this study turned to improvised solutions such as printing colouring pages or creating hand-written games. While these creative strategies speak to the adaptability and dedication of nursing staff, they also highlight the extra emotional and cognitive labour involved in providing non-pharmacological interventions. Furthermore, these findings illustrate how nurses' creativity compensates for systemic shortfalls. Jensen et al. (2023) described how the personality characteristics of nurses themselves make them more likely to be assigned to care for patients with dementia. This finding highlights that meaningful dementia care in hospitals subsequently depends on the initiative of individual staff rather than being embedded in a culture of dementia-friendly care.

Additionally, nurses described a range of practical challenges, such as storage bins that were difficult to open, limited quantities of materials, and resources stored in inaccessible or remote locations. Goonan et al. (2019) identified that for activity interventions to be successful, daily procedures such as cleaning and reorganization were required. In this study, the additional resources required to maintain the activity resources were not considered. Resources such as additional staff time and funding for materials are necessary to implement activity-based interventions successfully (Davis et al., 2023; Gitlin et al., 2017; Goonan et al., 2019; Moody et al., 2023). The nurses' reflections suggest that for activity interventions to be successful, they must be supported not only by materials but also by organizational structures that prioritize relational care and recognize the therapeutic value of non-pharmacological approaches (Fitzpatrick, 2018; Handley et al., 2017; Ryan, 2021).

Lack of Knowledge. Nurses in this study expressed that they lacked understanding of dementia and therefore felt uncertainty in their approach and in knowing how best to care for patients with dementia. This knowledge gap is consistent with previous findings that suggest nurses have limited knowledge in dementia (Hartung et al., 2021; Houghton et al., 2016; Soun et al., 2023), responsive behaviours (Walsh et al., 2022; Yous et al., 2019), and the implementation of non-pharmacological approaches (Davis et al., 2023). Nurses in this study expressed that the education they received in nursing school did not prepare them adequately for the psychological and behavioural challenges of caring for PLWD in the hospital. This lack of knowledge impacts optimal care for PLWD (Digby et al., 2016). In this study, nurses lacked dementia-specific education and training on the activity interventions themselves, creating a barrier to their use. Education focused specifically on dementia and the delivery of activity-based interventions have been linked to improved staff attitudes toward non-pharmacological approaches and greater consistency in their use (Dasgupta et al., 2021; Davis et al., 2023; Gitlin et al., 2017). However, Feast et al. (2020) suggest that improving staff knowledge does not equate to better dementia care due to contextual factors such as lack of accountability, poor communication, and inadequate clinical leadership.

The findings in this study suggest a potential disconnect between the intended purpose of meaningful activity resources as strategies to prevent delirium and responsive behaviours and how they are operationalized in practice. Interestingly, even though activity supplies were stored in the DPCs, nurses did not explicitly describe using them to prevent or manage delirium. This condition can co-occur with dementia and is highly prevalent among older adults admitted to the hospital (Inouye et al., 2014). Despite the clinical intent behind DPCs as part of a broader delirium prevention strategy, nurses primarily framed their use of activity-based interventions in terms of behaviour management and fall prevention, rather than as therapeutic measures to maintain or improve cognitive functioning or prevent acute cognitive decline. This may indicate a disconnect between the nurses' knowledge of delirium and dementia in older adults, as described by other scholars examining barriers to nurses' recognition of delirium in older adults in acute care (Bianchi et al., 2024; Papaioannou et al., 2023).

Implications for Practice, Education, Policy, and Research

Practice

Relational caring emerged as an important element in this study of dementia care. Nurses who used activities often did so in ways that aligned with a relational ethic of care, centering the patient as a person with a unique history, preferences, and emotional world. This kind of caring is not simply a matter of interpersonal civility but involves empathy, trust, and a commitment to understanding the individual beyond their clinical diagnosis (Abbott et al., 2022; Dupuis et al., 2016; Handley et al., 2017). Unfortunately, nurses who challenge clinical cultures that prioritize efficiency to engage in PCC practices are often considered "lone fighters" (Pinkert et al., 2018, p.

170). Therefore, institutional leaders must foster relational practice by encouraging continuity of assignments and supporting team communication about patients' preferences and behaviours (Ryan, 2021).

Non-pharmacological and relational forms of care should not be seen as 'extra' but as foundational to ethical and practical dementia care. Activities offered a non-pharmacological means of promoting emotional well-being, reducing distress, and enhancing PCC within the constraints of acute care. However, nurses did not identify these activities as formal nursing interventions. Instead, they were often perceived as ancillary or recreational, rather than as integral components of clinical care or behaviour management. Consequently, activities were not incorporated into care plans nor evaluated using formal or informal assessment tools. White et al. (2017) highlighted that a key limitation in the use of non-pharmacological interventions for managing responsive behaviours is the lack of monitoring and outcome assessment. To address this gap, behavioural care plans should be developed collaboratively with nursing teams, and nurses should monitor and document the effects of these interventions on patients' behavioural expressions in the EHR. To minimize the documentation burden, clinical informatics teams should support the development of streamlined and efficient documentation strategies.

Gwernan-Jones et al. (2020) and Ryan (2021) propose that organizations can improve the care of PLWD by fostering person and relationship-centred approaches, such as getting to know the patient. Currently, nurses rely heavily on informal, ad hoc methods of communication to guide the use of activities. Nurses in this study shared information about patients' interests and preferences primarily through informal means, such as word of mouth or sticky notes in the EHR. The use of word-of-mouth communication and collaborative care practices has been described by previous authors as strategies nurses use to enhance the care of patients with dementia (Jensen et al., 2023; Yous et al., 2019). While these practices were seen as helpful for getting to know patients and fostering engagement, they lacked consistency and structure. As a result, information may not be readily accessible or sufficient for nurses to provide adequate care, potentially limiting relational care strategies (Gwernan-Jones et al., 2020) and hindering the implementation of activity-based interventions.

The absence of coordinated interdisciplinary information sharing is a known organizational barrier to PCC for PLWD in acute care settings (Ernst et al., 2020; Gwernan-Jones et al., 2020). Moreover, while nurses used the EHR to some extent to transfer information, this act was nurse-dependent and not a standardized practice. Consequently, it is an unreliable means for transmitting information that promotes PCC and the use of activity-based interventions. Jensen et al. (2023) and Gwernan-Jones et al. (2020) further identified that cumbersome EHR systems hinder access to meaningful interprofessional communication and patient-specific details. Thus, while informal strategies helped nurses in this study to engage patients in activities, they also highlighted the lack of formalized, integrated care planning and communication processes to support consistent PCC and the use of activity-based interventions in this setting.

In addition to peer communication, nurses in this study emphasized the value of information provided by families. For instance, families left notes in patients’ rooms offering insights into patient preferences, routines, and comfort strategies. Other scholars have identified that nurses rely on families to provide information to support care (Yous et al., 2020) and facilitate patient engagement in activities (Dasgupta et al., 2021). While nurses in this study appreciated the information provided by families, there was no consistent approach to involving families in care planning or gathering information to guide the implementation of activity-based interventions.

Furthermore, nurses did not report on the involvement of family in supporting patient engagement in activities. This lack of structure occasionally led to families being surprised that activity interventions were even available in the hospital, reflecting a broader disconnect between institutional processes and family inclusion and collaboration (Moody et al., 2024). The organizational absence of a strategy for family engagement in dementia care has been previously identified as a barrier to person-centred, non-pharmacological approaches (Ernst et al., 2020; Moyle et al., 2011). Establishing standardized processes for gathering input from and including families could enhance continuity, personalization, and the effective use of activity-based interventions.

While practical, these informal approaches can compromise the quality and integration of non-pharmacological interventions into care. Gitlin et al. (2017) acknowledge that activity interventions tailored to an individual's preferences and interests are the most engaging and meaningful. Furthermore, Dasgupta et al. (2021) emphasized that recognizing patients' interests is essential for maintaining their engagement in activities. To support this, all patients with dementia should have a document that facilitates the collection of data to foster person-centred and relational care practices (Fitzpatrick, 2018). Utilizing tools such as My Personhood Summary© (Behavioural Supports Ontario, n.d.-a) or the Getting to Know Me profile (Alzheimer Scotland, 2023) can provide nurses with insight into patients' preferences and interests. However, it is necessary that the gathering and communication of this information be part of a standardized process within the interdisciplinary team to avoid burdening the nurse.

Additionally, the findings of this study highlight how small environmental and logistical changes can enhance the use of activity-based interventions in acute care settings. For example, strategically storing materials in visible locations may enhance nurses' use. When activity supplies were stored in shared, central areas, they became part of a collective care approach, enabling multiple team members, not just nurses, to engage with patients, further supporting a culture of collaborative care. Moreover, the convenience of having items close at hand enabled nurses to respond to patient needs quickly without disrupting their workflow (Yous et al., 2020). Given these findings, hospital leadership should identify accessible and visible storage areas when implementing non-pharmacological practices, recognizing that the physical placement of resources can influence nurses' use in daily care routines. By prioritizing simplicity, familiarity, and accessibility, nurses create low-effort yet meaningful opportunities for engagement, supporting both patient well-being and practical staff workflows. In the fast-paced and often understaffed hospital setting, ease of access is not a minor detail but a practical necessity that can determine whether an intervention is used at all.

Canadian Gerontological Nurses Association (CGNA) Standards of Practice. The findings of this study strongly align with the Aesthetic Standard of the CGNA Standards of Practice, which emphasizes the art of gerontological nursing (CGNA, 2020). This standard implies that nurses see the person beyond illness, cultivate presence, use creativity to support well-being, and engage in therapeutic, humanistic interactions. The nurses in this study enacted aesthetic nursing through relational and imaginative approaches to activity-based interventions, despite working in a medically driven and time-constrained environment.

Nurses demonstrated attentive presence, a key element of the aesthetic standard, by slowing down, engaging in conversation, and using activities as opportunities to "be with" rather than simply “do for” patients. Activities such as colouring, puzzles, or word games became relational encounters in which nurses showed curiosity, conveyed respect, and attended to the emotional world of the person with dementia. These practices reflect the CGNA’s emphasis on understanding the meaning behind a person’s behaviour, honouring personhood, and responding creatively to promote comfort and connection.

At the same time, several barriers were identified including lack of resources, insufficient education, and organizational cultures prioritizing biomedical tasks, which highlight areas where practice falls short of fully realizing the aesthetic standard. Supporting nurses to enact aesthetic gerontological practice requires institutional investment in accessible activity resources, dementia-specific education, opportunities for reflective practice, and systems that value relational work as legitimate clinical care. Overall, the results of this study illustrate how activity-based interventions can serve as a powerful vehicle for enacting aesthetic or artful care. When supported by appropriate resources and organizational culture, these interventions can enhance relational care, promote emotional well-being, and honour the lived experience of people with dementia in acute care.

Recommendations for the CGNA. The findings highlight the importance of meaningful activity engagement as a core nursing still, especially for addressing responsive behaviours, supporting emotional well-being, and promoting relational care. The CGNA could explicitly integrate examples of activity-based interventions into the aesthetic/artful standard of practice, thereby emphasizing that such interventions are foundational, not optional, components of gerontological nursing practice.

Furthermore, the CGNA could work with Behavioural Supports Ontario Provincial Coordinating Office (BSO-PCO), following their recent launched a Meaningful Engagement

Resource Guide (BSO-PCO, 2025), to create evidence-informed tools that help nurses select, adapt, and evaluate activities tailored to patient preferences and cognitive abilities. A toolkit could include quick-reference guides for choosing activities, assessment strategies for identifying patient interests, and documentation templates for capturing patient responses to activities. This would support consistent, standardized use of activities across acute care settings.

Nursing Education

Gerontological nursing is often undervalued and underrepresented as a specialized and engaging field of practice. This perception contributes to a lack of interest and preparedness among nurses working with older adults (Apgar & Hynes, 2025), particularly those living with dementia (Clissett et al., 2014; Keuning-Plantinga et al., 2022). Findings from this study and others suggest that nurses frequently feel underprepared to support patients with dementia, especially when it comes to responding to responsive behaviours in a non-pharmacological manner (Hartung et al., 2021; Walsh et al., 2022; Yous et al., 2019). Similarly, nurses in this study acknowledged that they did not have the knowledge or education to perform the practical elements of caring for someone living with dementia.

Despite being a common and growing patient population in acute care, dementia care is often underemphasized in both undergraduate nursing education and institutional training, resulting in nurses feeling frustrated and helpless (Dewing & Dijk, 2016; Hartung et al., 2021; Marx et al., 2014). Nurses in this study recognized the need for additional education on non-pharmacological interventions. Previous research also indicates that nurses require more hands-on skills training to enhance dementia care techniques (Marx et al., 2014). To build nursing confidence and competence, dementia care training must be prioritized as a fundamental component of nursing preparation and professional readiness. Nursing programs should include focused education on dementia, extending beyond theoretical knowledge to include practical, case-based, hands-on learning that addresses how to identify responsive behaviours, assess unmet needs, and apply non-pharmacological interventions (Dookhy & Daly, 2021; Marx et al., 2014).

Furthermore, hospital orientation programs should include not only the differentiation between dementia and delirium, but also the meaning of responsive behaviours and the use of non-pharmacological strategies. In addition, content should emphasize the relational aspects of dementia care, which can help shift perceptions and reinforce the importance of this field as a rich and skilled domain of nursing practice. Furthermore, mentorship from experienced staff can support knowledge translation and help new nurses navigate the emotional and clinical complexities of dementia care in acute settings. However, this should be attempted cautiously due to findings that experienced staff may choose to do nothing about responsive behaviours (Hynninen et al., 2016). As acute care continues to serve an aging population, foundational competencies in dementia care should be treated with the same urgency as other core nursing skills.

Research

Several unanswered questions arose from this study. First, there is a need to understand better how patients with responsive behaviours respond to activity-based interventions delivered by nurses in acute care. While this study elucidated how and why nurses use activities in practice and touched on relational care practices, further research is needed to explore the impact of these interventions from a patient's perspective and to understand their effects in real time. Observational studies may elucidate the perspectives and responses of patients with dementia when they are involved in activities during an acute care admission. Structured observations would help to identify which approaches are effective in reducing responsive behaviours and promoting well-being. It would also offer the perspective of PLWD, as their insights about receiving care in a hospital are limited (Reilly & Houghton, 2019).

Limited research exists on the feasibility of activity-based interventions in acute care (Dasgupta et al., 2021), and there is a lack of knowledge about nurses' involvement in utilizing activity-based interventions in this context. Observational studies are necessary to investigate how nurses implement non-pharmacological interventions, including activity-based interventions, in real-time clinical practice, a concept also proposed by Yous et al. (2019, 2020). Such studies could offer more profound insight into the contextual factors, decision-making processes, and adaptations that nurses make when engaging patients with dementia in activity. Hynninen et al. (2016) found that nurses with more work experience were more likely to respond to patients exhibiting responsive behaviours by taking no action. This finding prompts further inquiry into the characteristics that influence nurses' likelihood of using non-pharmacological interventions. Future research could be done to explore how factors such as years of experience and clinical training shape nurses' responses to behavioural expressions and use of activity-based interventions.

In this study, nurses reported the benefits of documentation or information sheets that provided insight into patients' preferences and histories. However, a lack of formal communication of this information was evident. Although person-centred care is widely endorsed in policy and best practice guidelines (Handley et al., 2017), the processes through which nurses come to know the person in busy, medically oriented hospital environments remain underexamined. Studies situated within the growing field of dementia-friendly hospital research have emphasized the importance of environments and care systems that recognize the individuality and social needs of PLWD (Manietta et al., 2024). Building on this work, future research could be done to investigate how acute care teams capture and communicate patients' personal histories, preferences, and routines, and how this information informs care practices.

There is also a need to examine how organizational structures, such as interdisciplinary communication, documentation tools, admission protocols, and the presence of specialized roles like dementia champions or geriatric resource nurses, facilitate or hinder the incorporation of personhood into everyday nursing practice. Understanding how these systems operate in practice can inform the development of tools, training, or workflow adaptations that enable nurses to utilize personhood knowledge to guide relational, non-pharmacological approaches, such as activity-based interventions. Future research should examine how embedding personhood within care planning contributes to dementia-friendly hospital environments that prioritize dignity, engagement, and emotional safety.

Nurses in this study described the BSO nurse as a key influence in broadening their understanding of dementia and encouraging the use of activity-based interventions. The presence of a specialized dementia nurse in this study appeared to foster greater awareness of PCC strategies and, in previous research, has offered practical support for utilizing activity interventions (Dasgupta et al., 2021). However, the specific mechanisms through which BSO nurses or other specialized geriatric leads contribute to knowledge translation and practice change are underexplored. Future research is needed to examine how these specialized nurses function within the interdisciplinary team, how they influence care planning and decision-making, and how their presence impacts staff confidence, skill development, and patient outcomes. Dasgupta et al. (2021) examined NPIs designed by these specialized nurses, highlighting the potential of their leadership in developing and implementing effective dementia care strategies. Building on this, future studies could investigate how dementia specialists support capacity building among bedside nurses, mentor staff in the application of NPIs, and promote a culture of dementia-friendly care in hospital environments. A deeper understanding of these roles could inform system-level efforts to integrate specialized geriatric expertise in acute care and improve the quality of care for patients with dementia.

Policy Implications

There is a well-recognized need to improve dementia care in hospitals (Digby et al., 2016; Fogg et al., 2018; Handley et al., 2017; Røsvik & Rokstad, 2020). Efforts to enhance PCC practices, such as increasing dementia awareness and understanding through education and training, adapting the environment, enhancing information sharing, and engaging volunteers and family, could foster PCC and benefit the experience of patients and staff (Abbott et al., 2021). The findings of this study underscore the need for organizational support to sustain and scale the use of non-pharmacological and activity-based interventions for patients with dementia in acute care. Nurses in this study demonstrated creativity and adaptability in facilitating meaningful engagement. However, their efforts were often limited by systemic barriers such as inadequate access to materials and time constraints. These findings align with broader concerns across the literature about the underutilization of NPIs to support the PCC of patients with dementia in hospital settings (Moyle et al., 2011; Soun et al., 2023; Tropea et al., 2017; Walsh et al., 2022; Yous et al., 2020). Nurses are not given sufficient time or resources to engage in non-pharmacological PCC practices (Davis et al., 2023; Gwernan-Jones et al., 2020; Jensen et al., 2023) and must balance competing demands in acute care settings.

As such, alternative human resources should be considered to support the implementation of activity-based interventions in this setting (Davis et al., 2023). The successful delivery of

NPIs that meet the psychosocial needs of patients with dementia relies heavily on staff who have adequate training (Handley et al., 2017; Røsvik & Rokstad, 2020). In the UK, an activities care crew was developed to enhance dementia care and reduce the financial burden of caring for patients with dementia in acute care, such as reducing costs associated with one-on-one support (Brooke & Herring, 2016). Hospital leadership should implement human resources that facilitate NPIs or meaningful activities (Fitzpatrick, 2018) to enhance the patient experience and improve outcomes (Brooke & Herring, 2016).

Furthermore, nurses' attitudes about PLWD are primarily influenced by organizational cultures that do not value the care of older adults with dementia (Handley et al., 2017). Hospital leaders must endorse a culture of care that values person-centred and relational care (Soun et al., 2023) and move beyond reliance on individual nurse initiative to implement NPIs. Time allocation for meaningful engagement and supporting patients with dementia should be embedded into staffing models and workload expectations, rather than being viewed as ancillary or discretionary. Furthermore, by auditing care leaders can recognize and value NPIs, such as activities, as a legitimate and essential aspect of clinical practice and reinforce their importance within nursing care. Without institutional investment, the burden of implementing NPIs will continue to fall disproportionately on nurses who care (Hynninen et al., 2016), rather than as an expectation for optimal dementia care. Organizational commitment is therefore vital to normalize and sustain NPIs as part of high-quality, person-centred practice in acute settings (Abbott et al., 2022; Handley et al., 2017).

Strengths and Limitations

A strength of this study was the inclusion of nurses from three professional designations, including RPNs, RNs, and NPs. This representation enriched the data by capturing a range of perspectives based on differing scopes of practice, responsibilities, and experiences in acute care. The diversity of roles enhanced the study's credibility by offering a deeper understanding of how activity-based interventions are perceived and used across various levels of nursing practice. The inclusion of these varied perspectives also supports the potential for transferability, a key criterion in interpretive description. As Thorne (2016) emphasizes, transferability is achieved when findings resonate with practitioners and offer meaningful insights that can be adapted to similar clinical settings.

While it was a goal to include PSWs to broaden the spectrum of voices in this study, none ultimately participated. Nevertheless, the range of nursing perspectives captured provides valuable insight into relational and practical dimensions of activity-based interventions in acute care. Additionally, the sample size aligned with previous interpretive descriptive studies, lending credibility to the analytic depth and ensuring the findings were grounded in a methodological approach appropriate for qualitative inquiry.

This study has several limitations. First, only one participant reported not using activity-based interventions in their practice. Although recruitment was open to all nurses regardless of their engagement with activity interventions, the limited representation of non-users restricts insight into the full range of barriers that may prevent implementation. As a result, the findings may reflect a bias toward more positive or proactive attitudes. Future researchers should purposefully aim to include non-users of these interventions to understand better the contextual, organizational, or personal factors that hinder the uptake of activity-based interventions in acute care settings.

Second, the study was conducted in a distinct medical-surgical unit within a small community hospital. While this context provided valuable insight into how relational and activity-based practices are navigated in smaller institutional environments, it may limit the generalizability of findings to larger, more resource-intensive urban hospitals or other specialized acute settings. Replicating this study across diverse hospital contexts could enhance the broader applicability of the findings and illuminate setting-specific facilitators and constraints.

Finally, the absence of PSWs represents a significant limitation to this study. As frontline staff who often deliver personal care to patients with dementia in this setting, PSWs hold critical perspectives that could further enrich understandings of activity use, relational care, and team dynamics. Their absence represents a missed opportunity in this study. Furthermore, it reflects a broader challenge in engaging PSWs in research. Future studies should prioritize the inclusion of PSWs and explore how their insights can inform practice improvements. Encouraging hospital leadership to support and allocate protected time for PSWs to participate in research may enhance their involvement and enrich the overall understanding of dementia care in acute settings.

CHAPTER SEVEN: CONCLUSION

Given the growing demand for acute care staff to support PLWD, there is an urgent need for more evidence to support enhancements of effective dementia care. Our understanding of nurses' use of non-pharmacological activity-based interventions in acute care settings is broadened through this study. The results of this study provide insight into nurses' motivations for using activity-based interventions and how they incorporate them into patient care. Activity-based interventions were found to serve multiple purposes, including promoting safety, reducing harm, and managing responsive behaviours such as agitation and wandering. They also helped reduce nurses' stress by offering a way to support patients while attending to other clinical responsibilities. Nurses often selected simple, easy-to-facilitate activities, but were also willing to invest time in identifying appropriate interventions and learning about the individual needs and preferences of patients. However, several barriers to implementation were identified, including time constraints, competing priorities, limited knowledge, and patient-related factors.

This study highlights how meaningful engagement in activities, such as colouring, puzzles, doll therapy, and interacting with robotic pets, can support person-centred and relational care. Relational care was not just a by-product of activity use, but a central benefit. Nurses described how shared activities provided opportunities for deeper understanding and connection that extended beyond routine tasks and clinical responsibilities. Engaging in activities fostered familiarity, trust, and emotional connection. Through these engagements, nurses experienced mutual joy, gained deeper empathy, and developed a more personalized approach to care. These moments allowed nurses to see the person beyond their dementia diagnosis, uncover individual preferences and life histories, and tailor care in ways that acknowledged the patient's identity and dignity. Furthermore, these relationships fostered a more humanizing care environment, enhanced patient care, and contributed to nurses' job satisfaction and emotional reward.

Practical strategies used by nurses to promote activity engagement included offering familiar, easy-to-use items and tailoring interventions to the patient's interests and abilities. Nurses emphasized the importance of flexibility, trial and error, and observing patients' responses to identify what was most engaging and comforting in the moment. These strategies offered a sense of normalcy and promoted patient safety. Furthermore, activity-based interventions supported nurses' relationships with patients, fostering relational and person-centred care by creating opportunities for connection and individualized support, even within the constraints of acute care.

To improve dementia care in hospitals, it is essential to foster a culture that values person-centred and relational approaches and supports the consistent use of non-pharmacological strategies. Nurses in this study were constrained by medical priorities, time pressures, limited resources, and a lack of education specific to dementia. Additionally, the absence of structured communication about patients' interests and histories hindered the integration of activity-based interventions as a reliable approach to reduce boredom and responsive behaviours. Future research should explore how nurses collect and communicate personhood information and how these insights can be embedded into care planning to enhance both meaningful engagement and relational care in acute settings.

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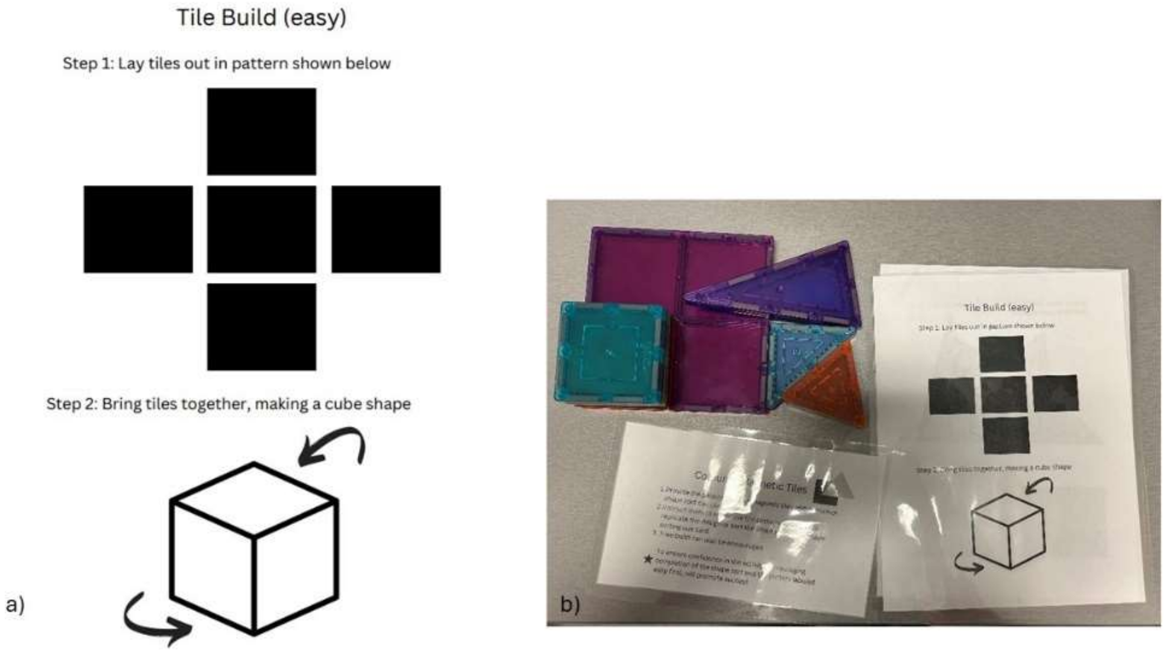
Appendix A

Example of Various Activity-Based Interventions

Figure 3

Magnetic Tiles Activity Kit



Tile Build (easy)

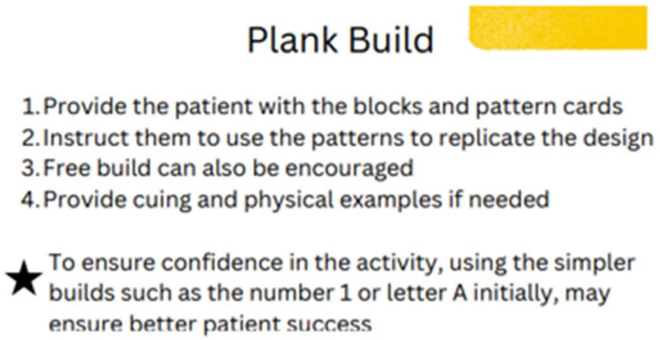
Step 1: Lay tiles out in pattern shown below

Step 2: Bring tiles together, making a cube shape

Note: (a) activity instruction sheet, and (b) items in the kit, including magnetic tiles and instructions.

Figure 4

Wooden Planks Activity Kit



Plank Build

1. Provide the patient with the blocks and pattern cards
2. Instruct them to use the patterns to replicate the design
3. Free build can also be encouraged
4. Provide cuing and physical examples if needed

★ To ensure confidence in the activity, using the simpler builds such as the number 1 or letter A initially, may ensure better patient success

Note: (a) activity instruction sheet, and (b) items in the kit, including wooden planks, templates, and instructions.

Appendix B

Recruitment Poster

TRENT UNIVERSITY

ATTENTION!

NURSES & PERSONAL SUPPORT WORKERS

JOIN OUR

RESEARCH STUDY

We are looking for RNs, RPNs, and PSWs to share their experience providing care to patients living with dementia utilizing non-pharmacological interventions.

Study Purpose: To understand the challenges and best practices in using activity interventions when caring for patients with dementia.

Who can participate?

- Nurses and Personal Support Workers
- Has worked on 2A/B for at least 3 months

What is involved?

- Participate in a 1-on-1 interview (In-person or Zoom)
- Interviews will last about 30-60 minutes
- Share your valuable insights and experiences

Why Participate?

- Contribute to meaningful research
- Help improve care practices for patients with dementia
- Make a difference in practice

This study has been reviewed by, and received ethics approval through Trent University's Research Ethics Board: File #29354.

JOIN NOW

by scanning the QR code
or **email Shawna: shawnapeddar@trentu.ca**

Appendix C

Recruitment Email

Subject: Invitation to Participate in a Research Study on Activity Interventions for Patients with Dementia

Dear [Recipient's Name],

You are invited to participate in an important research study examining the use of activity interventions with patients living with dementia. As a dedicated nurse (RN or RPN) or personal support worker (PSW) at Northumberland Hills Hospital, your expertise and experience are important to our research.

Study Purpose: The aim of this study is to understand the challenges and best practices in using activity interventions to enhance the care of patients with dementia.

Who Can Participate:

- Nurses (RNs or RPNs) and Personal Support Workers (PSWs)
- Currently working on an acute care unit at Northumberland Hills Hospital
- Employed at NHH for at least 3 months
- Exposed to the Delirium Prevention Carts and meaningful engagement activity items

Participation Details:

- Engage in a one-on-one interview lasting approximately 30-60 minutes
- Share your insights and experiences with activity interventions for patients with dementia
- Participation is voluntary, and there is no compensation for taking part in this study

Confidentiality:

- All interviews will be video and/or audio-recorded and stored securely on a password-protected laptop
- Personal identifiers will be removed from the transcripts and replaced with pseudonyms
- Only the research team will have access to the data, which will be securely stored
- Written transcripts and audio recordings will be retained for five years

Your participation will contribute to meaningful research that aims to improve care practices for patients with dementia. If you are interested in participating or would like more information, please contact Shawna Peddar at shawnapeddar@trentu.ca or 905-925-9373. Thank you for considering this opportunity to make a difference in dementia care.

Warm regards,

Shawna Peddar, Student Researcher
Trent University
shawnapeddar@trentu.ca

Appendix D

Recruitment Post for Acute Care Unit Newsletter

Join Our Study: Enhancing Dementia Care through Activity Interventions

We are seeking nurses (RNs and RPNs) and personal support workers (PSWs) to participate in a research study here at Northumberland Hills Hospital. The aim of this study is to explore the challenges and best practices in using activity interventions to improve the care of patients with dementia.

Who Can Participate:

- Nurses (RNs or RPNs) and PSWs currently working on an acute care unit at NHH
- Employed at NHH for at least 3 months
- Experienced with Delirium Prevention Carts and meaningful engagement activities

Participants will engage in a brief 20–45-minute interview to share their insights and experiences. Your contribution will help shape better care practices for dementia patients.

For more information or to participate, please contact shawnapeddar@trentu.ca or phone/text 905-925-9373.

Help us make a difference in dementia care!

Appendix E

Face-to-Face Interview Guide for Nurses

Introduction

Hello, thank you for volunteering to participate in this interview! I am graduate student in the masters of science in nursing program at Trent University. This study will aid me in meeting one of my program requirements.

The focus of the study is to gain a better understanding of the use of activity interventions for patients with dementia in acute care. I am seeking to answer the question *what are the experiences and understandings of nurses and PSWs in using activity interventions to care for people living with dementia.* As a nurse or PSW who works on the acute care unit at this hospital, I believe your experiences, thoughts, and feelings about the use of activity interventions with patients with dementia are important and should be shared.

This interview will be about 30 to 45 minutes in length. When answering the questions, please reflect upon your experience and take your time answering the question. I would appreciate you offering as much detail as possible to fully understand your experience. All the information that you share with me today will be kept confidential and will not impact your relationship with the hospital or myself. Please answer the questions honestly and in detail. If you would like to skip a question or come back to a question please let me know.

The interview will be recorded on two different devices so that I don't miss any details. I will store the information securely. Participants will be given pseudonyms to provide anonymity. Once the audio file is transcribed it will be destroyed.

Do you have any questions for me before we begin?

Firstly, would you please complete a demographic questionnaire.

Breaking the Ice

1. How long have you been a nurse?
2. How long have you worked on the acute care unit at this hospital?

Setting Question: Have you used the activity items provided on the unit?

If no:

3. Could you tell me what factors have influenced your implementation of activity interventions?
4. How do you think you could be better supported to use the activity items with patients living with dementia?
5. How do you feel when caring for a patient with dementia?

If yes:
Using Activity Items

1. Would you describe your experience using the activity items to support patients with dementia?
a. Can you share some stories or examples of your experience using activity items to support patients with dementia?

Guidance in Decision-Making

2. When you're deciding which activity items to use, how do you decide which item to use with a patient?
a. What other factors do you consider when deciding on an activity item?
3. Have you received any feedback directly from the patients about the activities?
a. If so, what have they said?
b. How did that make you feel?
4. Have family influenced your ability to introduce activity interventions?
a. How have they been influential?
b. Was it in a good or bad way?
c. Tell me more about what that was like for you and the patient
5. How have other staff influenced your choice in activity selection?
a. Do you collaborate with other healthcare professionals (e.g., occupational therapists, physical therapists) when deciding on or implementing activity interventions?

Selection of Interventions

6. Tell me what are some of your favourite activity items to use with patients?
a. Why do you like these items in particular?
b. Tell me more about what it looks like to use these items with a patient

Modification of Activities

1. Tell me about a time you modified the activity to better suit a patient?
7. How important do you think it is to personalize activities for each patient?
a. Can you give an example of a time when personalization made a significant difference?
8. How do you consider a patient's cultural background when choosing activities?
9. Have you noticed any changes in the effectiveness of activities as a patient's condition progresses?

Benefits

10. What benefits have you observed from using these interventions?
11. Have there been any surprising or particularly rewarding outcomes?
12. How do you measure the success or effectiveness of an activity intervention?
a. Are there specific indicators you look for?
13. How do these activities impact the emotional and social well-being of patients?
a. Have you noticed improvements in mood, social interaction, or overall quality of life?
b. How does this change make you feel?

Barriers in Using Interventions

14. What are some of the challenges you face when trying to implement these activities?

a. Can you tell me more about the barriers you've experienced?

Training and Education

15. What kind of training or education have you received regarding the use of activity items for dementia patients?

a. Do you feel it was adequate?

Suggestions for Improvement

16. Are there any activity items or interventions you wish you had access to?
17. What would you suggest for improving the approach to activity interventions for dementia patients?

Thank you for your participation. Do you have any additional comments or experiences that you would like me to know about?

*Provide a summary of key points to the participant before ending to seek clarification.

Reflexively Added Questions:

- How does the use of activity interventions impact your shift?
- Does the use of activity interventions impact your use of PRN medications?

Appendix F

Sample Initial Code Labels

- Enhancing patient safety
- Visibility and monitoring
- Reducing stress and worry for the nurse
- Managing unwanted behaviour
- Preventing falls and wandering
- Ensuring safety while working with other patients
- Minimizing restraints
- Safety strategy
- Collaborative care
- Interprofessional collaboration
- Collective responsibility
- Emotional connection
- Building relationships
- Learning from colleagues
- Sense of accomplishment / professional fulfillment
- Providing familiar activities
- Mutually rewarding interaction
- Seeking to know
- Purposeful/meaningful engagement
- Ease of use
- Readily available
- Low effort / simple activity
- Personalization of activities
- Provides comfort
- Engagement strategies
- Positive emotional response
- Patient disinterest
- Negative emotional response
- Tailoring activities
- Item selection
- Item availability
- Curiosity
- Initiation of activity
- Engaging conversations
- Mentally stimulating / cognitive engagement
- Sitting down with the patient
- Nurse chooses the activity
- Willingness to try
- Adaptability/flexibility
- Creativity
- Go to activity/default choice
- Respect and dignity
- Ward clerks
- Trial and error

Appendix G

Table 2: Code Tree Example

This is a sample of the coding and categorization that led to theme development.

Quote	Initial Code Labels	Code Category / Subtheme	Theme
RN2: We found that she loved puzzles. She loved the jigsaw puzzles. And so we would share from other floors because then we you know limited supply. But we were able and sometimes if the PSW for an extra moment. Sometimes our nursing scholars, instead of doing their charting if they had a free moment, would sit with her. She just wanted the socialization and the puzzles and it brought her and she would sit there and talk about her life. And it was like the dementia now again, earlier onset, but it was like the dementia was gone.	(Providing) familiar activities Sitting down with the patient Engagement strategies	Building relationships	Opportunity for Deeper Understanding
RPN4: And then sometimes it's it's as simple as just engaging with them. And asking them questions about that. So tell me about your job in you know what you did for your whole career or, you know, oh, your family member tells me you used to volunteer at the animal shelter.	Engaging conversations Curiosity Seeking to know	Building relationships	Opportunity for Deeper Understanding
RPN1: I think I like often would like just talk to the patients being like, oh, do you like doing puzzles? Do you like crosswords? Do you like painting? Do you like just talking to them. Obviously, it depends also on their like abilities	Curiosity Seeking to know	Building relationships	Opportunity for Deeper Understanding

RPN6: I find the ward clerks are really good at it. Because they're always just like, right at the desk, yeah, so this patient might just be there all the time. So they'll get to know the patient really well. They'll print off the colouring sheets, and they'll play the puzzles and with all the blocks or whatever, yeah,. They really get into it too.	Building relationships Ward clerks Interprofessional collaboration	Collective responsibility	Collective Responsibility and Collaboration
RN2: often these patients with dementia become the floor's patient. It's never when they need it to be. I mean, sometimes they're not but often the whole floor kind of keeps eyes on them that time. So yeah. And in so doing, they know what they like too. The floor starts to know what they like.	Collaborative care	Collective Responsibility	Collective Responsibility and Collaboration
RPN5: then it shows familiar faces, because obviously the ward clerk and them are always gonna be there. So then that's their thing. They'll come into the room, and then they're gravitated there instead of possibly going towards the doors	Interprofessional collaboration Ward clerks	Collective Responsibility	Collective Responsibility and Collaboration
RPN1: but they can be a challenge sometimes too. If the patient's like, not interested at all, that's a challenge, but I'm always up for it. It's just that could be a challenge.	Patient disinterest Willingness to try	Varied patient engagement and response	Barriers to Implementation
RPN5: Because if they're getting up there on that puzzle and they're like, No, I'm not interested, then you'll try to find another activity that they are interested in. Sometimes activities just don't, its just not what they want to do.	Patient disinterest	Varied patient engagement and response	Barriers to Implementation
NP2: I find yes, but I'll be honest, if someone's here for a month, they get tired of doing it day after day after day. And many of them do it. And then once they become accustomed to it. There needs something a little bit more, not challenging, maybe more challenging, but they need something a little bit different to stimulate a different part of their brain because what worked on Monday might not work on Thursday	Tailoring activities Adaptability	Varied patient engagement and response	Barriers to Implementation

Appendix H

Questionnaire for PSWs and Nurses: Participant Characteristics

1. How old are you?

2. What is your gender?
   ☐ Male ☐ Female ☐ Other ☐ Prefer not to say

3. What is your highest level of education?
   ☐ College Certificate ☐ College Diploma ☐ University Degree ☐ Graduate Degree
   ☐ Other (please specify): ________________________

4. How long have you been working as a PSW, RPN, or RN?
   ☐ 3 to 6 months ☐ 6 months to 1 year ☐ 1-2 years ☐ 3 to 5 years

5. How long have you been employed at the hospital?
   ☐ 3 to 6 months ☐ 6 months to 1 year ☐ 1-2 years ☐ 3 to 5 years ☐ More than 5 years

6. How long have you been working on the acute care units?

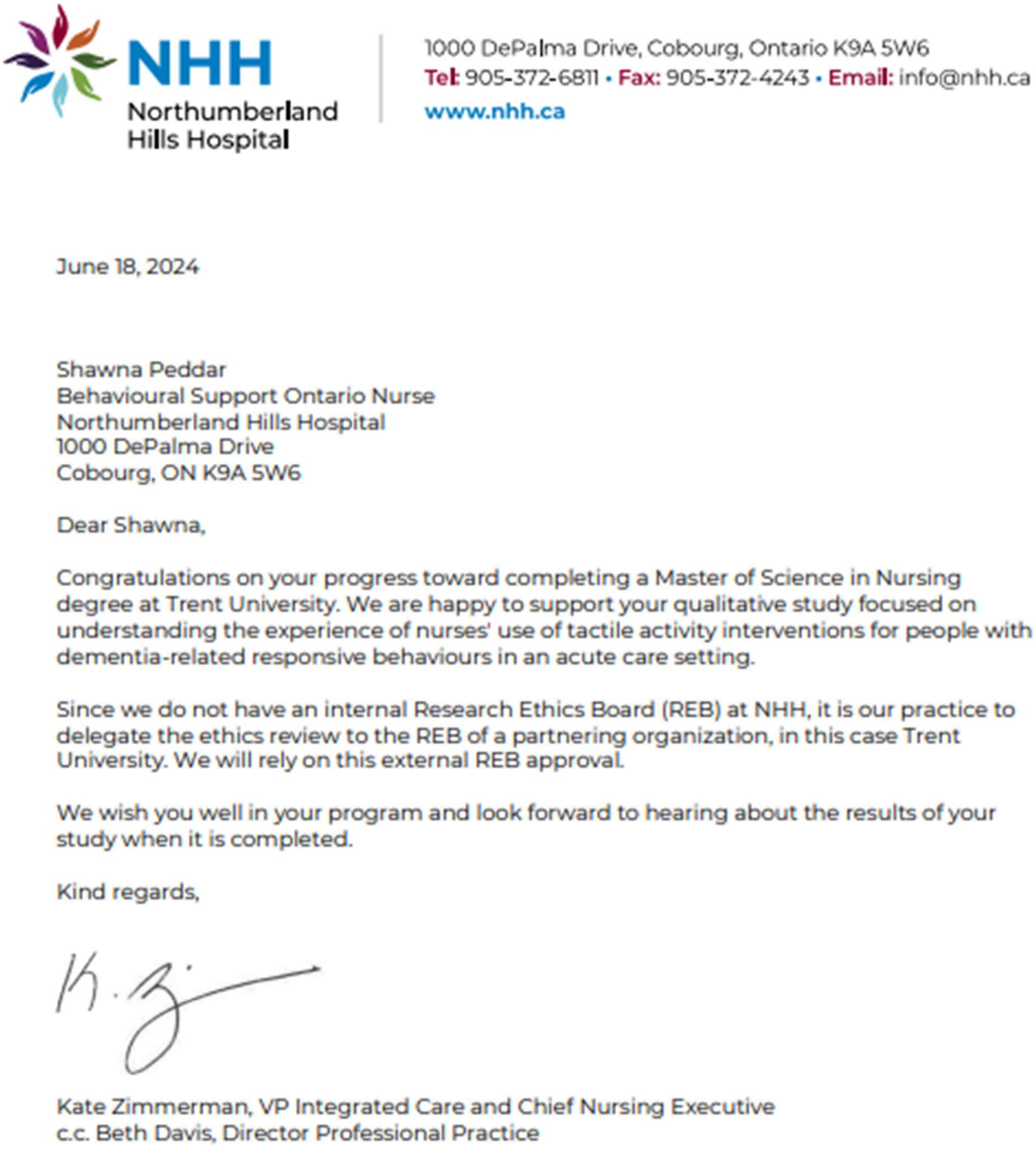
7. Are you aware of the Delirium Prevention Carts and the activity items?
   ☐ Yes
   ☐ No

8. How did you learn about the Delirium Prevention Carts and the activity items?
   ☐ General Orientation ☐ Huddle on Unit
   ☐ Other: ____

9. Do you have any additional training or certifications related to dementia care?
   ☐ Yes (please specify): ____
   ☐ No

Appendix I

Letter Indicating Support of External Ethics Approval



NHH
Northumberland
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1000 DePalma Drive, Cobourg, Ontario K9A 5W6
Tel: 905-372-6811 • **Fax:** 905-372-4243 • **Email:** info@nhh.ca
www.nhh.ca

June 18, 2024

Shawna Peddar
Behavioural Support Ontario Nurse
Northumberland Hills Hospital
1000 DePalma Drive
Cobourg, ON K9A 5W6

Dear Shawna,

Congratulations on your progress toward completing a Master of Science in Nursing degree at Trent University. We are happy to support your qualitative study focused on understanding the experience of nurses' use of tactile activity interventions for people with dementia-related responsive behaviours in an acute care setting.

Since we do not have an internal Research Ethics Board (REB) at NHH, it is our practice to delegate the ethics review to the REB of a partnering organization, in this case Trent University. We will rely on this external REB approval.

We wish you well in your program and look forward to hearing about the results of your study when it is completed.

Kind regards,

Kate Zimmerman, VP Integrated Care and Chief Nursing Executive
c.c. Beth Davis, Director Professional Practice

Appendix J

Consent Form

Research Informed Consent Form for Nurse and PSW Participants

Study Title: Understanding the Experiences of Nurses and PSWs Using Non-Pharmacological Activity Interventions for People Living with Dementia in Acute Care

Student Investigator:
Shawna Peddar, RN, BScN
Graduate Student, School of Nursing
Trent University
Peterborough, ON
(905)-925-9373
Email: shawnapeddar@trentu.ca

Funding Source: None

You are invited to participate in a research study examining nurses' experiences using non-pharmacological activity interventions for people living with dementia. You are being asked to participate in this study because you are a Registered Nurse or Registered Practical Nurse or Personal Support Worker (PSW) with relevant experience working in an acute care unit and providing care for people living with dementia. Before you agree to participate, please read this form carefully and ask any questions you may have to be sure that you understand what your participation will involve.

What is the purpose of the study:

The aim of this study is to gain a better understanding of nurses' and PSWs’ experiences using activity interventions for the care of people living with dementia admitted to an acute care unit at Northumberland Hills Hospital. The results of this study will be presented in a written thesis to the school of Nursing at Trent University in fulfillment of a course requirement. The results may also be published in a research paper or presented at conferences. The results may also be used by Northumberland Hills Hospital for quality improvement purposes.

Who is conducting this study?

This research study is being conducted by Shawna Peddar, Dr. Kirsten Woodend, and Dr. Cable-Williams from the Trent/Fleming School of Nursing at Trent University.

Who can participate?

Participants must be English-speaking, hold a professional designation of RN or RPN, or be PSWs, currently work on an acute care unit at Northumberland Hills Hospital, have been working there for at least 3 months, and have been exposed to the Delirium Prevention Carts and the meaningful engagement activity items.

Why is this study needed?

Ontario's aging population has led to an increase in acute care patients with dementia. Nurses in these settings face challenges, particularly with managing responsive behaviours. Non-pharmacological interventions are the primary strategy for addressing these behaviours. Tactile or activity interventions, such as fidget toys, puzzles, and sorting tasks, offer promising alternatives by providing meaningful activities to soothe and engage patients. Despite their potential benefits, there is limited research on nurses' and PSWs' use of these interventions in acute care and their experiences. Understanding your experience with these items will offer insights into the practical application of these interventions including challenges, and outcomes. The results can help to guide future dementia care practices in hospital.

What will you be asked to do during the study?

If you agree to participate in this study, you will:

- Be asked to provide background information regarding your age, gender, professional designation, and years of nursing experience in a short survey which will take about 5 minutes.
- Participate in a one-on-one interview one time, via Zoom or in-person.
- During the interview you will be asked to discuss your experience of delivering activity interventions to patients living with dementia.
- The interview will last approximately 30 to 60 minutes.
- The interviews will take place at Northumberland Hills Hospital, or another agreed upon location.
- If meeting in person for the interview is not possible, a meeting via Zoom will be arranged at a time that you and the researcher agree upon.
- The interviews will be recorded and then transcribed for analysis purposes.
- The researcher will take notes during the interview to help the data analysis.
- Transcriptions will be made available to you to review and/or edit.
- The research findings will be made available to you to review.

What are the risks or discomforts of participating in this study?

There are minimal risks associated with participating in this study. You may experience some discomfort when discussing your experiences of using the activity interventions with people living with dementia. You may experience unpleasant memories or feelings, such as frustration or embarrassment. You may request to take a break or stop the interview at any time, or you can choose to continue the interview at another time. If you feel too uncomfortable to continue, you may choose to withdraw from the study at any time and ask that your information be removed from the study. By agreeing to participate in this research, you are not waiving any legal right in the event that you are harmed during the research.

As a Registered Nurse, I am governed by the College of Nurses of Ontario (CNO) regulations, which includes a duty to report any information that may indicate a risk of harm to a patient or public safety. Though the focus of this study is on the use of activity interventions and not on patient-specific details I am bound by CNO regulations to report any unforeseen concerns related to patient safety that may arise during the research process.

What are the benefits of the study?

You may benefit from reflecting on your practices and contributing to research that could improve dementia care. Your participation will add your story and experience to the academic and professional literature regarding the care of people living with dementia in hospital. While there are no direct benefits to you, your participation may benefit future nurses through education on the use of activity interventions when learning about caring for patients with dementia. I cannot guarantee, however, that you will receive any benefits from participating in this study.

How will your information be kept confidential?

The audio recordings of all participant interviews will be stored on a password protected device. All records identifying participants will be maintained confidentially. In transcription, all personal identifiers including names will be removed from the raw data and replaced with non-personal identifiers, such as RN 1. No identifying information will be included in any reports or publications, unless you agree to use your real name in publication. You have the right to review and/or edit the recordings or transcripts. Only the research team will have access to the data, which will be stored securely in a password-protected digital format. A final written report may be provided to Northumberland Hills Hospital for the purpose of quality improvement. However, the identity of all participants will remain anonymous. Written transcripts and audio recordings will be kept for five years following the written report.

Will I be paid for my participation?

No, you will not receive any compensation for participating in this study.

What are the costs to participate?

Your participation in the study should not cost you. Should you wish to have your interview with me in-person outside of your work hours, you will not be reimbursed for your travel costs.

What if I decide I no longer what to participate in the study?

Your participation in this study is completely voluntary. You can choose whether to participate or not. If any question makes you uncomfortable, you can skip that question. You may stop participating at any time. If you choose to withdraw from the study, you are no required to provide a reason, and your decision will be respected without any consequences or pressure to continue. Participants have the right to withdraw without penalty. Your choice of whether to participate will not influence your current or future relations with Trent University and Northumberland Hills Hospital or the investigators, Shawna Peddar, involved in the research.

If you withdraw before data collection is complete, any information collected from you will be deleted and not used in the study. If you withdraw after data is collected in the interview or questionnaire, you may request the removal of your information from the study results. If you decide to withdraw after your data has been transcribed and anonymized, your data will remain in the study. Additionally, if necessary, I will offer a brief follow-up conversation to ensure that the participant feels comfortable with their decision and to address any concerns they may have, though this is optional.

How will the study results be shared?

The results of this study will be written in a thesis. A manuscript will be submitted to an appropriate academic journal for publication (i.e., Journal of Nursing Practice). A report of the data will be disseminated to the hospital executive team. A write-up may also be included in the hospital newsletter to disseminate findings to nursing staff and other staff in the organization. If accepted, the findings may be presented at conferences, including the Canadian Association of Gerontology and the Canadian Gerontological Nursing Association.

Who do I contact if I have any questions about the study?

If you have any questions or concerns about the study now, please ask. If you have questions in the future you can contact:

Shawna Peddar Research Student shawnapeddar@trentu.ca 905-925-9373	**Dr. Kirsten Woodend** Academic Supervisor kirstenwoodend@trentu.ca	**Dr. Beryl Cable-Williams** Academic Supervisor bcable@trentu.ca

This study has been reviewed by the Trent University Research Ethics Board, the study number is 29345.

If you have any questions about your rights as a research participant or if you have questions or concerns that you don't wish to share with the researchers, please contact:

Anna Kisiala
Coordinator, Research Conduct and Reporting
c/o Office of the Vice President, Research and Innovation
Trent University, 1600 West Bank Dr.
Peterborough, ON. K9L 0G.
705-748-1011 ext. 7866

annakisiala@trentu.ca

Research Informed Consent Form for Nurse and PSW Participants

By signing this consent form, you indicate that you have read and understood the information provided in the information above. You agree that you have understood the potential benefits and risks associated with the study. You will be given a copy of this consent form for your records.

☐ I have read, or have had read to me, the information in this agreement.
☐ I have asked any questions I have about the study.
☐ By signing, I agree to participate in the study.
☐ I am aware I can change my mind and withdraw consent to participate at any time.
☐ I have been given a copy of this agreement; and
☐ I am not giving up any legal rights by signing this consent agreement.
☐ I am aware that the researcher will use a pseudonym when discussing my contributions in their report.
☐ I agree to be audio recorded for the purposes of this study. I understand how these recordings will be used, stored and destroyed.

Participant's Name (Printed): ______________________

Participant's Signature: ___________________________

Date: ___________________________

Researcher's Signature: ___________________________

Date: _____________________________

Thank you for your time and participation in this study.