Mood and general behavior of patients with severe dementia during one year of supervised, individualized planned care and systematic clinical supervision. Comparison with a similar control group

A-K. Edberg¹, A. Norberg², and I.R. Hallberg³

¹Department of Health Sciences, Kristianstad University, Kristianstad, ²Department of Nursing, Umeå University, Umeå, ³Center for Caring Sciences, Lund University, Lund, Sweden

ABSTRACT. The aim of this study was to evaluate the effects of one year of systematic clinical supervision, and supervised individually planned care on the mood and general behavior of patients with dementia in relation to their cognitive function and level of confusion. The intervention was carried out in a ward devoted to the care of patients with severe dementia (EW), with a similar ward (CW) where no changes were made serving as a control. Each ward housed 11 patients, of whom 7 patients in each ward survived throughout the study time. Assessment of the patients’ mood, general behavior, cognitive functions (MMSE), orientation and confusion (OBS) was made at baseline, and after 6 and 12 months of intervention. Significant deteriorations for the patients in CW were seen during the study period as regards the factor strength, functional performance and orientation in the ward, and speech performance and psychomotor slowing. For the patients in the EW, deterioration was seen only in the factor accessibility, and improvement was seen in the factor sensitivity and euphoria. The differences indicated that the development in the two wards went in opposite directions to the benefit of the patients in the EW. Because of the small sample size, the findings are more the result of a pilot trial, rather than generalizable. The intervention, however, seemed to have a positive effect on the secondary symptoms of the disease.

INTRODUCTION

Interventions that are meant to improve the care quality for institutionalized patients with severe dementia are rarely described, and have been made mainly by changing the environment, physically as well as psycho-socially (1-9). Nursing care quality and the nurses’ actions when caring for the patients, however, are probably the most important environmental components, as the patient with severe dementia is fully dependent on others for her/his well-being.

The idea that the quality of nursing care is vital for the patients’ well-being is supported by earlier findings. Hallberg et al. (10) showed that patients with dementia, living in institutions, were often isolated and understimulated. The nurse-patient interactions were few and mainly task-oriented; the quality of the interactions, using a harsh tone of voice, for instance, was found to increase the occurrence of vocally disruptive behavior (11). The patient’s failure to reach mutuality in the encounter with the nurses could cause stress for the latter in their actions, which might in turn lead to an interaction characterized by resistance from the patients and the use of force by the nurses (12). Hence, a vicious circle may be created, where the patient becomes increasingly resistant, and the nurses even more stressed and unable to interpret the patient’s actions.

A training program aimed at integrity promoting care for nurses on a long-term ward for patients with severe dementia showed that the nurses made the environment easier to understand for the patients, and became more understanding and sensitive to the patient’s cue. (13). Before the intervention, negative
or intermediate patterns of interaction dominated between the nurses and the patients, while positive patterns of interaction prevailed after the intervention (14). Changes in the somatostatin concentrations were also found for the patients in the study (15).

Though cognitive losses in dementia may be similar, each person loses different abilities at different times, and responds and adapts differently to the loss as well as to interventions. Thus, it seems fair to say that an intervention to improve care quality should be based on each individual and his/her needs, as well as the needs of the nurses, as they may be the keys to improvement in the patients’ well-being.

An intervention consisting of systematic clinical supervision for the nurses, combined with individually planned care for the patients, showed positive effects on the co-operation between patients with severe dementia and their nurses (16). This intervention was based on the idea that supportive measures for the nurses, in the provision of nursing care, can be addressed cognitively and emotionally, and that the combination of the two is more effective. The intervention also revealed decreased burnout, tedium and work-strain, and increased job satisfaction, empathy and creativity (17-19). Whether similar improvement can be seen in the patients’ mood and behavior as a result of the intervention is the focus of the present study.

Our aim was to evaluate the effects of one year of systematic clinical supervision, and supervised individually planned care on the patients’ mood and general behavior in relation to their cognitive function and level of confusion, and compare the results with those from patients in a similar control ward.

**SUBJECTS AND METHODS**

The study was carried out in two wards for care of patients with severe dementia. One ward was randomly chosen to become the experimental ward (EW), and the other to become the control ward (CW). Both wards were similar regarding management, and methods of care provision. Each ward housed 11 patients (10 women and 1 man) with various dementia diagnoses, at advanced stages of the disease. In each ward, seven patients survived throughout the intervention period. The patients median ages, were 87 years (q1-q3: 83-91) in the EW, and 78 years (q1-q3: 75-82) (p-value 0.03) in the CW. In both wards, the patients had a median stay of 24 months. The staff situations were similar regarding the work climate, level of burnout and job satisfaction, tedium and view of patients, and strain in their work at the start of the intervention (17-19).

Registered nurses (RNs) and licensed practical nurses (LPNs), some with psychiatric training, staffed the wards. Each nurse was assigned to be a “contact person” for one or two patients; this meant being responsible for the patient’s private belongings, and contact with the patient’s family. At the start of the intervention, the contact person had no special responsibility for the care provided to the assigned patient. Both wards initially had a task assignment system for care provision, which was maintained in the CW.

**Intervention**

The intervention lasted 12 months, and started with a 2-day training session for all the nurses in the two wards, one ward at a time. The training program consisted of current knowledge of dementia diseases, care of people with dementia, and individualized planned care within the system of nursing diagnoses (20). The nurses also discussed shortcomings, and ways of developing the care provided.

Subsequently the implementation of individualized planned care was started at the EW, and there was a continuous discussion about how to organize the planning, provision, documentation and evaluation of care. The contact person, with support from the RNs, became responsible for collecting data about their assigned patient’s background, current needs, and functional ability, and for the care plan being followed and evaluated. The staff group decided that the care plan should cover the following areas: Rest - Activity, Nutrition, Elimination, Mobility, Hygiene - Dressing, Contact - Social needs, Personality and Special Problems if any (16). The contact person and the research assistant then met, discussed the data collected about the patients, and developed nursing diagnoses and nursing orders in each of the areas mentioned. At the start of the intervention, the first author together with a research assistant supervised the entire staff group in the development of care plans, but gradually handed over the responsibility to the RNs.

Simultaneously with the care planning, systematic clinical supervision was started at the EW initially every third week, and thereafter every other week (19). Clinical supervision particularly addressed the nurses’ emotional reactions in their provision of care, the nurse-patient relationship, and the interpretation of the patient’s current situation.

**Methods and instruments of data collection**

Data were collected prior to the intervention (baseline), and after 6 and 12 months (follow-up) at both