



Samudra Deewela Durayalage & Danthani Uda Walawwe

Promoting Emotional Well-being for Elderly People with Dementia in Care Homes through Non-Pharmacological Nursing Treatments

A descriptive literature review

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Abstract

Author(s): Samudra Deewela Durayalage and Danthani Uda Walawwe
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This literature review focused on the enhancement of emotional well-being for elderly people with dementia in care homes. The purpose of this literature review was to describe non-pharmacological nursing used to promote the emotional well-being of elderly people with dementia. The aim was to generate new knowledge about nursing treatment that promotes the emotional well-being of elderly people with dementia in care homes, and the challenges associated with it.

A qualitative study was considered a systematic search in PubMed and CINAHL (2014-2024), where eight articles were selected through PRISMA guidelines. The first category is non-pharmacological treatments, including collaborative and reflective practices, clinical decision making and care planning, nursing roles and core competencies, and therapeutic and holistic care. The second category is staff capabilities and support needs, resident-centred complex and impediments, organisational and environmental deficits, and external healthcare system shortcomings. Results may indicate that while non-pharmacological care of dementia is an effective tool in improving the well-being of residents, it has significant systemic challenges. The necessary change in focus towards person-centred care, sufficient staffing, and continuous training are necessary to eradicate them in the name of enhancing holistic practice.

Keywords: dementia, emotional well-being, nursing, non-pharmacological treatments, and care homes.

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Contents

Abstract

1	Introduction	1
2	Background	1
2.1	Non-Pharmacological Nursing Treatments	2
2.2	Challenges in implementing non-pharmacological treatment	2
3	Purpose, aims and research question	3
4	Methodology and methods	4
4.1	Data collection	4
4.2	The Data Search and Selection	5
4.3	Data analysis	6
5	Result	8
5.1	Non-Pharmacological Nursing Treatments	9
5.2	Nursing Challenges in promoting the emotional well-being	13
6	Discussion	16
7	Ethics, Validity and Limitation	18
8	Conclusion and Recommendations	20
9	References	22

Appendices 1. Data search and selection

Appendices 2. Article selection table

1 Introduction

Dementia was neurological syndrome which cannot be reversed, especially in the elderly and affects the areas of memory, cognitive ability, communication, and emotional control. It was a serious health challenge that attacks most people yearly, and some of them were detected annually, and hence it was a significant issue in the global population (World Health Organisation [WHO] 2023). Although pharmacological interventions to some degree were effective in reduced the symptoms associated with dementia, they were not effective in providing emotional well-being, and may give rise to other negative effects, particularly in the weak elderly population (Livingston, Huntley, Sommer-lad, Ames, Ballard, Banerjee, Brayne, Burns, Cohen-Mansfield, Cooper, Costafreda, Dias, Fox, Gitlin, Howard, Kales, Kivimaki, Larson, Ogunniyi, Orgeta, Ritchie, Rock).

As a result, the non-pharmacological nursing interventions to enhance the emotional lives of dementia residents are of concern to more researchers. Samples of nursing interventions that have been shown to reduce emotional distress, improve the mood and quality of life of residents are reminiscence therapy, validation therapy, music therapy, and person-centred care (Abraha, Rimland, Lozano-Montoya, Dell'Aquila, Vetrano, Giovanni, and Cherubini, 2020). As the primary caregivers in care home settings, nurses were the key performers of daily non-pharmacological interventions, providing holistic care that addresses patients' physical, psychological, social, and emotional needs. The purpose of this literature review was to describe non-pharmacological nursing used to promote the emotional well-being of elderly people with dementia. The aim was to generate new knowledge about nursing treatment that promotes the emotional well-being of elderly people with dementia in care homes, and the challenges associated with it, and thereby contribute to the provision of healthier and more effective nursing interventions.

2 Background

Dementia nursing care was based on the objective of satisfying physical, psychological, social, and emotional needs based on the person-centred and individual interventions.

Pharmacological interventions were frequently not useful in managing emotional symptoms in residential care and can be harmful; thus, non-pharmacological interventions in nursing have been widely recommended to achieve emotional health (Livingston, Kelly, Lewis-Holmes, Baio, Morris, Patel, Omar, Katona, and Cooper 2014).

2.1 Non-Pharmacological Nursing Treatments

Systematic reviews and meta-analyses of non-pharmacological treatments suggest that a variety of modalities, specifically, music therapy, sensory stimulation, structured activities, reminiscence/ cognitive stimulation, and person-centred care methods can be used to reduce neuropsychiatric symptoms (depression, anxiety, apathy) and in some cases even increase mood and some features of the quality of life in dementia patients in care facilities (Abraha et al 2017; Na et al 2019; Lam et al 2020; Xiang et al 2023).

Pooled randomised trial reviews found meaningful effects of depression and activities of daily living in moderate to severe dementia, and subgroup analyses frequently found promising results of music-based and multicomponent interventions (Na et al 2019; Xiang et al 2023). The models of person-centred delivery, where activities are customised to preferences, identity is maintained, and communication is tailored, were linked to better resident outcomes in certain reviews; however, the pool effects were mixed, and the heterogeneity was high (Berkovic et al., 2023; Livingston et al., 2014). Music-based interventions were identified to lead to anxiety, depression and apathy reduction specifically in many systematic reviews, but with inconsistent effect sizes and durability of the effect (Lam, Li, Laher, and Wong 2020).

2.2 Challenges in implementing non-pharmacological treatment

Despite these promising results, the systematic reviews constantly identify serious flaws and implementation problems that restrict translation to the normal nursing practice. These included: (1) that across trials the definitions of interventions, dose and mode of delivery and measure of outcome varied, and leads to a loss of comparability and a weaker overall evidence base; (2) that due to tailoring being central to emotional outcomes, the selection of residents, sensory or cognitive consideration and personalization process were not fully reported; (3) that staff and organisational factors (lack of

training, time constraints, workforce turnover and some institutional support) limited fidelity and sustenance of interventions; and (4) little evidence on the effects of interventions over time. The reviews thus suggest better quality, practical trials that were standardised in core elements but customized individually, along with process appraisals concentrating on implementation (Abraha et al 2017; Berkovic et al 2023).

In general, there are strong possibilities of non-pharmacological nursing interventions, especially music therapy, sensory and activity-based, cognitive stimulation, and person-centred treatment in enhancing the emotional well-being of the residents with dementia in care homes based on peer-reviewed systematic and empirical evidence (Abraha et al 2017; Berkovic et al 2023; Lam et al 2020; Na et al 2019; Xiang et al 2023). However, none of these interventions has the potential to be reliably scaled into standard nursing practice unless major gaps in methods and implementation associated with heterogeneity, measurement, skills of practitioners, and sustainability are resolved by re-searchers, and practitioners.

3 Purpose, aims and research question

The purpose of this literature review was to describe non-pharmacological nursing used to promote the emotional well-being of elderly people with dementia. The aim was to generate new knowledge about nursing treatment that supports the emotional well-being of elderly people with dementia in care homes, and the challenges associated with it.

The research questions of the review were

1. What kind of non-pharmacological nursing treatments can be applied in promoting the emotional well-being of elderly people with dementia in care homes?
2. What kind of nursing challenges can arise when promoting the emotional well-being of elderly people with dementia in care homes?

4 Methodology and methods

This thesis used a qualitative, descriptive literature review research design that was most suitable for nursing and health issues, where many different studies need to be understood without changing the variables (Sandelowski 2000). Additionally, the research design made it possible to collect, compare, and produce the most recent proof from peer-reviewed research. Data was analysed by inductive content analysis (Puurveen, Baumbusch and Gandhi 2020).

4.1 Data collection

Inclusion and exclusion criteria were the predefined rules researchers use to determine who can or cannot participate in a study. Inclusion criteria specify the characteristics that the primary study articles must have, while exclusion criteria identify factors that the articles must not have (Polit and Beck 2021). In our inclusion-exclusion criteria described within (Table 1). PICo of this thesis stands for Population (P), Interest (I), and Context (Co). Throughout the thesis, PICo analysis made the research interest well expressed by specifying the population of interest (elderly people with dementia), the focal point of interest (non-pharmacological nursing treatments for well-being), and the care homes. The PICo enabled seeking relevant literature to research questions in a structured format.

Table 1: Inclusion and exclusion criteria

Inclusion	Exclusion	Rationale
Peer-reviewed, primary studies	Dissertation, review article	Research method was literature review
Studies published in English	Studies published in other languages	The thesis project did not have external funding, and translation services were not available
Published between 2014-2024	Published before 2014-2024	To focus on recent and current updated data.
Nonpharmacological treatments	Pharmacological treatments	To identify and describe nursing non-drug treatment for promoting emotional well-being.
Elderly people with dementia	Younger and child	Target was elderly people

4.2 The Data Search and Selection

The data search phrase was: (“nursing care” OR “nursing intervention*” OR “nursing assessment*” OR nurse* OR “nursing management*” OR “nursing strategy*” OR “nursing approach*” OR “early detect*” OR “early prevent*”) AND (“emotional health” OR emotional* OR “mental health”) AND (dementia* OR Alzheimer* OR “cognitive impairment*” OR “memory loss”) AND (“care home” OR “residential care” OR “nursing

home*" OR "residential home*" OR "long term care") AND ("older adults" OR "elderly" OR "geriatric*" OR senior* OR "older people") (Appendix 1) According to these phrases, data was searched from CINAHL and PUBMED.

A PRISMA (Figure 1) was used to illustrate the selection process of this thesis. It helped to follow how many records were identified, screened, excluded, and finally included, increasing transparency and reliability in reporting (Page et al 2021). In total, eight records were included for the literature review of this thesis (Appendix 2).

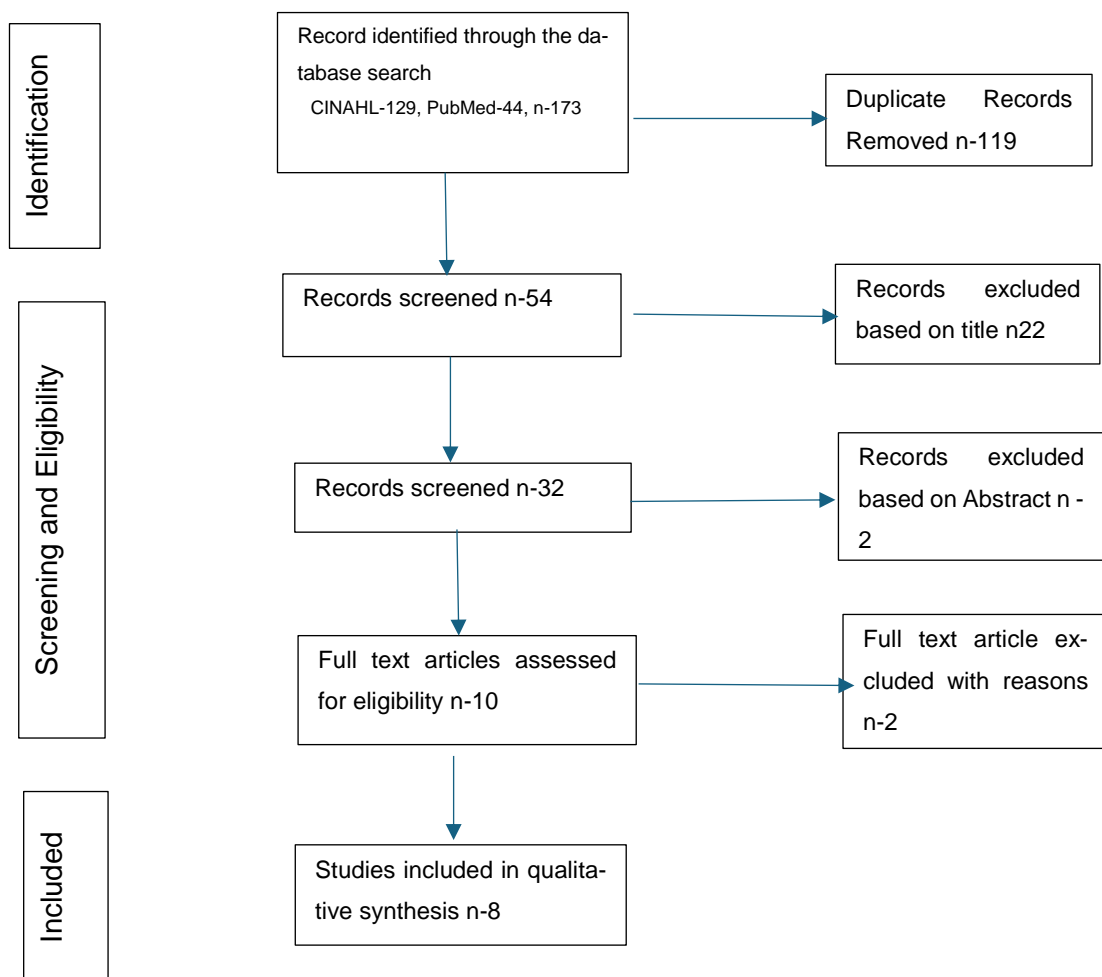


Figure 1. Prisma chart

4.3 Data analysis

The inductive content analysis method was involved in the analysis of the data based on the instructions of (Vears and Gillam 2022). Inductive content analysis is a systematic approach to the analysis of textual content in cases where the existing knowledge

about a phenomenon is scarce or disjointed. The method lets categories and patterns come out of the material in a systematic and clear process, as opposed to being thrust on it a priori. The analysis was initiated by preparation and familiarisation that involved repeatedly reading the articles included in the analysis to get an approximate idea of what was in the paper as it pertained to the research objective. The step allowed getting immersed in the content and helped to be sensitive to similarities, recurring ideas, and variations between the included works (Vears and Gillam 2022).

After familiarisation, the analysis continued on to open coding. Relevant parts of the text that were pertinent to the research questions were located and coded using descriptive codes which reflected their meaning. Coding was done inductively, that is, the codes were created directly as a result of the content and not as per existing theories or frameworks. This was to maintain close to the original meaning, but to do so in a systematic manner of organising the material (Vears and Gillam 2022).

In the following step, comparisons and grouping of the codes were done according to similarities and differences. Similar codes were grouped into sub-categories which shared common characteristics. All these subcategories were further abstracted into broad categories through a process of an iterative process of constant comparison. This procedure helped identify higher-level patterns while maintaining connections to the material. Lastly, abstraction was done to come up with broad categories, which portrayed the key results of the analysis. Such categories represent a synthesis of the material and an organised image of the most important aspects in the context of the research purpose. In the analysis, there was a preserved reflexivity and transparency that gave rise to a systematic and rigorous analytic process, in line with the postulates of inductive content analysis described by (Vears and Gillam 2022).

Table 2. An example of inductive content analysis

Meaning unit	Condensed meaning unit	Code	Subcategory	Generic Category
"There is a need for continuous and reflective discussions in the staff group, focusing on the patients' physical as well as emotional needs." (A1U1)	For satisfying patient needs, the staff group must have ongoing, introspective conversations. (A1U1)	Reflective Team Dialogue Shared Clinical Reasoning Group Processing of Care	Team reflection and Group Discussion	Collaborative and Reflective Practices

5 Result

This descriptive literature review included qualitative, quantitative, and mixed-method studies involving the assessment of dementia care in nursing homes in different countries (Appendix 2). Eight studies focusing on dementia care in nursing home settings were included in this review. The studies addressed various aspects of care, including mood assessment and emotional well-being, symptom progression and end-of-life care, management of challenging behaviours, residents' emotional experiences, staff-resident interactions, sensory care practices, staff responses to agitation, and spiritual care in nursing homes. The findings highlighted the importance of nursing competencies, as well as the challenges and contextual factors that influence the provision of non-pharmacological care for residents with dementia.

The studies reviewed were carried out in various countries that include the Netherlands, the United Kingdom, Norway, and England and used various research designs, which include cross-sectional surveys, qualitative interviews, observational and longitudinal cohort research designs. The literature synthesis showed two broad themes: (1)

non-pharmacological nursing treatments and (2) Nursing challenges in promoting emotional well-being. These broad categories were further divided into generic categories and specific sub-categories as below and discussed in detail in the sections that follow.

5.1 Non-pharmacological nursing treatments

The results showed that sensory and creative stimulation belonged to the key elements of non-pharmacological nursing interventions that enhance emotional well-being among residents with dementia. Some of the interventions encompassed music activities and engaging in significant daily activities. These interventions have been reported to aid in positive experiences of emotional states on the part of residents.

Moreover, the results showed that specialised care units used sensory stimulation as part of non-pharmacological nursing treatments to address behavioural expressions among residents with dementia. The findings also indicated that interventions tailored to residents' personal and social backgrounds were associated with more positive and calm emotional responses. Finally, such customised sensory and creative approaches are an inherent aspect of delivering holistic, person-centred care (Figure 2).

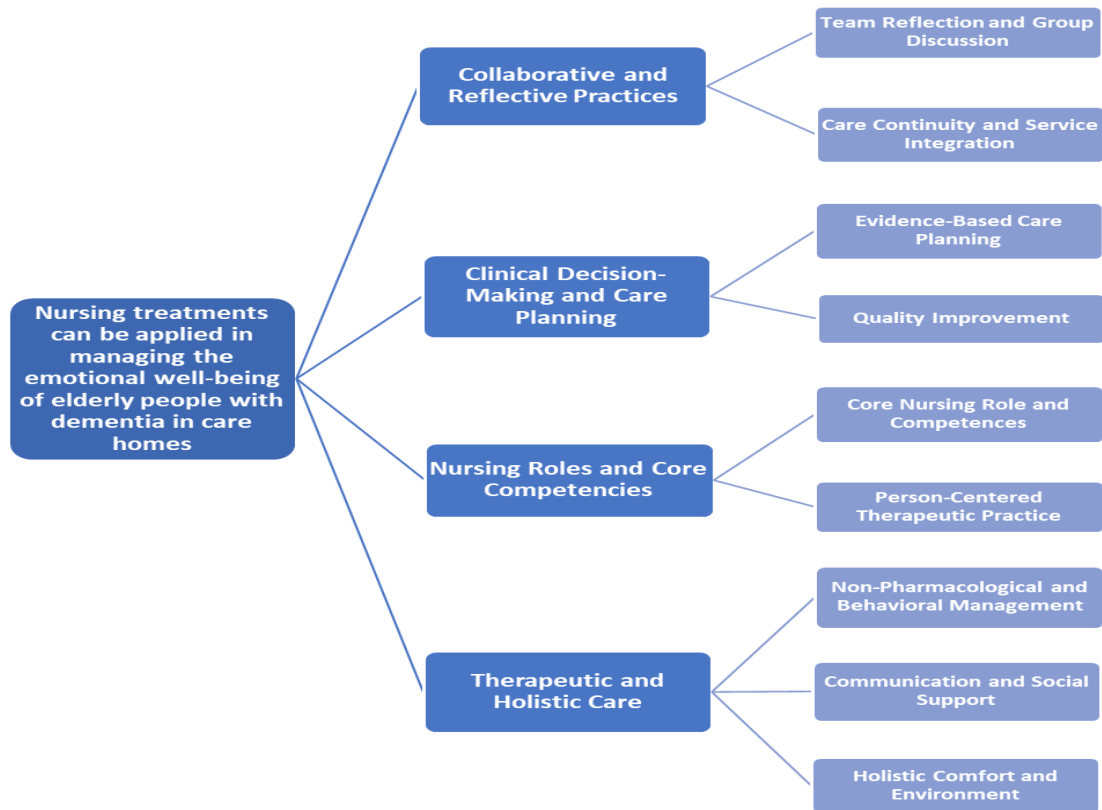


Figure 2. Non-pharmacological nursing treatments

5.1.1 Collaborative and reflective practices

Effective dementia care is based on collaborative and reflective practices, which worked under two main mechanisms. The former one is team reflection and group discussion, which was based on the interprofessional collaboration of nurses, doctors, and therapists who plan the care with the help of constant multidisciplinary assessment. The process was maintained through reflective practice guiding patient-centred care, where nurses jointly examine care strategies so that they can keep their care plans dynamic and responsive (van Voorden, Koopmans, Strik-Lips, Smallbrugge, Zuidema, van den Brink, Gerritsen 2024).

The second mechanism is care-continuity and service integration, which provides continuous support in a smooth manner by using various methods. This involves the introduction of the contact person system, where a specific nurse, with the assistance of regular access to external care providers, builds profound familiarity with the emotional

needs of residents (Hammink, van Buuren, Moor, Derks and Mohammadi 2024). Finally, proper care means that it needs to be coordinated with services across specialties to incorporate all elements of the well-being of residents (van Voorden et al 2024).

5.1.2 Clinical decision making and care planning

Clinical decision-making and care planning involve two processes that showcase the personalised care of dementia and are interrelated. Its basis is the evidence-based care planning, starting with the comprehensive assessment of the history and current situation of the resident. This includes the interpretation of the expressions of patients by decoding the verbal and non-verbal messages with a special consideration of non-verbal signs observations in order to comprehend the needs of the resident. Nurses then read behaviour interpreted as unmet needs, and they treat agitation as a possible symptom of unmet physical or emotional needs (van Voorden et al 2024; Edberg 2000; Ødbehr et al 2015).

In addition to this systematic strategy, there is clinical reasoning and quality improvement, which is an integration of clinical intuition in decision-making, where nurses use their experience and familiarity with this resident to make care choices. This thinking is modifiable enhanced in a systematic way by process-centred measures of quality improvement that guarantee sustained enhancement of practices of care. As a combination of these aspects forms a dynamic cycle of evaluation, intervention, and assessment that ensures the relevance and effectiveness of care (Ødbehr, Kvigne, Hauge and Danbolt 2015; van Voorden et al 2024).

5.1.3 Nursing roles and core competencies

Dementia care requires nursing roles and core competencies that will guarantee effective non-pharmacological care. The nurse also takes an integral role in treatment, where the nurse is the main facilitator and implementer of interventions in specialised care. This main role is facilitated by the key core nursing roles and competencies that embrace such critical skills as reflectiveness, stress tolerance, and behavioural flexibility in handling complex cases (van Voorden et al 2024).

The competencies are practically exhibited in the supportive care practices that are performed daily to offer vital emotional support. One of the most important abilities is

the use of therapeutic touch as one of the key non-verbal techniques of conveying safety and care, establishing therapeutic relationships, and providing spiritual assistance (Ødbehr, Kvigne, Hauge, and Danbolt 2015).

The guiding philosophy of any interaction with dementia care is person-centred therapeutic practice, which needs to be aligned with personal identity and preferences. Supporting patient autonomy (by providing daily choices to promote control and self-worth) and facilitating meaningful engagement (in activities related to personal history, e.g hobbies or religious practice) are the main features of this approach that evoke positive emotional reactions (Ødbehr et al 2015; Ødbehr, Kvigne, Hauge, and Danbolt 2015).

These values are implemented with the help of practice actions to improve comfort or calm, comprised of personalised moment-to-moment measures. These actions encompass the strategies such as going along with the reality of a resident and are aimed at preventing distress both in advance and reactively and therefore preserving emotional well-being by means of personalised responsive care (Ødbehr et al 2015).

5.1.4 Therapeutic and holistic care

Therapeutic and holistic care was a combination of various interventions aimed at helping the residents to live well by non-pharmacological and behavioural management and a supportive environment. The direct interventions encompass the sensory-focused care, which involves sensory modulation tools to control the problematic behaviours, and the diverse therapeutic modalities, which involve personalised activities and religious practices that help elicit the positive emotions. Protective Isolation can also be applied in particular situations when dealing with severe behavioural episodes (van Voenden et al 2024; Ødbehr et al 2015).

Communication and social support are the core of care, in which therapeutic verbal interaction and integrated verbal and non-verbal communication play major roles in enhancing positive emotions. This strategy will help to help the spiritual needs with human connection and communal engagement to avoid isolation (Lee et al 2017; Ødbehr, Kvigne, Hauge, and Danbolt 2015). Moreover, the concept of holistic comfort and environmental support is based on the finding joy in ordinary moments encountered in everyday activities and spiritual enrichment of identity and inner peace (Hammink et al., 2024; Ødbehr, Kvigne, Hauge, and Danbolt 2015).

5.2 Nursing Challenges in promoting the emotional well-being

The review revealed a list of issues nurses must deal with to promote the emotional well-being of elderly residents with dementia. These problems are categorised into four generic categories: staff capabilities and support needs, resident-centred complexities and impediments, organisational and environmental deficits and external healthcare system and resource shortfalls. (Figure 3)

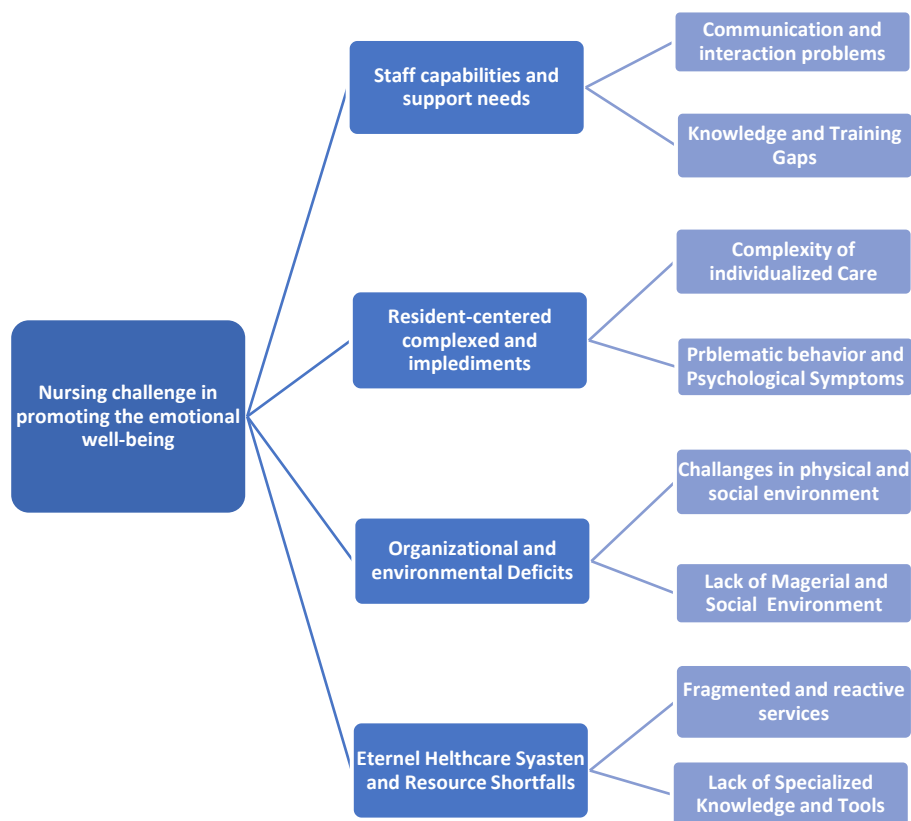


Figure 3. Nursing challenges

5.2.1 Staff capabilities and support needs

The major challenges in dementia care can be found within the areas of staff capabilities and support needs, in particular within communication and Interaction skills. The ambiguous patient expressions can hardly be interpreted by nurses. This results in staff having different emotional assessments, implying a risk of subjectivity at the assessment stage; care decisions might well be based upon personal opinions rather than the needs of the resident. Nor is the inner world of a resident in advanced stages of dementia accessible. Besides, over-reliance on verbal language does not work for the non-verbal resident (Edberg 2000; Lee et al 2017).

These challenges are compounded by significant knowledge and training gaps within the care system. A critical systemic failure pertains to the lack of feedback and reinforcement, where staff are not properly trained and supported on an ongoing basis. This has been manifested in more than 85% of the care staff requesting more information about basic care topics, hence indicating a wide need to develop educational resources and improve professional development (Andrusjak and Mountain 2021).

5.2.2 Resident-centred complexities and impediments

There are resident-centred complexities and impediments in the provision of dementia care, characterised by fundamental challenges present: complex communication barriers and behavioural symptoms. Advanced dementia residents represent a profound communication barrier to nurses, which is very challenging in terms of giving consistent emotional support. This constitutes a major barrier to empathic connection, impeding in-depth therapeutic relationships, while a lack of spontaneous engagement from the residents contributes to the difficulty of social contact (Lee et al 2017; Edberg 2000; Hammink et al 2024).

These communication problems are further exacerbated by problematic behavioural and psychological symptoms, especially the profound social and emotional Isolation of residents. Such social and emotional isolation not only adds much to the distress of the residents but also presents particular challenges to the nursing staff in trying to provide effective emotional support and social contact with them (Hammink et al 2024).

5.2.3 Organisational and environmental deficits

Person-centred therapeutic practice is the philosophical guide to any interaction of dementia care, as it makes sure that it responds to the identity and preferences of the individual. This model is defined by supporting patient autonomy with the provision of daily options to promote control and self-esteem, as well as by facilitating meaningful engagement in the activities related to their personal history, e.g. hobbies or religious practices, to create positive emotional reactions (Ødbehr et al 2015; Ødbehr, Kvigne, Hauge and Danbolt 2015).

These principles are operationalised through practice actions to enhance comfort or calm, consisting of individualised moment-to-moment interventions. Such actions include strategies like "going along" with a resident's reality and are designed to both proactively prevent and reactively reduce distress, thereby maintaining emotional well-being through personalised responsive care (Ødbehr et al 2015).

5.2.4 Healthcare system and resources shortfalls

Healthcare System and Resource Issues are severe deterrents to fragmented and reactive healthcare services. The system tends to work through a reactive vs. proactive care model whereby services respond to crises as opposed to preventing them in the first place, even as there is an acute lack of a centralised tracking system that perpetuates uncoordinated care. Critical leadership void in care coordination creates a major gap in specialist service, where specialist input and guidance are limited.

These gaps in service provision are magnified further by some bottom-line knowledge and tools deficits in the practice of dementia care. For one, there is a lack of comprehensive assessment instruments that would reliably investigate emotional states in dementia, while a general lack of empirical evidence for non-pharmacological approaches challenges their evidence-based implementation (Edberg 2000; Andrusjak and Mountain 2021).

In this review, it is acknowledged that proper support of emotional well-being needs to consider collaborative practice, clinical reasoning, core competencies and person-centred approaches by means of therapeutic strategies. Conversely, the implementation is

pre-empting four critical challenges in capability gaps in personnel, complexity of residents, organisational deficits and systemic deficits. Success is, therefore, not only dependent on competent nursing interventions but also on the ability to overcome structural barriers to quality provision of care.

6 Discussion

In this review, it is acknowledged that proper support of emotional well-being needs to consider collaborative practice, clinical reasoning, core competencies and person-centred approaches by means of therapeutic strategies. Conversely, the implementation is pre-empting four critical challenges in capability gaps in personnel, complexity of residents, organisational deficits and systemic deficits. Success is, therefore, not only dependent on competent nursing interventions but also on the ability to overcome structural barriers to quality provision of care.

The results are highly consistent with the existing background literature regarding the kinds of interventions that are useful. The focus on approaches like sensory and creative stimulation directly aligns with evidence that found music therapy and structured activities to be effective in reducing neuropsychiatric symptoms (Lam et al 2020; Xiang et al 2023). Nonetheless, this review goes beyond simply naming these interventions to explain how they were successfully integrated. It reveals that their success is not automatic but heavily depends on person-centred adaptation based on the resident's social and personal history (de Boer, Bozdemir, Jansen, Hermans, Hamers, and Verbeek 2020). This factor, mentioned in the background (Berkovic, Ayton Park, and Enticott 2023) is elaborated here as a core operational practice.

In addition, the background literature identified person-centred care as a model linked to positive outcomes yet noted that its pooled effects were mixed due to high heterogeneity (Livingston et al 2014). This review helps explain this heterogeneity by unpacking person-centred care into tangible, interrelated nursing processes. It is shown not as an ambiguous term, but as an activity consisting of Clinical decision-making and care planning, which involves comprehensive assessment and interpretation of non-verbal signs (van Voorden et al 2024; Edberg 2000), and Therapeutic and Holistic Care, which encompasses therapeutic verbal exchange and spiritual support (Lee et al 2017; Ødbehr et al 2015). This granular description responds to the background's identified

"lack of complete reporting regarding the personalisation processes" (Abraha et al 2017) by clarifying what person-centred care means in everyday practice.

A significant contribution to this review's results is the detailed identification of the nursing roles and core competencies necessary to provide these interventions. Although the background focused on the interventions themselves, the current findings clarify that the nurse is the central figure in treatment delivery (van Voorden et al 2024). Competencies such as reflectiveness, stress tolerance, behavioural flexibility, and the application of therapeutic touch are named as foundational (van Voorden et al 2024; Ødbehr et al 2015). This directly addresses a gap in the larger literature by shifting the emphasis from the intervention-as-a-protocol to the nurse-as-the-interventionist.

Likewise, the theme of collaborative and reflective practices provides a tangible process for achieving the "standardised in core elements but customised individually" approach demanded in the background (Abraha et al 2017). The findings indicate that this customisation is achieved through structured team reflection, interprofessional teamwork, and care continuity systems such as an assigned contact person (van Voorden et al 2024; Hammink et al 2024), offering a practical model for real-life implementation.

The obstacles identified in this review powerfully echo those predicted in the background but add critical specificity. While the background listed "staff and organisational issues" as a primary barrier (Abraha et al 2017), this review specifies these as profound knowledge and training gaps, including a lack of feedback and reinforcement, and an over-reliance on verbal communication that proves ineffective with non-verbal residents (Edberg 2000; Lee et al 2017). The finding that more than 85% of staff sought more training (Andrusjak and Mountain 2021) quantifies a systemic failure that the background could only describe generally.

Furthermore, the background discussed "inconsistencies in definitions" across studies (Abraha et al 2017). This review demonstrates the clinical consequence: a "Risk of subjective assessment" where care decisions are based on individual interpretation rather than standardised understanding (Edberg 2000), a root cause of the heterogeneous outcomes reported in literature. Lastly, while the background noted a lack of evidence on long-term effects (Abraha et al 2017), this review's findings on healthcare

system shortcomings like a reactive model of care and a severe deficit of specialist input (Andrusjak and Mountain 2021; Edberg 2000) explain why sustained long-term intervention is so hard to achieve and research.

In summary, this discussion has shown that the findings of this literature review both confirm and significantly elaborate upon existing knowledge. The similarities affirm the validity of established intervention types, while the differences offer a crucial, ground-level perspective of the competencies, processes, and systemic barriers that define their real-world success. The main implication is that future efforts must shift from solely proving that interventions work towards a dual focus on enabling their implementation. This necessitates educational programs that foster the identified core competencies, organizational models that support collaborative and proactive care, and research that tests strategies for overcoming the specific structural issues outlined in this review. By combining the what of the background with the how of the current findings, this review provides a more comprehensive roadmap for converting the promise of non-pharmacological interventions into the reality of improved emotional well-being.

7 Ethics, Validity and Limitation

In every research, ethics should be taken into consideration, but in medical research, it is of great importance, as human rights, social security, and respect should be safeguarded. The ethical codes applied in research incorporate the concept of informed consent, privacy, human respect, kindness, and the truth (Polit and Beck 2021). There are also several situations when there is no first-hand interaction with individuals, literature-based research is not disloyal to the ethical norms, particularly in choosing, analysing, and presenting published information. Researchers must be transparent, honest, and accurate in the conduct of research, besides preventing plagiarism and the misconception of original results (Aveyard 2019).

This thesis did not have to be approved by the ethical committee since it did not involve using any human subjects, and it was done based on a descriptive literature review. Nonetheless, responsible research practices and educational ethics were highly observed.

All the included articles were from quality, peer-reviewed databases, such as CINAHL and PubMed. The selected 8 articles were well cited and referenced using the APA 7th edition format. According to (Creswell and Poth 2018), the researcher ensured that the assets of the first authors were acknowledged, and the outcomes were assessed with the same degree of respect without altering or interfering with the context. Validity in qualitative research deals with the degree to which the results of the research are reliable, accurate, and trustworthy.

In qualitative research, the validity proves the authenticity and reliability of data interpretation, unlike quantitative research, which assesses validity based on statistical findings (Lincoln and Guba 1985). Some key aspects of the qualitative validity are credibility, dependency, confirmability and transferability, which entail that the inferences made based on the literature should be presented rightly and without bias and must be supported in their entirety by the evidence. This thesis demonstrates better emotional health among the elderly community with dementia and contributes to their living situation amenities. It is emerging as a special ethical concern. Further, as per this study, not face-to-face contact with the people but credible research and civil discovery need to be exhibited in respect, empathy and cognisance of their civil rights and condition. This is the reason why they are a decent but unstable population (WHO 2023). The research upholds the ethics and ethical results and contributes to a correct application in future nursing practice and policymaking by selectively including high-quality research and respecting the views of residents and caregivers as presented in the literature.

Owing to a descriptive literature review, in this study, themes are synthesised, but no critical analysis of the methodological quality of each of the articles included is performed with a standardised instrument (e.g. CASP). In turn, although the specified interventions and issues have been properly documented, the weight and rank of the evidence supporting one or the other is not mitigated. Moreover, the qualitative design of the review is a deliberate choice that allows the construction of a big picture that does not allow any. In this review, it is acknowledged that proper support of emotional well-being needs to consider collaborative practice, clinical reasoning, core competencies and person-centred approaches by means of therapeutic strategies. Conversely, the implementation is pre-empting four critical challenges in capability gaps in personnel, complexity of residents, organisational deficits and systemic deficits. Success is, therefore, not only dependent on competent nursing interventions but also on the ability to

overcome structural barriers to quality provision of care. statistical inferences or meta-analysis on the effectiveness of certain interventions.

Search Strategy Limits: The definition of inclusion was restricted to the articles in the English language and published in the past decade (2014-2024) only, and only two databases (PubMed and CINAHL) were chosen, which could lead to linguistic, publication date, and database selection bias (Aveyard 2019). The reason to focus on English-language articles published in the past decade (2014-2024) is to guarantee relevance, but it might have added linguistic and publication date bias. This probably left out the good ideas of the non-English speaking parts and older seminal work that are still in practice. Using two databases (PubMed and CINAHL) is necessary, but it is possible that some of the potentially important studies in the databases of psychology or social care (e.g. PsycINFO) are overlooked.

The inductive content analysis, although systematic, was done by one research group as a bachelor's thesis. It is a part of the condensation of meaning units and the formation of categories, which necessarily presuppose interpretation. Even though the process was recorded, a more multi-researcher team would have offered more perspectives and enhanced the confirmability of the thematic framework by peer debriefing.

The review includes an eloquent list of the systemic and practical problems that prevent implementation: staffing shortages and training gaps. Nevertheless, the chosen literature lacks a granular description of the particular, proven operational models of overcoming these barriers because of the selection of literature. It establishes the problem in a more holistic way than establishing how to fix it.

8 Conclusion and Recommendations

This qualitative descriptive literature review confirmed that non-pharmacological nursing intervention is central to help people with dementia in nursing homes to achieve emotional well-being. The findings found that interventions based on person-centred communication, sensory and creative stimulation, meaningful activities, and positive staff-resident interaction had a continuous relationship with better emotional outcomes such as reduced agitation, improved mood, a sense of safety, and a sense of dignity

and belonging. It was also revealed in the findings that the success of these interventions is directly connected with the knowledge, attitudes, and the capacity of nurses to shape the care based on the personal and social experiences of nurses. Simultaneously, the findings also indicated a considerable obstacle to implementation especially in the form of staff shortages, time limitations, lack of dementia-specific training, and organisational culture that values physical work over the emotional and psychosocial care. Generally, the results underscore the importance of emotional well-being as a type of dementia care, and non-pharmacological nursing interventions must be entrenched in the daily execution of nursing activities in nursing homes.

On the nursing practice level, as well as on the level of the management of a care home, it is proposed that non-pharmacological nursing interventions should be systematically introduced into the daily care. This can involve the adoption of the holistic assessment methods that take into account the emotional, social, and personal history of the residents, the presence of the secured time of the nurses to have significant communication with the residents. The care homes should also invest in continuous education on dementia and facilitate the generation of in-house expertise to enhance the confidence and competence of staff in regard to the provision of emotionally supportive care.

Sufficient staffing, leadership, and distribution of resources should be provided at the organisational and policy level to ensure the ability to use non-pharmacological interventions consistently. Policymakers and healthcare leaders ought to endorse care models that appreciate emotional and psychosocial care, as well as physical care, such as access to specialist dementia care and opportunities to further professional growth. The development of future studies should be in terms of how non-pharmacological interventions can be maintained in real-life nursing homes and how organisational characteristics affect the sustainability of the intervention in sustaining the emotional well-being of people with dementia.

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Appendices

Appendices 1. Data search and selection

Database /Date/Limits	Total number of hits/citations	Papers/records included based on title*	Papers/ records included based on the abstract	Papers/ records included based on full text*
11/07/2025				
CINAHL	129	38	8	5
PubMed	44	13	8	6
Records in total	173	51	16	11
Records after duplication were removed		54	32	10
Total number of included studies				8

Appendices 2 -Article selection table

Danthani and Samudra Article selection table					
Running number of the study	Aim(s)	Study participants	Research design, data collection methods and data analysis methods	Major findings - Most relevant for the research questions of this literature review	Limitations
1 Edberg, A-K. 2000, Sweden Scand J Caring Sci	To investigate the reliability of the PMAS, GBAS, and GBS scales; to investigate mood, behaviour, degree of dementia, and symptoms in patients.	75 patients with dementia living permanently in nursing homes and their 67 contact nurses.	Design: Cross-sectional study. Methods: Nurse interviews based on scales (PMAS, GBAS, GBS). Analysis: Internal consistency, inter-rater reliability, principal component analysis.	Difficulty Assessing Emotions: Inter-rater reliability was low for emotional aspects compared to ADL and intellectual functions. Risk of Inconsistent Care: Nurses had varying understandings of patients' emotional states, suggesting care may be based on nurses' opinions rather than patient needs.	Reliance on nurse assessments, not patient self-report. Relatively small sample size. Lack of nurse demographic data to analyze its influence on assessments.
2 .Hamminck, J.H.W., van Buuren, L.P.G., Moor, J.A., Derks, D.A.J.A., and Mohammadi, M. 2024, Netherlands Dementia	To describe the course of physical and psychological symptoms in people with advanced dementia. To examine health and social care service utilization. To describe the care received at the end of life in people with advanced dementia.	Sample: Greater London, England, people with advanced dementia (Functional Assessment Staging Scale 6e and above) from 14 nursing homes or their own homes. Has aimed to help 100 people with advanced dementia, 70 from nursing homes and 30 residing	Design: 9-month prospective longitudinal cohort study. Data Collection: Monthly assessments using validated scales (e.g., PAINAD, CMAI, NPI, QUALID, SM-EOLD, RUD-LITE, CSRI) via direct observation, record review, and staff/carer report. Post-death data collection. Data Analysis: Descriptive statistics (means, medians, frequencies, percentages) for participant characteristics, symptoms, service use, and end-of-life care at four time points (baseline, final visit if alive, final visit if died, final visit all).	High prevalence of persistent, distressing symptoms: pain on movement (61%), clinically significant agitation (54%), apathy (53%), depression (36%), anxiety (35%). Aspiration, dyspnea, septicemia, and pneumonia were more frequent in those who died. Service provision was reactive and not tailored to needs; GPs and emergency paramedics were main contacts, with little input from geriatricians, psychiatrists, or palliative care specialists. 76% had a DNAR order, but less than 40% had advanced care plans. Care planning focused on	No verification of whether nurses' assessments reflected patients' true states. Limited demographic data on nurses. Scales may not capture the nuances of severe dementia (e.g., unresponsive patients). Risk of bias from nurses' personal views rather than patient needs.

		in their own homes.		resuscitation/place of death rather than type of care. Most deaths (81%) occurred in the nursing home and were 'expected' (90%). Aspiration pneumonia was the commonest cause of death.	
3 van Voorden, G., Koopmans, R.T.C.M., Strik-Lips, M., Smallbrugge, M., Zuidema, S.U., van den Brink, A.M.A., ... & Gerritsen, D.L. (2024). The Netherlands. <i>BMC Geriatrics</i> .	To investigate the organizational characteristics (admission/discharge, staffing, physical environment) and management of severe challenging behaviour in highly specialised units for people with dementia in the Netherlands.	Units: 13 highly specialized units for temporary admission of people with dementia and severe challenging behaviour.	Design: Mixed-methods, multi-method exploratory study. Data Collection: 1. Digital questionnaire for unit managers (n=13). 2. Semi-structured interviews with physicians (n=12) and other practitioners. 3. Physical environment observation using the OAZIS-Dementia tool. Data Analysis: Descriptive statistics for quantitative data. Thematic analysis for qualitative data (interview transcripts, open-ended questions). Integration of quantitative and qualitative data.	Strong heterogeneity found across units in management approaches (intuitive vs. methodological), staffing levels (2.9–6.2 nursing hours/patient/24h), interventions used, and physical environment. Similarities included: central role of nursing staff, frequent multidisciplinary evaluation, and attention to sensory stimuli. Patients were mainly admitted from regular DSCUs, homes, or mental health care, and discharged back to DSCUs. Key nursing staff competences: reflectiveness, tolerance for stress, ability to observe behavior, and flexibility. A stable, well-supported nursing team was seen as crucial. Diagnostic phase relied heavily on observation and biographical analysis. Safety of the physical environment scored high; domesticity scored low.	Data collected in 2018; units were pioneering and may have evolved. Incomplete administrative data from units required manager estimation. Perspective of nursing staff themselves was not directly captured (only managers and physicians were interviewed). Heterogeneity makes it difficult to generalize findings to all such units. The study describes organization and processes, not patient outcomes or effectiveness.

<p>4</p> <p>Hamminck, J.H.W., van Buuren, L.P.G., Moor, J.A., Derks, D.A.J., & Mohammadi, M. (2024). The Netherlands. <i>Dementia</i>.</p>	<p>To explore the lived experiences of older adults with dementia in Dutch nursing homes, focusing on daily activities and emotional responses, and how different contexts (personal, social, organizational, physical) shape these experiences.</p>	<p>Patients: 8 residents with dementia from psychogeriatric wards in two nursing homes. Biometric data was successfully collected from 6 of them.</p>	<p>Design: Explorative empirical study with a mixed-method, narrative approach.</p> <p>Data Collection: Fly-on-the-wall observations.</p> <p>Informal interviews with staff and participants.</p> <p>Observational scales for mood and agitation (OERS, MEDLO).</p> <p>4. Physiological monitoring via wearable sensors (HR, HRV).</p> <p>Data Analysis: Narrative inquiry, deductive thematic analysis based on an observational framework and four contextual layers (personal, social, organizational, physical). Integration of qualitative observational data with quantitative biometric data.</p>	<p>Eating/drinking and communication were generally positive experiences, heavily influenced by social and organizational structures.</p> <p>Mobility and inactivity showed highly diverse physiological responses, indicating a complex interplay of emotions (stress, concentration, relaxation).</p> <p>Biometric data revealed emotional states (e.g., stress, relaxation) that were not apparent from neutral observational data alone.</p> <p>The study highlights the need to redefine 'inactivity' as 'under-stimulation' and distinguish between physical and mental engagement.</p> <p>The physical and organizational context of the nursing home (e.g., locked doors, set routines) plays a dominant and constricting role in residents lived experiences.</p>	<p>Small sample size (n=6 for biometric data).</p> <p>Short duration of physiological measurements, capturing immediate but not prolonged responses.</p> <p>Biometric interpretations can be ambiguous (e.g., physical exertion vs. stress).</p> <p>Observations were conducted in communal areas, potentially underrepresenting activities in private rooms.</p> <p>The researcher's positionality and perspective inherently shape the narrative co-construction.</p>
<p>5</p> <p>Kyung Hee Lee, PhD, RN, MPH, GNP1, Marie Boltz, PhD, RN, GNP-BC2, Hana Lee, PhD3, and Donna L. Algase, PhD, RN4</p> <p>American Journal of Alzheimer's Disease & Other Dementias®</p> <p>2017, Vol. 32(4) 207-212</p>	<p>The Relationship Between Staff-Resident Interactions and the Psychological Well-being of Persons with Dementia.</p>	<p>A total of 831 observations of 110 people with dementia in 17 nursing homes and 6 assisted living facilities.</p>	<p>Can Staff-Resident Interactions Facilitate Psychological Well-being in Residents with Dementia?"</p> <p>by Lee et al. (2017).</p> <p>To examine whether staff-resident interactions affect the psychological well-being of dementia residents in residential care.</p> <p>110 individuals with dementia in 17 care homes and 6 assisted living facilities (831 observations).</p> <p>: Observational study based on video recordings.</p> <p>Methods: Resident emotional expressions (positive/negative) and staff interactions (type: verbal, nonverbal, both; quality:</p>	<p>Any social interaction was positively related to greater positive emotions.</p> <p>Verbal interaction and combined verbal or non-verbal interaction significantly increased positive emotions (combined greatest impact).</p> <p>Positive-quality interaction contributed to positive feelings.</p> <p>Negative-quality and neutral-quality interactions contributed to an increase in negative emotions.</p> <p>The analysis did not take into account interaction length or categorize interactions with others (family members or other residents). It also did not</p>	<p>It did not require measuring the duration of interactions or interactions with other people (e.g., family or other residents). It did not require consideration of the potential impact of the nursing home environment.</p>

Canada Implementa- tion Science			<p>positive, negative, neu- tral) were coded by certi- fied coders.</p> <p>Analysis: Used statistical models to determine in- teractions between inter- action type/quality and emotional expressions, with control for level of cognitive functioning and time of day.</p> <p>Any social interaction was positively related to greater positive emo- tions.</p> <p>Verbal interaction and combined verbal or non- verbal interaction signifi- cantly increased positive emotions (combined greatest impact).</p> <p>Positive-quality interac- tion contributed to posi- tive feelings.</p> <p>Negative-quality and neu- tral-quality interactions contributed to an in- crease in negative emo- tions.</p> <p>The analysis did not take into account interaction length or categorize inter- actions with others (fam- ily members or other resi- dents). It also did not control the potential am- bient effect of the nursing home as a whole.</p>	control the potential am- bient effect of the nursing home as a whole.	
6 Ana Barbosa and Gail Mountain Andrusjak et al. BMC Geri- atrics (2021) 21:32	This study aimed to identify the gaps in staff knowledge re- garding hearing and vision diffi- culties in older residents, and which practices known to improve ear and eye care in older care home residents are not com- monly imple- mented in care homes in Eng- land.	A total of 400 care home staff responded from 74 care homes. The results re- vealed that less than half of staff re- spondents reported using screening tools	<p>Cross-sectional survey.</p> <p>Method Vision and hear- ing care provided to older residents in care homes: a cross-sectional survey of care home staff" by Andreaka et al. (2021).</p> <p>In order to find out about the areas of knowledge deficit for care home staff and the evidence-based practice of vision and hearing care which care homes in England sel- dom use.</p> <p>400 care home staff from 74 care homes in Eng- land:</p> <p>Cross-sectional survey.</p> <p>Methods: The staff were given an online/paper</p>	<p>A cross-sectional survey of care home staff: Hear- ing and vision care pro- vided to older people in care homes" by An- drusjak et al. (2021): To determine care home staff gaps in knowledge and which evidence- based hearing and vision care practices are not routinely implemented in English care homes.: 400 care home staff from 74 care homes in England.: Cross-sectional survey.</p> <p>Methods: Staff were emailed/papered with an online/paper question- naire. Practice, knowledge, and confi- dence in hearing and vi- sion care were covered under questions.</p>	<p>A convenience sam- ple of care homes is not necessarily gen- eralizable to all care homes in England.</p> <p>The response to the survey was also lim- ited in depth because staff were not able to say why some prac- tices were occurring and why some listed barriers were absent.</p>

			<p>questionnaire. Practice, staff knowledge, and self-assessed hearing and vision care were measured.</p> <p>Analysis: Chi-Square analysis and descriptive statistics were used to compare data and explore relationships between staff/care home characteristics and care received.</p> <p>Gaps in Practice: Hearing and visual screening tools (46% and 43.8%, respectively) were not used regularly. The availability of other equipment for support (e.g., magnifiers) was minimal. Audiologist annual hearing check-ups (46.8%) were not standard practice.</p> <p>Knowledge by the Staff: Most of the staff respondents lacked faith in hearing/vision impairment identification, impairment recognition, or hearing aid servicing. Over 85% of the staff asked for information on both.</p> <p>Other Findings: Responses varied immensely based on work function and staff experience, indicating inadequate normalised practice and communication between homes.</p> <p>Convenience samples may not be generalizable to all care homes in England. The survey approach also limited response depth, as workers were unable to provide descriptions of the rationale behind certain practices or specify unspecified barriers.</p>	<p>Analysis: Chi-Square analysis and descriptive statistics were applied for data analysis and identification of associations between care home/staff characteristics and care provided.</p> <p>Practice Gaps: Screening devices for hearing (46%) and vision (43.8%) were often not used. Use of other assistive devices (e.g., magnifiers) was lacking. Regular hearing check-ups by an audiologist yearly were not common (46.8%).</p> <p>Knowledge of Staff: Most staff members were not sure they could identify hearing/vision conditions, measure impairments, or clean hearing aids. Over 85% of staff asked for more information about both subjects.</p> <p>Other Findings: Responses varied significantly by staff role and experience and implied a failure of standardised practice and communication between homes.</p> <p>It is possible that the convenience sample employed here may not be representative of England's care homes. The survey also limited the depth of response in that staff members could not answer the reason for some of the practices or non-existent barriers.</p>	
7	to describe how care home staff understand and respond to agitation and the factors that determine how it is managed	25 care home staff from 6 different care homes in England (including nurses, care assistants,	<p>qualitative thematic analysis.</p> <p>Methods: Researchers conducted in-depth interviews to understand staff perspectives and experiences.</p> <p>Analysis: Thematic analysis was used to identify</p>	<p>Employees viewed agitation as a response to unmet needs (environmental, emotional, or physical).</p> <p>Employees typically find themselves experiencing helplessness, fear, and</p>	<p>Staff were asked to participate on the basis of manager recommendations, which might introduce bias (i.e., staff who were self-confident or had a good relationship with managers might be</p>

		managers, etc	key themes from the interview transcripts.	<p>overwhelmed when confronted with agitation, as opposed to aggression.</p> <p>The successful intervention was based on knowing the resident as an individual (history, likes/dislikes). Staff utilised strategies such as "going along" with the residents' reality.</p> <p>Workers' actions were under strict control by structural sources: lack of time, routine task-character, below-critical staffing levels, low pay, and culture of fear (e.g., fear of making a mistake or in the public eye).</p>	more willing to participate). The study also relied on staff self-reporting rather than on observation of care.
<p>8</p> <p>Liv Skomakerstuen Ødbehr^{1,2*}†, Kari Kvigne^{1,3†}, Solveig Hauge^{4,5†} and Lars Johan Danbolt^{6,7†}</p> <p>BMC Nursing (2015) 14:70</p>	to investigate how nurses and care workers provide spiritual care for people with dementia in nursing homes	Interviews were conducted in eight focus groups with 31 nurses and care workers in 4 Norwegian nursing homes.	<p>Qualitative study with exploratory design grounded on a phenomenological-hermeneutic approach.</p> <p>Methods: 8 focus group interviews were utilized for data collection.</p> <p>Analysis: The data were analysed with a three-step phenomenological-hermeneutic method (naive reading, structural analysis, comprehensive understanding)</p>	<p>The research recognised three general methods of spiritual care provision by nurses:</p> <p>Integrating it into daily care by way of physical contact (e.g., handholding) and response/intuition to residents' needs.</p> <p>Building togetherness by being present and empathetic in communication.</p> <p>Provision of meaningful activities for daily living, e.g., facilitating hobbies and religiosity demands (e.g., reading the Bible).</p> <p>Nurses were unsure of how to define or provide spiritual care at the outset but reached a new understanding through group discussion. They came to it mostly intuitively and not with tacit knowledge.</p>	The findings cannot be generalised due to the small, homogeneous sample (mostly older female workers in a Norwegian context). The over-representation of women and lack of male participants may have affected the results.