

# Acceptability of Namaste Care for patients with advanced dementia being cared for in an acute hospital setting

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## ABSTRACT

**Background** Despite a quarter of acute hospital beds being occupied by people with dementia, many hospitals lack appropriate services to meet their holistic needs. Namaste Care is a sensory programme that has been developed to meet the spiritual needs of people in the more advanced stages of dementia. It has been implemented successfully in care homes but it is not known whether it is an appropriate service for the acute hospital setting.

**Aim** To explore whether Namaste Care is an acceptable and effective service for people with advanced dementia being cared for in a busy inner-city teaching hospital.

**Methods** This was an exploratory qualitative interview study. Individual, semistructured, face-to-face interviews were conducted with hospital healthcare staff working in an area of the hospital where Namaste Care had been implemented. Data were analysed using the framework approach.

**Results** Eight interviews were completed with members of the multidisciplinary ward team. Two main themes emerged, with associated subthemes: (1) difficulties establishing relationships with people with dementia in hospital (subthemes: lack of time and resources, lack of confidence leading to fear and anxiety); (2) the benefits of a Namaste Care service in an acute hospital setting (subthemes: a reduction in agitated behaviour; connecting and communicating with patients with dementia using the senses; a way of showing people with dementia they are cared for and valued).

**Conclusions** This small-scale study indicates that Namaste Care has the potential to improve the quality of life of people with advanced dementia being cared for in an acute hospital setting. However, further research is required to explore more specifically its benefits in terms of

improved symptom management and well-being of people with dementia on acute hospital wards.

## INTRODUCTION

In the UK, one in four acute hospital beds are occupied by people with dementia, and over 30% of people with dementia will die in the acute hospital setting (Alzheimer's Society, 2009, 2014; National End of Life Care Intelligence Network, 2010; Sleeman *et al*, 2014). There are currently 850 000 people living with dementia in the UK and this number is predicted to increase to 1 million by 2025 (National End of Life Care Intelligence Network, 2010; Alzheimer's Society, 2014). The rising prevalence of dementia is having an impact on acute hospitals and placing increased expectations on health and social care professionals in terms of the support and services they should be delivering (National Institute for Health and Care Excellence (NICE), 2006; Sampson *et al*, 2009, 2014; Ham *et al*, 2012; Department of Health (DH), 2013).

Concerns have been raised regarding the level of care that people with dementia receive in acute hospital environments in terms of symptom management, the provision of person-centred care, the support received by families/loved ones and care at the end of life (Alzheimer's Society, 2009; Royal College of Nursing (RCN), 2011; Royal College of Psychiatrists, 2011, 2013; DH, 2012a; The Mid Staffordshire NHS Foundation Trust, 2013; Royal College of Physicians and Marie Curie Cancer Care, 2014; Sampson *et al*, 2014). The DH is keen to improve the quality of care and services

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provided to people with dementia and their caregivers in all environments, including acute hospitals (DH, 2009, 2012b, c). It has been recommended that good practice in dementia care relies on adopting a palliative approach to care and meeting people's physical, psychological, social and spiritual needs (NICE, 2006; Merel *et al*, 2014; Robinson *et al*, 2014; Volicer and Simard, 2015).

Spirituality is considered to relate to people's fundamental beliefs and values that help them interpret what it is to be human, and the existential search for meaning and purpose in their lives (Frankl, 1963; Ortiz and Langer, 2002). As people approach the end phases of their lives, spirituality has also been found to be associated with maintaining hope, understanding and coming to terms with loss and preparing for death (Frankl, 1963; Murray Parkes *et al*, 1996; Ortiz and Langer, 2002; MacKinlay, 2006; MacKinlay and Trevitt, 2010; Wilkinson and Coleman, 2010; Carr *et al*, 2011; Powers and Watson, 2011). Therefore, spiritual caregiving is an important aspect of older people's care (The Scottish Government, 2008; van der Steen *et al*, 2014). However, spiritual care is often a neglected area of care in hospitals (Royal College of Physicians and Marie Curie Cancer Care, 2014).

The spiritual needs of people with dementia, particularly when they are in the advanced stages of the disease, tend to be ignored in all care settings, including hospitals (Sampson *et al*, 2005; Volicer, 2005, 2007; Mitchell *et al*, 2009; Alzheimer's Society, 2012; van der Steen *et al*, 2014). Spiritual care is of particular importance for people living with dementia (Bell and Troxel, 2001; Alzheimer's Society, 2013). Bell and Troxel (2001) have described the spiritual needs of people with dementia (box 1). It is important that these needs are recognised and integrated into the care delivered to all people with advanced dementia, including in the acute hospital setting (NICE,

2006; Alzheimer's Society, 2013). Spiritual care is closely related to person-centred care (Kitwood, 1993, 1997), which is well recognised as an essential component of high-quality dementia care, whatever the care setting and regardless of the stage of the disease (Brooker, 2003; NICE, 2006, 2013; The Scottish Government, 2010). Like spiritual care, person-centred care aims to support and maintain the person's sense of self and self-worth and recognises the fundamental needs of people with dementia, such as the need for attachment, identity, occupation, social interaction, comfort and inclusion (Kitwood, 1997; Sabat, 2001, 2010; box 2).

The majority of the spiritual care services that have been developed in dementia care settings, for example, reminiscence therapy, life story/life review work and creative activities, are aimed at people with mild to moderate dementia, who can still communicate verbally and engage in group activities, with little development in services for those in the later stages of the disease (Lipe, 2002; Mackinlay and Trevitt, 2010; Simard, 2013). However, just being with the person, carefully listening and giving the person with dementia time and attention is a spiritual practice as it helps him/her to maintain a sense of hope, meaning and purpose (Kelly, 2012; Mowat *et al*, 2013).

Multisensory programmes have been developed to help people with advanced dementia feel a sense of connection with themselves and others (Staal *et al*, 2007; Bauer *et al*, 2012). One example of a multisensory programme is Namaste Care, which was devised in the USA by Professor Joyce Simard, a geriatric consultant. The term 'Namaste' is an Indian greeting which means 'to honour the spirit within'. Namaste Care is a systematic spiritual care programme specifically for people with advanced dementia, who are socially withdrawn and no longer able to benefit from social and group activities, have severe cognitive impairment, spend a lot of time sleeping, have limited verbal abilities and require care with all activities of living (Simard, 2013). The programme integrates meaningful activity and multisensory stimulation (such as massage and aromatherapy, touch, music, colour,

### Box 1 The spiritual needs of people with dementia

- ▶ The need to connect with others
- ▶ The need to be respected and valued as a person
- ▶ The need to love and serve others and be loved
- ▶ The need to feel recognised, known and understood
- ▶ The need to be compassionate, caring and helpful
- ▶ The need to be productive and successful
- ▶ The need to be involved in the community in which they are living
- ▶ The need to become and still be in the flow of life
- ▶ The need to find meaning, purpose and have hope
- ▶ The need, if relevant to them, to engage in religious behaviours/activities
- ▶ The need for a sense of personal dignity and self-worth

Source: Bell and Troxel (2001)

### Box 2 Fundamental needs of people with dementia

- ▶ The need for attachment
- ▶ The need to feel safe, loved, respected and valued
- ▶ The need to feel comfortable, both physically and mentally
- ▶ The need to be occupied, included and stimulated
- ▶ The need to feel that they have self-worth
- ▶ The need to explore self-awareness through sensory experiences

Source: Kitwood (1997)

tastes and scents), with nursing care, person-centred care and reminiscence, and provides carers with education and family/loved ones with support (Simard, 2013). The aims of the programme and its key elements are outlined in boxes 3 and 4.

Namaste Care has been implemented in care homes and some hospices in the USA, Australia and parts of Europe. Evidence is starting to emerge in relation to its benefits, including improvements in social interaction, communication and nutritional intake, increased interest in the surrounding environment, decreased indicators of delirium, and a reduction in agitated behaviours and the need for antianxiety medications (Simard, 2007; Simard and Volicer, 2010; Stacpoole *et al*, 2013, 2015; Stacpoole and Thompsell, 2015). In addition, one of the benefits in terms of service provision is that the programme requires no extra staff or expensive equipment (Stacpoole and Thompsell, 2015).

Namaste Care has recently been implemented in the Health and Ageing Unit of an inner-city teaching hospital. It is a new addition to the hospital's dementia services and was introduced to try and improve the quality of life of people with advanced dementia being cared for in the hospital. This is the first implementation of the Namaste Care programme in an acute hospital setting. Since Namaste Care is a new service to the acute sector, no research is available regarding the effects of its implementation in this particular area.

### AIM AND OBJECTIVES

The aim of the research was to explore whether Namaste Care is an appropriate service within an acute hospital setting. Its objectives were to explore: staff perceptions of the challenges in caring for patients with advanced dementia; staff awareness and understanding of Namaste Care; whether staff members felt (and in what ways) Namaste Care has helped them to care better for patients living with advanced dementia; and if staff felt patients' symptoms were better controlled (and in what ways) after implementation of Namaste Care.

#### Box 3 The main aims of the Namaste Care programme

- ▶ To provide a respectful and compassionate approach to the care of people with advanced dementia
- ▶ To promote comfort and pleasure
- ▶ To communicate and connect with the person
- ▶ To honour the person as an individual
- ▶ To provide company through the presence of others
- ▶ To improve quality of life
- ▶ To promote dignity
- ▶ To help facilitate a good death

Sources: Simard (2013), Stacpoole and Thompsell (2015)

### METHODS

#### Study setting and intervention

The study setting was the Health and Ageing Unit of a large inner-city teaching hospital. The Unit comprises three elderly care wards. The Unit's day room has been developed into a sensory room, which is mainly used by the activities team but is available for use by patients on all the three wards. The sensory room features blackout blinds, mood lighting, a multimedia system for both music and nature videos and aromatherapy diffusers. This area provides the setting for the group activities associated with the Namaste Care programme. Before introduction of the programme, Professor Joyce Simard delivered teaching sessions to staff at the hospital, which provided information about dementia care and Namaste Care and practical planning and strategies for development of the programme within the institution.

Involvement in the programme is currently only available to patients on the Health and Ageing Unit. Patients are identified for inclusion in Namaste Care by the occupational therapy team. Appropriate patients are referred to the activity coordinators who provide the Namaste Care service. The activities department is currently only funded for two part-time positions that run Monday–Friday 09:00–13:30. Namaste Care is provided either as a group or one-to-one session, depending on the patients' level of need. Group sessions comprise no more than six patients. During the session, the room is dimly lit, scented with lavender and relaxing music appropriate and appreciated by the patient group is played.

The focus of care is to create relaxing, enjoyable and stimulating experiences. Group sessions usually last 1 h, with single sessions lasting between 20 and 30 min. The content of the sessions varies, depending on individual patients' likes, wants and abilities. All patients are greeted with a loving touch. Generally, session contents include hand and foot massage, reminiscence, singing familiar songs and pampering, such as combing and styling of hair, painting patients' nails or providing a wet shave for the men. For those nursed in bed, music equipment, lotions and reminiscence equipment are taken to the bedside and used in the same way as during group sessions. There is no set structure to the amount of Namaste Care sessions a person receives. However, most patients are seen three times per week, during either group sessions or on a one-to-one basis. There is no individual Namaste Care budget within the unit, so all Namaste Care is provided using current or donated equipment. Feedback from each session is recorded using the electronic patient records system.

Since the service is led by activity coordinators, not health professionals, families/loved ones do not benefit from formal family meetings where discussions take place about the patient's current health status, likely disease trajectory and future care priorities (see box 4).

**Box 4 Key elements of the Namaste Care programme**

- ▶ Education/training is essential to the successful implementation of Namaste Care. Educational topics should include: the history of dementia; possible causes; signs and symptoms; medications; best practice; the impact of dementia on families; the burdens and benefits of medical intervention for people with advanced dementia (such as cardiopulmonary resuscitation, tube feeding, hospitalisation and treatment of infection); the importance of communicating with families about prognosis and priorities for future care; care of dying people and after-death care; and an overview of the Namaste Care programme.
- ▶ Following education, care staff will identify residents who are in the advanced and end stages of the disease process who it is deemed would benefit from being part of the programme. A family meeting is then held to discuss the progression of the person's dementia and the ways in which staff can provide comfort and pleasure in the final phase of life. Therefore, inclusion in Namaste Care facilitates the need for discussion with the family about the deterioration in the patient and the expectations and decisions regarding future care. These conversations give families/carers the opportunity to discuss the care of their loved ones and to prepare for the end of life, and facilitate advance care planning discussions. Broaching the topic of end-of-life care at this point occurs in the context of offering meaningful care for the person with dementia and is preferable to last-minute discussions about invasive intervention in the hospital setting.
- ▶ The design and duration of the Namaste Care programme varies slightly between care homes. Ideally, the programme should be conducted 7 days a week, for 2 h in the morning and 2 h in the afternoon, thereby increasing the amount of time that care home staff spend engaging and connecting with residents with advanced dementia.
- ▶ Namaste Care is delivered in a designated space in the care home or at the person's bedside, depending on the person's physical condition. Being part of a social group helps the person with dementia to feel included in the community in which he/she is living. When Namaste Care is offered at the bedside, sensory tools such as music and grooming equipment and linen sprays can be stored on a trolley. The implementation of Namaste Care does not require extra staff or a new space.
- ▶ In all its forms, Namaste Care aims to provide meaningful activity, relaxing experiences and good nursing care for people with advanced dementia using therapeutic touch, stimulation of the five senses (touch, hearing, sight, smell and taste), music and life review/reminiscence. In order to ensure comfort, residents are brought to the Namaste space and placed in comfortable seating and their pain levels are assessed and managed. Special emphasis is given to therapeutic touch, using massage and aromatherapy oils, and nutrition and hydration needs, with residents being offered sweet treats and nourishments throughout the session. Activities include hand and foot massage, soaking of feet, gentle combing of hair and other personal grooming specific to the likes and wants of the resident. During this time, the carer makes eye contact with the resident, talks in an affirmative way and explores with the individual his/her wishes and preferences for care. The Namaste Care worker will have researched the resident's life story so that the programme's activities can be adapted to the individual resident.
- ▶ Family members and friends are encouraged to visit the Namaste Care room and to get involved with delivery of the programme. The activities used in Namaste Care can serve as a communication tool between the patient and their loved ones.

Sources: [Simard \(2013\)](#), [Stacpoole et al \(2013, 2015\)](#)

Such meetings are considered an important aspect of the Namaste Care programme ([Simard, 2013](#)). However, ward staff are encouraged to liaise with families to inform and educate them about Namaste Care and to encourage them to bring in patients' personal items suitable for activities during Namaste Care.

**Study participants**

Only staff members working on the wards within the Health and Ageing Unit were eligible as participants. The inclusion criteria were nursing staff, healthcare support workers, doctors, physiotherapists, occupational therapists and activity staff. It was hoped that including representatives from the multidisciplinary team would enable different perspectives to be captured. Exclusion criteria were ward porters, kitchen

staff and staff not working on the Health and Ageing Unit.

**Recruitment**

Potential participants were approached by a person independent of the research (the Assistant Director of Nursing) and were provided with an information sheet explaining what participation in the study would involve and requesting their voluntary consent to be interviewed. After a minimum of 24 h in which to consider, the independent party gained informed written consent from interested parties.

Eight participants were recruited to the study. The participants included trained and untrained nursing staff, an occupational therapist, a dignity manager and activity workers. The participants varied from band 2

to 8, demonstrating a broad range of views in relation to patient care and the provision of services (table 1).

### Data collection

In view of the lack of evidence regarding the feasibility of incorporating the Namaste Care programme within an acute hospital setting, and the intention to explore the effectiveness of a new service through staff experience, an exploratory qualitative interview study design was adopted using semistructured, face-to-face interviews (Holloway, 2005; Pope and Mays, 2006). The interview format comprised a series of open-ended questions based on specific topic areas (box 5). The interviews took place on the Health and Ageing Unit. Interview data were collected over a 2-week period using a digital recording device. Notes were taken during the interviews with regard to the interviewees' body language and general attitude during the process.

### Analysis

All interviews were transcribed verbatim and then read and re-read to ensure familiarity with the data. The transcripts were then analysed using the framework approach (Ritchie *et al*, 2003). Framework analysis provides a linear and systematic process to qualitative analysis and is deemed suitable for policy research that asks specific questions, has a limited time frame and a pre-designed sample (Gale *et al*, 2013). In the analysis, a hierarchical thematic framework was developed to organise/classify data according to key themes, which were then subdivided into related subthemes. In order to enhance analytical rigour, a reiterant process of discussing areas of agreement and disagreement took place between KSJ and JK to achieve consensus. Alternative interpretations were incorporated in the analysis. We also paid attention to non-confirmatory cases where emerging themes contradicted more common ideas. Each main theme was then charted by completing a table containing the theme, its related subthemes and definition summaries. The charts enabled differences, patterns and connections between the categories to be explored (Ritchie *et al*, 2003; Gale *et al*, 2013).

### Ethical considerations

The research project was planned with the aim of minimising distress and inconvenience to both

### Box 5 Topics within the interview guide

- ▶ The difficulties experienced in caring for patients with advanced dementia
- ▶ What Namaste Care represents
- ▶ Whether the implementation of Namaste Care has aided the participant in caring for patients with advanced dementia
- ▶ Whether dementia symptoms are better managed post-implementation of Namaste Care

participants and patients. Informed and voluntary consent was sought from participants, who were able to withdraw from involvement within the research project at any time, and all potential participants were able to decline involvement without prejudice (Koffman *et al*, 2015). Anonymity and confidentiality of participants were maintained throughout all stages of the research process and the collection and storage of research data adhered to the Data Protection Act 1998. If participants became distressed when discussing the interview questions, telephone counselling support was available if required. However, no participant required this service.

Permission to conduct the research was sought and gained from relevant senior clinicians within the Trust and the Deputy Director of Nursing. An ethics application was submitted to King's College London Biomedical Sciences, Dentistry, Medicine and Natural and Mathematical Sciences Research Ethics Sub-Committee, with full approval to conduct the study being granted on 21 February 2014 (BDM/12/13-117).

### RESULTS

Two main themes, with associated subthemes, emerged from the analysis. The main themes were: difficulties establishing relationships with patients with dementia in hospital; and the benefits of Namaste Care in an acute hospital setting. In reporting the results, excerpts taken from a wide range of participants have been used to illustrate the themes and are denoted by sample number and participant role.

#### Difficulties establishing relationships with patients with dementia in hospital

This theme refers to the difficulties in the acute hospital setting that participants perceived were associated with preventing staff from caring effectively for patients with advanced dementia and developing therapeutic relationships with them. The theme is characterised through two subthemes: lack of time and resources; and lack of confidence leading to fear and anxiety.

**Table 1** Characteristics of participants

Role of participants	Band	Number
Staff nurse	5	1
Healthcare support worker	2	2
Activity worker	4	2
Dignity manager	8a	1
Occupational therapist	8a	1
Student nurse	3	1

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## Lack of time and resources

The participants stated that caring effectively for people with advanced dementia takes time and requires an adequate number of staff on the wards:

With um various dementia symptoms, the confusion, the agitation, umm, in patients can be very difficult to deal with...Everything is always very time consuming...And well that needs to be allowed for...Because I mean the practicalities and reality of it is that we haven't got the staffing for it. I mean the ward is short staffed...Even when we are fully staffed it's asking a lot to be able to spend enough time to calm a patient down enough to be changed. (002/01 Staff Nurse)

Because if we actually did have more resources then we would be able to sort of do more for those type of patients whereby they actually need more of our time, compared to the others...Because unfortunately when you are in therapies you...can't concentrate all of your time on one patient...You need to sort of balance it, among all of the patients that you've got on the wards. (004/01 Occupational Therapist)

Although the participants wanted to provide the best care for their patients with dementia, they experienced difficulties in managing individual needs while at the same time having to meet the needs of the ward as a whole. Increased staff numbers were considered particularly important in relation to maintaining a safe environment for patients who wandered persistently around the ward and were at high risk of falls. Such patients were considered to require one-to-one care.

Patients with advanced dementia on the wards were reported to have varying levels of physical ability. Those who were more physically dependent required regular hoisting and repositioning, which placed a large physical burden on the staff caring for them. The level of patient dependency left staff members feeling physically and mentally drained. The activity workers found the manual-handling component of care particularly challenging. The sensory room was specifically designed for people in the more advanced stages of dementia. Such patients tended to be non-ambulant. However, the activity workers were not allowed to do hoist transfers and ward nurses were too busy to take patients to the sensory room and settle them down. Added to this, wheelchairs were not always available in which to take non-ambulant patients to the room. This meant that many patients with advanced dementia could not get to the sensory room. In addition, participants felt limited by the amount of resources available to be able to engage with patients in holistic activities such as aromatherapy and massage. They stated that they often had to make and bring in their own massage oils and sensory items, for example, foliage from the garden and scents, to compensate for the lack of items available within the hospital.

Lack of time, staff numbers and resources caused participants to conclude that the services provided by the hospital were only sufficient to cater for people with early to moderate dementia, not those with advanced dementia. This resulted in a lack of social engagement and stimulation for people with advanced dementia on the hospital wards:

It can be very sad sometimes to see the patients, because they are not engaging, they are not stimulated, even if they are in a bay. There's nurses and healthcare assistants, plenty of people coming in and out of the bay. They've got other patients around them but... They're just sat in the corner. They're not engaging, they're not stimulated...umm, that can be very difficult. (002/01 Staff Nurse)

Lack of time and the minimal resources available led to participants feeling helpless when trying to provide care to this patient group. It was felt that if there were more staff, the level of care provided to patients with advanced dementia would improve, as more time could be spent caring for, communicating with and stimulating them, gaining better insight into their needs, as well as caring for them physically.

## Lack of confidence leading to fear and anxiety

Participants stated that staff lacked confidence in terms of managing certain symptoms associated with dementia, particularly agitation. This, in turn, resulted in staff experiencing anxiety and fear when caring for patients with advanced dementia who displayed agitated and/or aggressive behaviour. The fear emanated from not knowing how best to manage such behaviours and concerns about their own safety:

There was a particular patient, patient X that I will call...he was wandering, very high risk of falls, very high risk of absconding. Umm, very aggressive, quite a large man and people used to hold him at arm's length. (005/02 Healthcare Support Worker)

I think it's the fear from staff has been one of my challenges. You know, just how to interact with different people. (006/01 Dignity Manager)

The anxiety and fear experienced by staff in relation to caring for some patients with advanced dementia could lead to patients with advanced dementia being ignored, which only served to worsen the agitation and aggressive symptoms, further increasing staff's anxiety levels.

Participants perceived that aggressive and agitated behaviours could be the result of hospitals being an inappropriate environment in which to care for people with advanced dementia. For example, the noise levels on hospital wards were considered to be distracting, disorientating and frightening. It was also deemed that people with dementia could get agitated because they did not want to be in hospital and just wanted to go home:

Sometimes if you get a patient that's very agitated, very, you know...don't want to be here. Don't want to be in hospital, period. But it's sometimes when you break, when you sort of listen to their needs, umm just have a general conversation with them they will come round, but sometimes you know the barriers can be that they want to go home, and no matter what you say won't make a difference you know, they want to go home. (003/01 Activity Worker)

Lack of confidence when caring for people with dementia was also related to the problems that some patients experienced in terms of verbal communication and their inability to express their feelings and wishes for care. This led to staff finding it difficult to establish therapeutic relationships and understand patients' needs, which left them feeling inadequate and anxious about providing care:

Knowing what to do can be quite frightening too because people can't communicate their wishes. (006/01 Dignity Manager)

Nurse participants found that poor communication meant they experienced difficulties in relation to assisting patients with basic tasks such as eating and drinking, administering medication and providing proper symptom assessment. In addition, activity staff felt that since patients could not state clearly what they wanted, they could not plan general individual or group activity sessions efficiently as they did not know whether particular activities would be to a person's taste, or would cause psychological distress to the patient.

Difficulties in communicating and establishing relationships with patients with dementia, and the fear they felt if patients became agitated or aggressive, resulted in participants not finding caring for, and engaging with, this group of patients rewarding. In addition, participants found that patients with dementia did not always remember them, which left them feeling unappreciated.

#### **The benefits of Namaste Care in an acute hospital setting**

This theme refers to the ways in which Namaste Care was perceived by participants to improve the care of people with advanced dementia in the acute hospital setting. It is characterised through three subthemes: a reduction in agitated behaviour; connecting and communicating with patients with dementia using the senses; and a way of showing people with dementia they are cared for and valued.

##### **A reduction in agitated behaviour**

All participants felt that Namaste Care had a positive effect on the agitated behaviour:

Their body language seemed more relaxed, they are less agitated. (003/02 Activity Worker)

I found out that he loved church music. He used to like going to church. So on my telephone I've got,

umm, hymns. I used to play him hymns and it calmed him completely. It took him back to a place where he was happier, content. (005/02 Healthcare Support Worker)

Patients were observed to be more relaxed and calm. For example, the staff nurse (002/01) described how a particular male patient had been very agitated and confused and kept wandering around the ward and trying to get into other patients' beds. The ward staff found caring for him challenging. Following Namaste Care sessions, he was still confused but he was much calmer and started to have playful conversations with the nurses and healthcare assistants about how nice he smelt because of the use of aromatherapy oils. He still wandered around but not in an agitated manner and did not try to leave the ward. Participants also found that following inclusion in Namaste Care, patients who had been distressed and agitated overnight would sleep better, particularly if they were given gentle massages before settling for the night.

Some participants expressed that they had begun to perceive agitation and distressed behaviours as a means of communication for people with advanced dementia with limited verbal skills. When Namaste Care was observed not to be having an effect on patients in terms of alleviating distressed and agitated behaviour, staff would look for reasons why this was the case:

Sometimes Namaste doesn't work...and I think that's really good because it shows that there's something else going on...like the patient's in pain or has a wet pad. I think it helps us in finding out what's going on with the patient when they can't really tell you. (006/01 Healthcare Support Worker)

Therefore, Namaste Care was also considered to have improved the assessment of symptoms in patients with advanced dementia.

##### *Connecting and communicating with patients with dementia using the senses*

Namaste Care was perceived to be different from usual activities for people with advanced dementia as its central tenet was sensory stimulation. For example, touch was observed by participants to be a powerful means of communicating and connecting with patients with advanced dementia:

There's something about touching the skin. You are connecting with that person. I find it very soothing... Especially if you have a patient that's very agitated. (005/02 Healthcare Support Worker)

I think it's a way of actually connecting with that patient. (005/01 Staff Nurse)

The perception of the Dignity Manager (006/01) was that infection control guidelines within the acute hospital setting had made staff reluctant to actually touch patients' skin. The approach adopted by

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Namaste Care gave staff confidence and permission to touch patients and be tactile with them. Regular massage of the patients' skin with aqueous cream and oils also helped to improve the skin integrity of frail elderly people with advanced dementia and prevented patients' skin feeling dry, which helped patients' level of comfort.

As well as helping patients to become more relaxed, calm and less agitated, participants found that the use of sensory activities, such as therapeutic touch and massage and music, resulted in patients displaying an increased interest in their surroundings, becoming more alert and confident. This helped to establish therapeutic relationships between staff and patients. When patients were more calm and relaxed, staff were less anxious and found they were better able to communicate with patients, which had a positive effect on the well-being of people with dementia, as well as the staff caring for them.

A way of showing people with dementia they are cared for and valued  
The participants perceived that Namaste Care provided staff with the means to express care for patients with advanced dementia and demonstrate that they are valued and honoured as people. It enabled staff to show the patients that they cared about them, which improved patients' sense of well-being and made them feel better about themselves:

It helps...patients feel, that they are listened to, and their needs are still met you know...the communication side that you get from Namaste...because just sitting there and shaving someone who can't do it, sitting there and just putting facial cream on someone's face who used to that and they haven't done that in ages makes a big difference...makes them feel a sense of beauty again. (003/01 Activity Worker)

Spending time with them and making them feel a person...valued. Like, they are human...It's just sending out a strong message that despite someone [having] advanced dementia they are just as important as someone who can continue with everyday living. As long as someone is breathing and is able to take a breath, then they are just as valued and it's important just like anybody else in this world. (003/02 Activity Worker)

Namaste Care was considered to fill a gap in service provision in the acute hospital setting for patients with advanced dementia. The participants had observed that patients with advanced dementia were often ignored and left alone. However, the multisensory stimulation techniques associated with Namaste Care gave staff the opportunity to reach out to patients with advanced dementia, stimulate them, engage with them in a way they had not done previously, promote a sense of social inclusion and create relaxing, comforting, reassuring and enjoyable experiences. These factors were deemed to improve patients' quality of life while in hospital:

They don't get...talked to and then have the time to express anything they could be able to sort of express. So this service actually provides that to patients, and it's actually sort of more about that smile as well because, that you actually need to provide for patients whereby you know, they actually sort of feel there is someone, you know, the contact, you know, the listening to music. That calmness, that actual calmness of this is really sort of benefit, more effective to the patient. (004/01 Occupational Therapist)

All participants perceived that Namaste Care had aided them in better caring for patients with advanced dementia. It was felt that the different activities in Namaste Care gave new ideas for meaningful activity, communication, calming techniques and for enriching the quality of life of those living with the disease. Participants were visibly moved by their experiences while working within the Namaste Care service. One participant felt overwhelmed by seeing a patient's reaction to a Namaste Care pampering session:

I just brushed her hair, she shut her eyes. I just thought, you know, this is lovely...I don't deserve this...I think I've seen first-hand something positive. (006/01 Dignity Manager)

As a service, it was felt that Namaste Care was easy to set up and maintain in acute hospitals due to the flexible nature of the sessions, which can be carried out on an individual basis by the bedside or within a group. All participants felt positive towards Namaste Care, feeling that it truly focused on and delivered care specific to the needs of those with advanced dementia and was a true demonstration of quality care.

## DISCUSSION

One aspect of this study was to explore the challenges experienced by hospital staff when caring for people with advanced dementia. The participants discussed the various difficulties that they considered prevented them from establishing therapeutic relationships with patients with advanced dementia. Communication difficulties were cited as a barrier to identifying patients' needs and forging connections with patients. Behavioural symptoms, for example, agitation and aggression, resulted in staff feeling anxious and fearful in relation to caring for people with dementia.

Similar results have been well documented in the associated literature. There is evidence that hospital staff, including nurses, do not feel that their training is sufficient to enable them to care effectively for people with dementia, which leads to them finding looking after people with dementia challenging, not knowing how to communicate properly with people with dementia and lacking confidence on how best to handle agitated and distressed behaviours ([Alzheimer's Society, 2009](#); [RCN, 2011](#); [Royal College of Psychiatrists, 2011, 2013](#); [O'Shea \*et al\*, 2015](#)).

Behavioural symptoms are common in older people with dementia admitted to acute hospitals (Mitchell *et al*, 2009; Sampson, 2010; Sampson *et al*, 2014; O'Shea *et al*, 2015). Sampson *et al* (2014), in their longitudinal cohort study of 230 people with dementia aged over 70 years, who were admitted to two acute hospitals in London as a result of acute medical illness, found that the most common behavioural and psychiatric symptoms were aggression, activity disturbance, sleep disturbance and anxiety.

Participants also considered that the hospital environment was not conducive to the provision of good dementia care due to its hectic and noisy attributes and the lack of services to meet the needs of people with more advanced dementia. In addition, there was limited time to care effectively for this client group. Patients who were agitated and wandered around the ward required a great deal of attention and time, which was a major strain on the available staff resource. This finding is echoed by the RCN's (2011) survey research which found that nurses consider that the barriers to delivering high-quality dementia care in the hospital setting include the pressure of the existing workload and insufficient staff levels, inappropriate environment and lack of funds and support to implement improvements.

Not being able to provide an effective service to meet the needs of patients in the more advanced stages of dementia created an emotional burden among the participants when they observed that patients were left alone and unstimulated. Although not relevant to the hospital environment, people with advanced dementia living in institutions, and who are unable to participate in the activities provided for people with mild to moderate dementia, often spend long hours isolated in their rooms or are left alone in communal rooms with minimal interaction with carers (Alzheimer's Society, 2007; Fullarton and Volicer, 2013). Low social interaction has been associated with increased agitation (Cohen-Mansfield and Marx, 1992; Kutner *et al*, 2000). Family carers of people with dementia who are admitted to hospital perceive that being in hospital can actually exacerbate their loved one's confusion, agitation, distress and difficulties with communication as a result of the lack of opportunity for social interaction and hospital staff's limited understanding of dementia (Alzheimer's Society, 2009).

However, the participants considered that introduction of Namaste Care bridged the gap in service provision in the acute hospital setting for people with advanced dementia. It was perceived to enrich the lives of the patients as it was responsive to patient need, provided stimulation, comfort and relaxed experiences, increased social interaction and demonstrated to patients that they are valued and that they matter. Participants also considered that Namaste Care helped them to care more effectively for people

with advanced dementia as it provided a means of communication. Better communication led to improvements in participants' sense of connection with patients and their ability to stimulate and exhibit care and compassion. Namaste Care was therefore considered to provide pleasure to both the staff delivering the care as well as the patients receiving it.

Similar perceptions can be found in research into the benefits of Namaste Care within care homes (Simard, 2007; Simard and Volicer, 2010; Trueland, 2012; Fullarton and Volicer, 2013; Stacpoole *et al*, 2013, 2015; Stacpoole and Thompsell, 2015). For people with advanced dementia who are withdrawn and have reduced social interaction, involvement in Namaste Care can lead to improved communication and interactions with their carers and increased interest in the surrounding environment (Simard, 2007; Simard and Volicer, 2010). In turn, staff can feel less frustrated when caring for people with advanced dementia (Simard, 2007). The introduction of Namaste Care in a care home has also been found to result in care home staff becoming less task-orientated, more patient-centred and better able to assess patients' conditions (Trueland, 2012).

An action research study was conducted by St Christopher's Hospice, London, in five UK care homes, to establish whether Namaste Care can enrich the quality of life of care home residents, families and staff without requiring additional resources. Both quantitative and qualitative data were collected from residents with advanced dementia, care staff, managers and relatives, before, during and after introduction of the programme (Stacpoole and Thompsell, 2015; Stacpoole *et al*, 2015). Analysis of the qualitative data, which were gathered using focus groups with care staff and families and individual semistructured interviews with the care home managers, revealed that residents were perceived to enjoy being involved in the programme, were more alert and responsive and engaged more actively with others. Residents also appeared more relaxed and became less agitated. The care home staff felt that Namaste Care helped them connect and communicate with residents, meet their human needs, gave them permission to provide more intuitive care, encouraged them to be creative in developing the programme for individual residents and assisted them in fostering easier, closer relationships with relatives. Overall, staff found that Namaste Care was rewarding, and increased their confidence and self-esteem (Stacpoole *et al*, 2013, 2015).

Participants in the current study observed that Namaste Care calmed and relaxed patients and reduced levels of agitation. A reduction in agitated behaviour is a common theme within Namaste Care research (Simard, 2007; Simard and Volicer, 2010; Fullarton and Volicer, 2013). The quantitative aspect of the St Christopher's Hospice study used the Neuropsychiatric Inventory-Nursing Homes

(NPI-NH) and Doloplus-2 behavioural pain assessment scale for the elderly to collect data from the 37 residents included in the research. Analysis found that the severity of behavioural symptoms, pain and occupational disruptiveness decreased over time in four of the five care homes included in the study after initiation of Namaste Care. The overall severity of behavioural symptoms was not associated with increased analgesia. In one care home, however, the severity of behavioural symptoms increased, but the researchers considered that this was most likely related to poor pain management, as reflected in increased pain scores, and disrupted leadership within the care home (Stacpoole *et al*, 2015). It has also been found that following enrolment in Namaste Care programmes, delirium indicators and the administration of anti-anxiety, anti-psychotic and hypnotic medications among residents decreases and residents sleep less during the day (Simard and Volicer, 2010; Fullarton and Volicer, 2013).

Researchers have concluded that the training in symptom assessment that staff members receive before implementation of Namaste Care may be one of the reasons for a reduction in agitated behaviour (Fullarton and Volicer, 2013). It has also been suggested that other causes of reduction in agitated behaviour include the provision of soothing, individualised, person-centred care and activities, the calm atmosphere and approach to care, regular, structured, one-to-one time with a care worker, as well as the opportunity to communicate and express emotion and therapeutic touch (Fullarton and Volicer, 2013; Stacpoole and Thompsell, 2015; Stacpoole *et al*, 2015). Improved symptom assessment was also cited as a benefit of Namaste Care in this study as, if a patient involved in the programme continued to be distressed or agitated, staff would assess the patient to see whether another problem, such as undiagnosed pain, was present. Therefore, Namaste Care facilitated a more thorough and holistic assessment of the symptoms of patients who were unable to verbalise clearly their needs.

One participant commented on the restrictions in terms of rules and regulations within the NHS, which left some staff members feeling reticent about using a tactile approach while caring for people with dementia. However, the participant felt that Namaste Care had given staff the reassurance and confidence to be able to touch patients in a caring way, to which the patients' responses were emotional and moving. Loving touch was, in turn, seen as a means of increasing staff's confidence and enabling them to connect with patients with advanced dementia. This supports research carried out by Nicholls *et al* (2013), who undertook a mixed-methods study in three residential care facilities in New South Wales, Australia, the aim of which was to explore the mental health benefits of touch for people with advanced dementia using the

Namaste Care programme's 'high-touch' technique. Residents enrolled in the programme were in the end stages of dementia and had severe cognitive and functional impairment. One component of the study was a series of seven focus groups with a convenience sample of registered nurses, nursing aids and family members, conducted 6 months' post-implementation of Namaste Care. The physical act of touch appeared to result in an emotional response from residents, who would become aware of the presence of the person touching them and in turn would reach out to touch them, for example, their hands, face or body. They would also initiate touch with objects such as life-like dolls and soft animal toys, which appeared to evoke an emotional response of nurturing and caring.

Touch appeared to reignite dormant emotions within the person with dementia and led to social connections, relationships and rapport between the people with dementia and carers and family members. This, in turn, gave caregivers a greater sense of satisfaction in their caring role. The researchers concluded that people need physical touch in order to feel connected. However, as older people start to lose their physical connections, such as hugs from family members/friends, they have fewer opportunities to reach out and touch others. Namaste Care therefore provides touch as a therapeutic intervention (Nicholls *et al*, 2013).

Although the study participants did not use terms such as 'spirituality' and 'spiritual care', their descriptions of Namaste Care indicate that the programme fulfils many of the components of what is generally perceived to be spiritual caregiving in relation to people with dementia (see box 1). Therefore, introduction of the programme into an acute hospital setting may have the potential to help hospital staff meet the spiritual care needs of patients with advanced dementia.

## CLINICAL RECOMMENDATIONS

- ▶ Namaste Care as a programme has several different components (see box 4). In this study, the programme was led by the activity coordinators, which meant that the components of advance care planning and counselling for families were lost. A key recommendation for improved provision of the Namaste Care service is for it to be delivered by the team as a whole, including nurses and doctors.
- ▶ Although the Namaste Care service provided by the hospital was considered by participants to be beneficial, the programme had no clear structure. Generally, patients received Namaste Care three times per week, which is substantially different from the proposed 4 h/day proposed in the original programme (Simard, 2013). There needs to be a more specific plan in place for those receiving Namaste Care in order to better understand the needs and benefits associated with the varying frequency of Namaste Care.

- ▶ In order for Namaste Care to be fully effective, and to improve the quality of life for people with dementia, it requires strong leadership, adequate staffing and good nursing and medical care (Stacpoole and Thompsell, 2015; Stacpoole *et al*, 2015).
- ▶ Whatever the potential benefits of the Namaste Care programme, it is not a substitute for good clinical care (Stacpoole *et al*, 2015). Staff caring for people with dementia in the acute hospital environment require training in dementia care and support from specialist services (NICE, 2006; Alzheimer's Society 2009; Sampson *et al*, 2014). It has also been recommended that within the acute hospital setting there needs to be greater involvement of family carers, more person-centred care planning, strategies to respond to life histories, more activity/therapies on the ward, greater use of volunteers to provide additional support and closer links with palliative care (NICE, 2006; RCN, 2011).

### RECOMMENDATIONS FOR RESEARCH

- ▶ As preliminary data, the study results indicate that there may be potential benefits of having Namaste Care as an established hospital service. However, a more in-depth, reliable and robust understanding into the benefits of Namaste Care as a hospital programme needs to be ascertained. Namaste Care (a complex intervention) could be explored within mixed-methods research (including a randomised clinical trial) to provide high-quality data in relation to the implications for implementing Namaste Care as a hospital service. A variety of research techniques, for example, both quantitative and qualitative, should be used in order to ensure research rigour and reliability (Medical Research Council, 2013).
- ▶ Although it has been found that extra staff and financial resources are not required to implement the programme within care homes (Stacpoole and Thompsell, 2015), whether this is also true of the acute hospital setting needs to be investigated.

### LIMITATIONS

This exploratory study has a number of methodological limitations:

- ▶ This study used purposive sampling, that is, staff working on one dementia unit in one acute hospital where Namaste Care had been introduced. This was because the information required could only be acquired from a specific clinical area in which the care programme had been implemented. Inclusion within this study was open to all members of the multidisciplinary team working on the unit to allow as much variation as possible within the results.
- ▶ Qualitative research has the potential to result in researcher bias. To combat this, it was important to appreciate the concept of reflexivity, which understands the researcher's place in the research (Symon and Cassell, 2012). As a healthcare worker, the first author had experience of the positive effects of Namaste Care in care homes and hospices. Therefore, it was important

for her to recognise her role as a researcher and not a clinician, keeping any pre-conceptions separate from the data gathered. However, unintentionally, this may have affected the way the data were analysed.

- ▶ The sample was small, with only eight members of staff agreeing to participate in the study. It is possible that the eight participants were those with a genuine interest in the Namaste Care programme and that those who chose not to participate were more ambivalent about the programme or found it unsatisfactory. Therefore, the findings may not be representative of all members of staff with experience of the Namaste Care programme in the hospital's Health and Ageing Unit (Patel *et al*, 2003).
- ▶ The study explored the potential benefits of the Namaste Care programme and not whether staff had any issues or discrepancies with the service. This may have restricted participants in that they were only directly asked to discuss how they felt this service had helped them and not if it, in any way, disturbed their usual work. In addition, the study did not address the depth and scale of improvement felt by the participants. For example, it is not known if the effects were seen only within the Namaste Care session or if the benefits lasted over a longer period.

### CONCLUSION

The services provided in acute hospitals for people with dementia have been found to require improvement, including services that cater for the spiritual needs of people with advanced dementia. In addition, hospital staff consider that they lack training in how best to care for people with dementia, including communication strategies and the management of behavioural symptoms. Namaste Care has been successfully implemented in care homes in varying locations all over the world but never in an acute hospital setting. The programme was well received by the study participants, who felt that Namaste Care served as a tool in providing effective communication with patients with advanced dementia, which helped them to connect with the person through the activities used within the programme. It was also considered to improve well-being and reduce agitation, with patients appearing more calm and relaxed afterwards. Therefore, Namaste Care appeared to provide some answers to the challenges faced by healthcare workers caring for people with advanced dementia. The results of this small-scale research indicate that the programme may be an appropriate service to implement within acute hospitals and has the potential to benefit people with more advanced dementia being cared for in acute hospital settings and the staff who care for them.

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# Acceptability of Namaste Care for patients with advanced dementia being cared for in an acute hospital setting

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