



From darkness to lightness: developing a working definition of special observation in an acute aged care setting

Michael Kerr, Yvonne Verner and Victoria Traynor*

*Corresponding author: School of Nursing, Midwifery and Indigenous Health, Faculty of Health and Behavioural Sciences, University of Wollongong, Australia. Email: vtraynor@uow.edu.au

Submitted for publication: 8th February 2012

Accepted for publication: 25th March 2013

Abstract

Background: Special observation is a practice in common use in acute care settings for older people, in particular when dementia and/or delirium are/is experienced, but there is little evidence of best practice approaches.

Aim and objectives: The overall aim of this project was to develop a working definition of special observation in acute aged care settings. The objectives were to identify barriers and enablers for undertaking special observation and compare descriptions of special observation practice by staff with those in policy and related documents.

Methods: The setting was an acute care ward in a large regional hospital in New South Wales, Australia and the participants worked on this ward. Data consisted of policy and related documents and focus groups (Round 1 and Round 2). The data analysis technique adopted was content analysis.

Findings: A total of four policy and related documents were reviewed and a total of six focus groups were undertaken (3 in Round 1 and 3 in Round 2). Participants consisted of Registered Nurses, Enrolled Nurses and Assistants in Nursing (n=11). All participants completed Round 1 and Round 2 focus groups. The outcome was a working definition of special observation in acute aged care.

Conclusions: The working definition reflects current and aspirational practice. Special observation is delivered following an individual assessment undertaken by nurses with advanced assessment and care planning skills using a nurse-patient ratio of 1:1 to: (i) enable person-centred therapeutic practice interventions and (ii) promote safety. Best practice special observation is promoted through the delivery of evidence based education and monitoring of adherence to a single policy. Future initiatives include writing a new policy and influencing other services in the hospital with reviewing their special observation practice.

Implications for practice: Special observation with older persons is an area of practice where the potential for therapeutic activities remains unrecognised.

- Definitions need to have meaning for staff at a local level
- Staff need help to know how to make better use of locally available evidence
- Evidence based policies can be more easily developed from clearly generated definitions of special observation in acute aged care

Keywords: Aged care, special observation, dementia, delirium, acute care

Introduction

We know that, internationally, the ageing population is growing (World Health Organization, 2013) and that in developed countries older people are two to three times more likely to experience an

inpatient hospital admission than younger age groups (Australian Health and Welfare Institute, 2007a, 2012a; Wier, 2010; Centers for Disease Prevention and Control, 2013; HM Government 2013). With the exception of the obvious specialities of paediatrics and obstetrics, most practitioners working in acute care settings will care for older people every day in their clinical work. Acute aged care is everybody's business and internationally the importance of developing acute care for older people was recently recognised as a priority issue (Magee, Parsons and Askham, 2008; Department of Health, Victoria, Australia, 2013).

Acute care hospital admissions have worse outcomes for older populations than for younger age groups, including longer length of stays and an increased likelihood of experiencing long term morbidity problems post-discharge (Australian Health and Welfare Institute, 2007b; Brown et al., 2011). It is therefore important to focus on how to improve practice in acute settings for older people. Particularly vulnerable population groups of older hospitalised patients are those living with a dementia (Australian Health and Welfare Institute, 2012b; Sheehan et al., 2013) and experiencing a delirium (Siddiqi et al., 2006; Cole et al., 2009). Worse mortality rates and an increased likelihood of longer term disability following a hospital admission are experienced by these groups than other older population groups.

A nursing practice known as special observation is commonly implemented for older people living with a dementia or delirium during acute care hospital admissions (Dewing, 2012). Special observation was described broadly in the literature as a formal and structured close monitoring of a patient who requires intensive care. Constant observation is an activity where an allocated member of staff is constantly aware of the precise whereabouts of patient through visual observation or hearing (Dewing, 2012). Although commonly implemented, many unanswered questions and gaps in the research exist about the nursing practice special observation in acute care settings for older people. We do not yet have evidence about best practice special observation despite it being a common daily practice in acute care provision for older people (Dewing, 2012). In addition, provision of special observation in acute care settings to older people is associated with significant financial costs to the service (Dick, LaGrow and Boddy, 2009; Wilkes et al., 2010; Dewing, 2012) and is another reason to address how better to deliver this nursing practice.

Aim

The overall aim of this project was to develop a working definition of special observation in acute aged care settings. Specifically, the objectives were to identify barriers and enablers for undertaking special observation and compare the practice of special observation with descriptions in policy documents.

Current understanding about special observation

Older people are identified as the major consumers of acute health services due to the ageing of the population and their evolving patterns of disease, with multiple co-morbidities, resulting in longer lengths of stay and increasing expenditure (Koch et al., 2009). It is well known that, when admitted to hospital, many older people develop confusion, agitation, delirium or cognitive decline. Along with this, the hospital environment can precipitate acute confusion and disorientation in people with dementia, as they have been removed from their familiar environment (Wilkes et al., 2010). Identifying how to care for these individuals using best practice outcomes based on research is an area for development for the health services. Jones et al. (2006) found that individuals living with dementia are being increasingly admitted into hospital settings where many staff are ill prepared to meet their needs and an environment which is bereft of what is required for truly effective care. Nursing staff often struggle to manage unpredictable behaviours where there are limited specialist resources and a lack of time to supervise patients exhibiting behaviours which are seen as challenging (Wilkes et al., 2010).

Dick et al. (2009) found that only in the speciality of mental health was there any support in the literature for the practice of one-to-one observation, with evidence in the acute care setting being missed. Special observation in the mental health field is used in conjunction with a range of other

strategies to prevent harm to self or others (Bowers and Park, 2001). The evidence about special observation practice specifically for older people with dementia and/or delirium is sparse (Dewing 2012). This author notes that attempts that have been made in the literature to define or classify special observation consist of different levels: 'general, constant and special'; 'constant observation' and 'constant observation of either close or distant types'. Attempts to define the term special observation seek to specify how close the nurse undertaking the observation needs to be to the person being observed and whether the nurse needs to be in view of the person. Other examples of definitions include 'close, one-to-one nursing care of patients with challenging behaviours' (Wilkes et al., 2010, p 132) 'specialling', 'one-to-one observation' and direct patient monitoring (Dick et al., 2009, p 19).

A review of the literature on special observation found that the research on this topic focused on four distinct areas of interest in special observation practice:

- Improving care initiatives
- Staff education and practice development initiatives
- Patient management and assessment
- Developing guidelines and policies

However, it needs to be noted that the volume of overall literature is small. Our project provided an opportunity to contribute further to an understanding about special observation in acute aged care settings across each of these themes in the literature, within a local acute care service.

Project design

This was a practice development project undertaken over 13 weeks which focused on getting evidence into practice. Qualitative research methods were adopted to collect and analyse evidence (Mathers and Huang, 2004). The project was led by two Registered Nurses enrolled in Masters of Science degrees ('Gerontology and Rehabilitation Studies' and 'Dementia Care') who were working on the ward where the project was undertaken and supervised by university academic staff and hospital-based practice development staff. Approval to undertake the project was provided by a local university and hospital ethics committee. An Advisory Group was formed to guide how the project was undertaken and was made up of academic, clinical and practice development colleagues.

Setting and participants

The setting for the project was a ward in a large regional referral and teaching hospital in New South Wales, Australia. The ward was a 17-bed acute aged care 72 hour-stay ward. The reason that this ward was recruited to participate in the project was that the management team acknowledged the expectation that each day at least one person is likely to need special observation. Further, they included in the daily staffing complement a dedicated member of staff to provide this special observation practice. The daily staffing quota for this ward consisted of a '+1' formula with a 'built-in' Assistant in Nursing. This additional quota of staff enabled the ward to provide special observation care without needing to escalate a request for additional staff to provide special observation care or being over-stretched in the delivery of its other services while waiting for a request for additional staff to be met. Therefore we knew there was a readiness to explore the practice.

All Registered Nurses, Enrolled Nurses and Assistants in Nursing working on the ward were invited to participate in this project using posters on notice boards to promote the project. Recruiting from all levels of staff enabled the generation of a wide of range of views and experiences about the practice of special observation.

Evidence collection

Collection consisted of the following activities:

1. Retrieval of local policy and related documents by: searching the hospital intranet; and gathering together hard copy ward files and asking staff to tell the two project leaders about related

documents they have used or were aware of being talked about or used by other colleagues.

2. Focus groups with staff: two rounds of focus groups (Round 1 and Round 2). Both sets of focus groups were undertaken in a meeting room in the hospital. The focus groups were repeated three times to provide opportunities for as many staff as possible to contribute to the project. Round 1 of the focus groups was structured using a 'claims, concerns, and issues' activity with the stakeholders (Guba and Lincoln, 1989) to generate views from staff about their knowledge of and experiences of delivering and observing special observation practice. Round 2 of the focus groups was used to feedback findings from both the policy and related document review and the Round 1 focus groups and also to generate further discussion to develop the content for a working definition of special observation from the participants. The two project leaders undertook the focus groups and alternatively fulfilled the facilitator and note taker role during each of the focus groups. During each focus group staff discussions were recorded using hand written summary notes on butchers' flip chart paper. At the end of each focus group, the two project leaders alternately completed the task of typing up the handwritten summary notes into Microsoft Word documents.

Analysis

Policy and related documents and transcripts of the focus groups discussions were analysed (De Poy and Gitlin, 2005) to identify all the elements of practice which are described as special observation in policy and local documents and by staff. During the first stages, line-by-line data analysis was undertaken on the policy and related documents and transcripts of the Round 1 focus groups to generate categories which were used to explain the practice of special observation. Each transcript was reviewed and re-viewed until all relevant data was labelled as one type of enabler or barrier for the delivery of special observation practice in an acute aged care setting. The strengths of the staff and their expertise in delivering special observation practice as well as the challenges and difficulties they experienced in delivering special observation were used to identify these enablers and barriers of special observation practice.

Findings

Local policy and related documents

A total of three policy and related documents were located and reviewed. In addition, a 'Companion Nurse Observation Chart' was also listed on the intranet site for 'Aggressive/Confused Patients and Patients Requiring Close Protective Monitoring—Management of' but was never located. Overall, the documents were difficult to locate for the staff on the ward, including Clinical Nurse Consultants and the project leaders. Analysis of these documents identified two areas: a comprehensive list of the terminology used to describe special observation practice and its related activities; and similar and contradictory practice guidelines to inform and/or direct the care provided by hospital staff when implementing special observation practice (see Table 1).

Table 1: Document summary				
Document purpose	Category of document	Procedure	Terminology	Comments
<i>Management of patients with behaviours of concern (2007) (6 pages)</i>				
A policy providing a framework for clinical staff to assess and plan care for patients in the acute care services who display behaviours of concern.	Policy: 'limited to the management of confused aged patients exhibiting behaviours of concern'.	a staff member will be allocated to stay with the patient in accordance with ...	'[to] provide one-on-one supervision of the patient'.	This policy is limited to the management of confused aged patients. Providing one-on-one supervision, where identified as required, is listed as a strategy to decrease behaviours of concern.
<i>Aggressive/ confused patients and patients requiring close protective monitoring: management of (2006) (3 pages)</i>				
A procedure outlining staff responsibilities when providing close protective monitoring to an individual patient. An outline of who to contact to arrange appropriate staff to monitor patients is provided.	Procedure	Procedure assessment: 'Nursing and security staff are required to assess the patient using appropriate risk assessment tool to identify the level of observation required [for example] Companion nurse or Aggression trained companion nurse. '	Definition(s): Companion nurse '...a nurse who remains with the patient at all times promoting their safety through constant supervision, engagement in activities and other therapeutic interventions.' (p 1) Aggression trained companion nurse. (p 2)	Encompasses a wide range of patients, including management of violent, aggressive, cognitively impaired patients and those scheduled under the Mental Health Act. Definitions, assessment, strategies, monitoring and documentation are included. A section on the role of the companion nurse and security staff is provided.
<i>Role of the companion nurse caring for the confused elderly patient: education package (2009) (8 pages)</i>				
Education package to provide information for Enrolled Nurses and Assistants in Nursing who are assigned to promote safety through constant close monitoring to one or more than one patient.	An 'education package'	Enrolled Nurse or Assistant in Nursing 'will be allocated as a companion nurse to patient(s) to promote their safety through constant supervision, monitoring of their wellbeing, therapeutic interventions and engagement with the patient(s) in meaningful activities.'		

During Round 1 of the focus groups, staff were asked to list documents they had used or were aware of which related to special observation practice and during Round 2 of the focus groups staff were asked to comment on the summaries of the documents located and reviewed for this project. It was found that staff were:

- Confused about differences between policies and the related documents
- Unable to easily locate relevant policies and documents
- Unclear about the purpose of the policies and documents
- Unable to use the policies and related documents to inform their practice of special observation because the content of the policies and documents was vague, definitions across policies and documents were contrasting and contradictory and when procedures were included they were confusing to follow
- Requesting that a single policy be developed to inform special observation practice with the same policy to be used for people who have been scheduled under the Mental Health Act
- In agreement that a range of terms was currently used to describe the single practice special observation (for example, companion nurse, one-to-one observation) and that this was unhelpful

Staff recognised that no policy existed that governed their current practice of using a built-in nurse 'special' on the ward. Staff assumed there was a policy and mentioned one but when they searched the intranet they had difficulties locating any relevant policies or related documents. One contributing factor to these difficulties was the inconsistent use of technical terminology in the titles of relevant policies and related documents. When searching for local policy and related documents, staff uncovered the term 'companion observer', although this was found in what is now an unused document. The description of 'companion observer' in this document exemplifies a closer alignment of what does occur in this ward. There was also confusion among staff about what constituted a 'policy' and what was therefore mandatory practice and what was not and was therefore merely a guideline for practice. One policy and related educational document made reference to the need to read and reference a related 'procedure' document for the care of older people with dementia and/or delirium. The 'procedure' included a risk assessment approach stating that before special observation practice begins an 'assessment' needs to be undertaken by:

'[N]ursing and Security staff ... to assess the patient and identify the type of support required based on whether the patient is aggressive, scheduled or requires close protective monitoring ...'

The contents of this document did not include the need to refer to the 'policy' document 'Management of Patients with Behaviours of Concern' as part of the assessment of older people with dementia and/or delirium and did not mention the need for nursing staff need to have specific or advanced assessment skills. The combined effect of these two documents and their relationship to the 'procedure' document gave pre-eminence to procedural concerns around the 'management of' older people who are aggressive or confused.

Focus groups

Ward staff who participated in the focus groups all had experience of delivering special observation practice (n=13). The staff participants included Registered Nurses, Enrolled Nurses and Assistants in Nursing (Table 2).

Table 2: Summary of focus group participation			
	Category of staff member		
<i>Group</i>	<i>Registered Nurse</i>	<i>Enrolled Nurse</i>	<i>Assistant in Nursing</i>
1	1	2	2
2	1	2	1
3	1	2	1
Total	3	6	4

Findings from Round 1 were analysed to identify factors which staff identified as enablers and barriers for undertaking special observation (see Table 3).

Table 3: Enablers and barriers identified using claims, concerns and issues		
Claims (favourable assertions)	Concerns (unfavourable assertions, barriers to progression)	Issues (questions arising from claims and concerns)
Extra staff built into staffing allocation to cover specialising (1)	Decision making, grey area (3), such as decisions on staff allocation (3), why specialising is needed (3); sometimes a mismatch of patient to ward, for example suicide watch (1)	<ul style="list-style-type: none"> • How can handovers be improved? (3) • How can assessments and planning be improved? (3) • More education is needed and who is responsible for this? (3) • How can consistency be improved? (3)
Skilled experienced team (2) Skills: accommodate and manage individual needs(3), identify triggers (1), do not use restraints (1), include the family (2), include the patient (2)	Protocols and procedures to follow are absent (2), different views exist (2), expected to know what to do (2), sometimes asked to do other things at the same time (1)	<ul style="list-style-type: none"> • How can all staff be included in sharing information to prevent injuries to staff? (2)
Team approach (3), share the load by making the best of a difficult situation (2), we make a difference (2), flexible (3), we have had feedback on this (2)	Too difficult to special more than 1–1 (2), for example: falls (3), toileting (3), proximity (2), gender issues (2), draining (1), no personal space for patient or staff (2), other patients miss out on care (1)	<ul style="list-style-type: none"> • How can we improve insight for staff who escalate behaviours? (2) • Why are Assistants in Nursing used in the role of specialising? (2)
	Team concerns, guilt as you can't help others (2), some don't share the load (2)	<ul style="list-style-type: none"> • Why do we not have input from diversional therapy? (1)

Analysis of the focus groups generated the understanding that the staff believed they were doing well when they delivered special observation practice. The funding for this ward enabled the allocation of one member of staff each day to deliver special observation and because of this staffing profile, patients from other wards who required special observation were moved to this ward. The staff believed they

had an opportunity to develop an expertise in the delivery of special observation. An analysis of what the staff considered to be their expertise is summarised below:

- Person-centred approach
- Prevention of sustaining injuries
- Provision of a supportive environment
- Skills

Findings from the 2nd round of focus groups also generated an understanding about the confusion among staff about the existing decision pathway to implement and deliver special observation (see Table 4).

Table 4: Decision pathways	
Issue of concern	Decision pathway
What is the policy we follow for special observations?	Unclear
Who decides and approves which patients need special observation and why?	Unclear, erratic process
How are individual people assessed as needing special observation?	Unclear and variable
How are decisions made as to who will provide special observations, for example Assistant in Nursing or Registered Nurse?	Unclear and variable
Who, how and what do we document about people who require special observations?	No specific document

The findings from Round 1 of the focus groups were compared with findings from the analysis of policy and related documents reviewed during this project. These preliminary findings were therefore sensitive to the context of this particular organisation. A summary of these preliminary findings was presented to staff during Round 2 of the focus groups. Staff were invited to provide feedback on this context specific list of enablers and barriers for special observation practice and to further elaborate on their views and experiences about special observation and provide more specific details about their practice. This activity was used to begin the process of creating a working definition of special observation with staff.

To start with, staff categorised the type of special observation practice they deliver:

- Some staff seeing essential care (for example, showering) as special observation
- The use of two security guards at a time close by with one patient
- Observing one patient more frequently than hourly
- Visitors volunteering to remain, or being asked if they were able to remain, with a single patient

Findings from Round 2 of the focus groups were also used to identify the elements of practice which explained special observation:

- Person-centred care: claims or favourable assertions around practice were: 'treated patient as a person', 'good at managing people', 'aware of [patients'] needs', 'include the family' and 'identify triggers'
- Policy: unfavourable assertions or barriers to practice were: lack of policy/protocols to guide special observation, practice was described as a 'grey area' and as having 'no single protocol or policy' expressed (n=4). Issues relating to special observation, for example how to define it and what constitutes it, such as 'number of staff with the person' [ratio] 'prefer 1:1', '1:4 too many', 'who will be the special', 'proximity'. Concerns and issues of this kind raised by staff were numerous

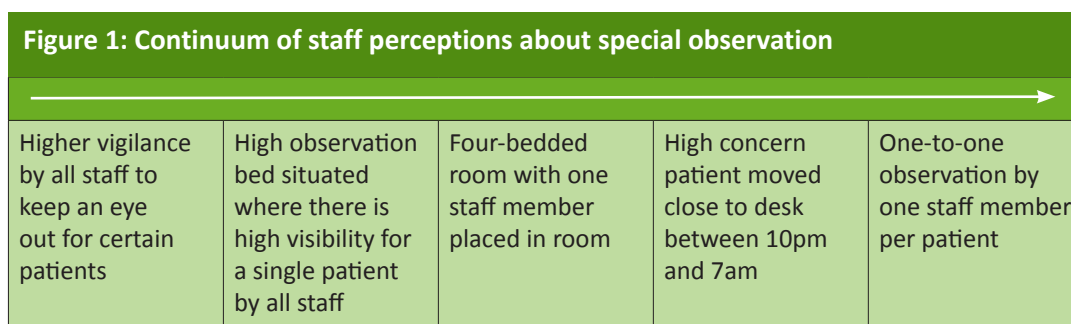
- Education: unfavourable assertions or barriers to practice and issues arising were: 'lack of education' (n=3)
- Assessment: unfavourable assertions or barriers to practice were: 'lack of planning', 'lack of assessment', 'handover [lacking] adequate depth of patients' needs, triggers, behaviours/ activities of concern' (n=2), Behaviour Assessment Tool (BAT) versus staff insights and not valuing staff concerns, ideas/reasoning (n=2)
- Privacy and Dignity: 'degrading for patient', 'gender rooms' and 'no personal space for person being specialised' (n=4)

These elements of special observation practice were drawn on later to formulate the working definition of special observation.

Discussion

If special observation is to be seen as therapeutic in value it should be acknowledged as a skilled nursing intervention, informed by research and supported by education and specialist nursing assessment (Dewing, 2012). The aim of this project was to develop an evidence informed local working definition of special observation; this discussion explains how this was developed from the findings of the project. A review of current policy and related documents in the organisation where this ward provided acute aged care services did not provide sufficient detail to inform staff how to deliver special observation practice. The word 'policy' is described by Daly et al. (2004) as providing a purposeful plan of action directed towards an issue of concern. Findings from the review of the policy and related documents and the concerns of staff about the policies they would use to inform their practice for special observation identified many issues and therefore no purposeful plan was discernible from the staff's perspective.

The findings from Round 2 of the focus groups demonstrated that a working definition of special observation must acknowledge evidence other than local policy and the importance of special observation as a skilled nursing intervention supported by education and skilled assessment. In addition, special observation practice should be delivered at different levels determined by the needs of the person in receipt of special observation (see Figure 1).



When determining the level of special observation required by an older person the staff gave pre-eminence to procedural concerns in assessing the needs of older people who might require special observation. Bezzant (2008), in reporting on a practice development project for older people with delirium and dementia in acute care settings, notes those carrying out assessment need 'specialist skills in assessment and care planning' and that the 'forced pace' around the processing of patients that can occur in acute settings can lead to less than satisfactory assessment of the needs of patients with challenging behaviours and ultimately is an inefficient use of resources and a false economy.

Formulating clear assessment criteria, incorporating suitable education programmes, and providing appropriate documentation are seen as essential developments to ensure that special observation for

older people with challenging behaviours in an acute ward results in these people receiving quality care (Wilkes et al., 2010). The acute health setting is geared towards compliance and patient conduct fitting into a well-defined mould (Jones et al., 2006). A system that provides a dementia-friendly environment in the acute setting needs to be developed through continual staff education, which includes management of 'close supervision', early comprehensive assessment and dementia-centred organisational policies (Jones et al., 2006).

The importance of assessment has also been linked to the privacy and dignity of older people in hospital. Moyle et al.'s (2008) review of the literature on best practice for older people with dementia in the acute care setting highlighted the importance of individual assessment which was considered essential to maintaining the dignity of older people. In relation to the needs of older people with dementia and/or delirium in acute settings, the need for education is consistently referred to in the research literature (Bezzant, 2008; Moyle et al., 2008; Dick et al., 2009; Wilkes et al., 2010).

The use of unregistered carers as 'specials' has increased over time and become part of the culture of caring for patients at risk, including those with dementia (Dick et al., 2009). One-to-one observation by a care assistant is a costly intervention, the effectiveness of which is unknown. Staff voiced their concerns about why Assistants in Nursing are used for special observation, as AINs identified that they often did not have the skills for this practice. Suggestions from the literature about special observation (Bowers and Park, 2001; Dick et al. 2009; Wilkes et al. 2010; Dewing, 2012) were linked to the comments staff made when voicing their concerns about the skills required for special observation. The findings from the project demonstrated clearly that special observation was obviously more than simply observing a patient. The staff articulated their ideal of best practice which was person-centred special observation practice and the enablers and barriers to being able to deliver this ideal.

The last stage of the project was to compare the findings from the project with an understanding in the literature about special observation practice to create a local working definition of special observation practice. A draft working definition of special observation practice was developed by the project leads, and then reviewed by the project Advisory Group which included the ward Nurse Unit Manager and an aged care Clinical Nurse Consultant. The draft definition was amended and a final working definition of special observation for a person with dementia and/or delirium in an acute aged care setting was created:

'Special observation is delivered following an individual assessment undertaken by nurses with advanced assessment and care planning skills using a nurse-patient ratio of 1:1 to: (i) enable person-centred therapeutic practice interventions and (ii) promote safety. Best practice special observation is promoted through the delivery of evidence based education and monitoring of adherence to a single policy.'

As this definition stands, there are some ideal elements which need to be made more transparent to understand what special observation could be. These elements are: identifying what a skilled intervention is; how to assess, plan, implement and evaluate special observation; defining what 'person-centred' is; and describing what a supportive environment looks like.

This definition could become the starting point for many potential quality initiatives. With further refinement, using a more inclusive approach of opinions from a wider field — for example, including people with dementia, their carers and other team members, such as medical staff or the nursing unit manager — this definition could be used for practice development initiatives. Some suggestions are:

- Developing a policy specific to special observations for people with dementia and/or delirium
- Evaluating the effectiveness of special observations
- Developing an education package
- Developing further research projects (for example, whether special observation is the most cost-effective way to spend health dollars)

Strengths and limitations

The definition of special observation was developed from a small scale project and has an authentic practitioner voice in its content. Constraints of time and the small size of the project have restricted and limited some of the processes that have, or could have been used, for example, other stakeholders could have been included. More time was needed to undertake observations of practice and document reviews of patient records of older people who experienced receiving special observation.

Conclusion

This project consisted of enabling two post graduate students as project leads to review local policy and related documents and carry out focus groups with staff working on an acute aged care ward about the enablers and barriers to providing special observation practice. The outcome from the project was to create a local working definition of special observation for people with dementia and/or delirium in an acute aged care setting. The next steps require the ward team to take the practice development approach further and begin to refine and improve their practice to ensure improvements in care are experienced. Themes that were identified for attention are:

- Improvement of care initiatives
- Staff education
- Identification of research needed
- Patient management and assessment
- Development of guidelines and policies

The acute care setting presents unique challenges for nursing staff in providing care given the 'challenging' and 'complex' needs of older people with dementia and/or delirium. For nurses caring for older people in this setting, Barba et al. (2011) have found:

Modifications of hospital geriatric practice environments and leadership commitment to evidence-based practice guidelines that promote autonomy and independence of patients and staff could improve acute care nurses' perceptions of quality of geriatric care.
(Barba et al., 2011, p 838)

This project presented an opportunity to develop the practice of special observation for the benefit of persons with dementia and, according to Barba et al. (2011), nurses' perceptions of the quality of care they provide to older people. The question we are taking forward in our future practice development and research initiative is: if special observation is an ideal therapeutic answer to providing a best practice outcome for the management of people with dementia and/or delirium in an acute care setting, what would need to be different?

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Acknowledgements

This project was made possible by the staff who generously gave their time and so clearly articulated the important clinical practice issues about special observation. Thank you to the Advisory Group that guided the project and the Directors who approved the project. And finally thank you to Jan Dewing for her support.

Michael Kerr (BSc, RN), Postgraduate Learner, Master of Science 'Gerontology and Rehabilitation Studies', The University of Wollongong, NSW, Australia.

Yvonne Verner (BA in Nursing, MSc Dementia Care, RN), graduate of the University of Wollongong, NSW, Australia; Dementia Nurse Specialist, Waitemata District Health Board, Auckland, New Zealand.

Victoria Traynor (PhD, BSc Hons Nursing Studies, RGN), Associate Professor (Rehabilitation Continuing and Aged Care), Associate Director NSW/ACT Dementia Training and Study Centre and Postgraduate Co-ordinator for the Graduate Certificates and Masters of Science in 'Gerontology and Rehabilitation Studies' and 'Dementia Care', School of Nursing, Midwifery and Indigenous Health, Faculty of Health and Behavioural Sciences, University of Wollongong, NSW, Australia.