

Person-centred oral hydration care for older people with dementia admitted to acute hospital wards: Empirical research qualitative

Shanlee Higgins PhD, RMN, Senior Lecturer¹   | Lesley Baillie PhD, RN, Professor¹   | Calvin Moorley PhD, RN, Professor¹   | Fiona Nolan PhD, RMN, Clinical Professor²  

¹Institute of Health and Social Care, School of Nursing and Midwifery, London South Bank University, London, UK

²Faculty of Health, Education, Medicine & Social Care, School of Nursing and Midwifery, Anglia Ruskin University, Chelmsford, UK

Correspondence

Shanlee Higgins, Institute of Health and Social Care, School of Nursing and Midwifery, London South Bank University, London, UK.

Email: shanlee.higgins@aru.ac.uk

Present address

Shanlee Higgins, Faculty of Health, Education, Medicine & Social Care, School of Nursing and Midwifery, Anglia Ruskin University, Cambridge, UK

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Abstract

Aims and Objectives: To conduct an in-depth exploration of oral hydration care provided to people living with dementia in acute hospital wards, using a person-centred care framework.

Background: Oral hydration care is an important, yet rarely explored aspect of fundamental care for people with dementia admitted to acute hospitals. Using person-centred care as a conceptual framework we investigated how oral hydration care is delivered for people living with dementia in acute hospital wards.

Design: A qualitative, multiple-case study. The cases were three acute wards in one hospital.

Methods: Direct observation of care for 13 people with dementia (132h), semistructured interviews with ward staff ($n=28$), ward leaders ($n=4$), organisational leaders ($n=5$), people with dementia ($n=6$), their relatives ($n=5$), documentary analysis of clinical inpatient records ($n=26$) and relevant hospital policies. Data were analysed using framework analysis.

Results: Four themes were identified: (1) The acute hospital: oral hydration is obscured and not prioritised (2) Overshadowing of oral hydration at ward level (3) Siloed nature of hydration roles (4) Strategies for, and barriers to, delivering person-centred oral hydration care.

Conclusions: This study combines the concept of person-centred care and oral hydration care for people living with dementia admitted to acute hospital wards, demonstrating that person-centred hydration care was complex and not prioritised.

Relevance to Clinical Practice: Nurses should consider means of improving prioritisation and cohesive delivery of person-centred hydration care in acute hospital wards.

KEYWORDS

case study, dementia, fundamental care, hospital, older people, oral hydration, person-centred care, qualitative

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1 | INTRODUCTION

Improving the care people with dementia receive when admitted to acute hospitals is of international importance. Despite people with dementia accounting for high numbers of hospital admissions, hospital staff express ongoing difficulty meeting the physical, social and psychological needs of this group (Gwernan-Jones et al., 2020). Once admitted to an acute hospital, people with dementia can experience negative biopsychosocial consequences. Person-centred care (PCC), (a biopsychosocial approach), is regarded as the optimal approach to dementia care. International evidence suggests that person-centred dementia care is not consistently achieved within acute hospital settings (Brossard Saxell et al., 2019; Gwernan-Jones et al., 2020).

People with dementia often require support with fundamental physical care; for example, help with eating, drinking, washing or dressing. Within the PCC literature, physical care in acute hospitals can be regarded concurrently as task-orientated which is potentially damaging to PCC, as an aspect of care potentially forfeited due to a focus on safety, and also as an area of care that can be complemented by interactions, aligning physical and PCC (Brossard Saxell et al., 2019; Gwernan-Jones et al., 2020). The evidence often presents physical care as an all-encompassing term; however, there are a variety of physical care needs with which a person with dementia may require support. Understanding the delivery of different aspects of physical care for people with dementia in the hospital setting could provide information to improve their experience of care. This study uses the concept of PCC to provide an in-depth exploration of a specific, underexplored aspect of physical care, that is hydration care, for people with dementia admitted to acute hospital wards, and to offer evidence about the barriers and strategies when providing this care within acute ward settings.

2 | BACKGROUND

Dementia is an umbrella term for a set of cognitive and behavioural symptoms that over 55 million people are living with worldwide (World Health Organisation, 2021). There has been a sharp increase in emergency admissions for older people living with dementia, who already made up a large part of hospital users (Alzheimer's Society, 2020). Hospital admission can be damaging to the psychological and physical well-being of people with dementia (Digby et al., 2018). People with dementia in the United Kingdom (UK), their relatives and professionals, have stated they would value research that improves hospital care, and strategies to support eating and drinking (Alzheimer's Society, 2013). To date, there are few studies that have explored the delivery of everyday hydration care (which we categorise as hydration excluding nutritional supplements, thickened fluids or artificial hydration) for people with dementia in acute hospital wards. Due to cognitive impairment, people living with dementia may forget to eat or drink or require support from others with this activity, so improving this fundamental of care could improve their experience of hospital admissions.

What does this paper contribute to the wider global clinical community?

- There is an inextricable link between person-centred care and hydration care when people with dementia are admitted to acute hospital wards
- Person-centred hydration care for people with dementia may be doubly disadvantaged within acute hospital settings, as both person-centred dementia care, and hydration care can be obscured at organisational level
- Communication, action, resources and physical and social environmental adaptations can be barriers or facilitators in providing person-centred hydration care in acute hospital wards

Hydration is a fundamental of nursing care globally, as it is physiologically vital for life (Keller & Marieb, 2021). Fundamentals of care may be discussed by nurses as 'basic' or 'common sense' (Feo et al., 2019). Internationally, nursing scholars increasingly recognise that the fundamentals of care, are reliant on interactions, are complex and under-researched (Feo et al., 2019). Hydration for older adults requires special consideration, as physiological factors increase their susceptibility to dehydration. Dehydration causes an increased risk of morbidity or mortality from factors such as urinary tract infections, constipation, heat stress, delirium, bradyarrhythmia and transient ischaemic attacks (Edmonds et al., 2021). Older adults with a diagnosis of dementia have additional factors related to their cognitive impairment which results in them having an increased risk of low fluid intake, as they may forget to drink or depend on others for support (Herke et al., 2018).

Despite people with dementia experiencing challenges with maintaining adequate hydration, there is a dearth of evidence about behavioural or environmental interventions to increase their intake and most hydration research has been undertaken in care or nursing home settings (Herke et al., 2018). Studies that have investigated everyday hydration for older people in hospitals identified they had a low fluid intake but had not focussed specifically on the care of people with dementia (Gaff et al., 2015; Godfrey et al., 2012). Through observations and interviews, Godfrey et al. (2012) found that hydration care within hospitals does not always provide for the individual needs of the person; reasons included poor choice and drink rounds conducted with regimented routines and a lack of social interaction. The importance of considering an individual's hydration needs and wishes aligned with Cook et al.'s (2019) literature review of hydration interventions for older people in nursing and care homes, which identified hydration interventions are complex and require multi-component interventions and person-centred approaches. Although there is limited evidence about how hydration care for older people with dementia is managed in the hospital setting, evidence suggests hospital staff are having challenges delivering PCC, so understanding how oral hydration care is delivered in the hospital setting is a topic of importance.

2.1 | Person-centred care

Person-centred care (PCC) is recognised internationally as essential for delivering the optimal biopsychosocial dementia care in health-care settings (Gwernan-Jones et al., 2020). Kitwood's (1997) seminal work on personhood, malignant social psychology and positive person work within dementia care has influenced the development of frameworks for PCC. The VIPS (valuing people, individual lives, personal perspectives and social environment) framework for PCC for people with dementia (Brooker & Latham, 2016, p. 19) is recommended in UK guidelines (National Institute for Health and Care Excellence, 2018) and formed a conceptual framework for this research. The study drew on the Triangle of Care model for dementia (Carers Trust, 2016), which represents the relationships between professionals (staff), carers (relatives) and the person with dementia, in care delivery. Currently, there is no cure for dementia, so providing optimal biopsychosocial care, which improves quality of life, physical health and psychosocial well-being for people living with dementia, is essential (Livingston et al., 2017). Evidence suggests hospital staff have difficulty providing the physical and relational care required to deliver PCC in the acute setting, contributing to negative experiences for people with dementia in hospital (Røsvik & Rokstad, 2020). Although PCC and fundamental hydration care are international nursing issues, there is a gap in aligning these concepts for the investigation of oral hydration care for people with dementia in acute hospitals.

3 | THE STUDY

3.1 | Aims and objective

To conduct an in-depth exploration of oral hydration care provided to people living with dementia in acute hospital wards, using a PCC framework.

3.2 | Research questions

1. How do the hospital setting, individual wards and staff roles affect person-centred oral hydration care for older people living with dementia?
2. What strategies can be used to facilitate person-centred oral hydration care for older people living with dementia in hospital wards?

4 | METHODOLOGY

4.1 | Design

The research questions concerned a real-world issue, within a clinical environment, with an intention to explore practice, guided by a conceptual framework. This contributes to bridging the

theory-practice gap and situates this research within the paradigm of pragmatism (Mayumi & Ota, 2022). Yin's (2014) case study methodology was adopted. (Yin, 2014, p. 17) argues that case study is 'all-encompassing' and flexible for use with different research paradigms. Nurse researchers have asserted that case study methodology can act as a bridge across research paradigms and is a process for using the methods which best investigate the research topic (Luck et al., 2006). Thus case study can be philosophically pragmatic (Creswell, 2013, p. 29; Brogan et al., 2019).

Yin (2014, p. 2) states case study is used to: 'investigate a contemporary phenomenon (the 'case') in depth and within its real-world context, especially when the boundaries between phenomenon and context may not be clearly evident.' Case study does not seek to control variables, but aims to gain an understanding, from various perspectives, using multiple methods and sources of data to examine relationships and processes (Thomas, 2016). There are several case study designs, but this study utilised a multiple case study design with embedded units of analysis, which were the older people with dementia admitted to the wards. Figure 1 illustrates the multiple cases (acute wards) within the context (hospital) and the units of analysis (individual patients), which were investigated to contribute to an in-depth understanding of oral hydration care delivery in this setting.

4.2 | Conceptual framework

The overt concept of PCC, as defined by the VIPS framework (Brooker & Latham, 2016) contributed to the development of research questions, and the study design including data collection methods and tools, and data analysis. We argue that PCC is in keeping with a biopsychosocial approach to care and cannot be achieved without consideration for the physical health needs of a person with dementia. The hospital and staff have a responsibility to provide hydration care and PCC, which involve interactions between the staff, the person with dementia and their relatives. Therefore, all these perspectives should be included in understanding hydration care within hospital wards. This conceptual framework warranted supported the investigation of this phenomenon using a qualitative case study, with data collected through observation, interviews and documents, to gain an in-depth understanding of interactions and hospital organisation, ward and staff approaches. The lead researcher formulated the conceptual framework, drawing on a literature review and their extensive clinical experience with people with dementia in varied environments, including hospital settings.

4.3 | Participants

Following the Triangle of Care model (Carers Trust, 2016), the study included staff, people living with dementia and their relatives. Participants were first approached by ward staff and asked if they were interested in speaking to a researcher. If they agreed, they

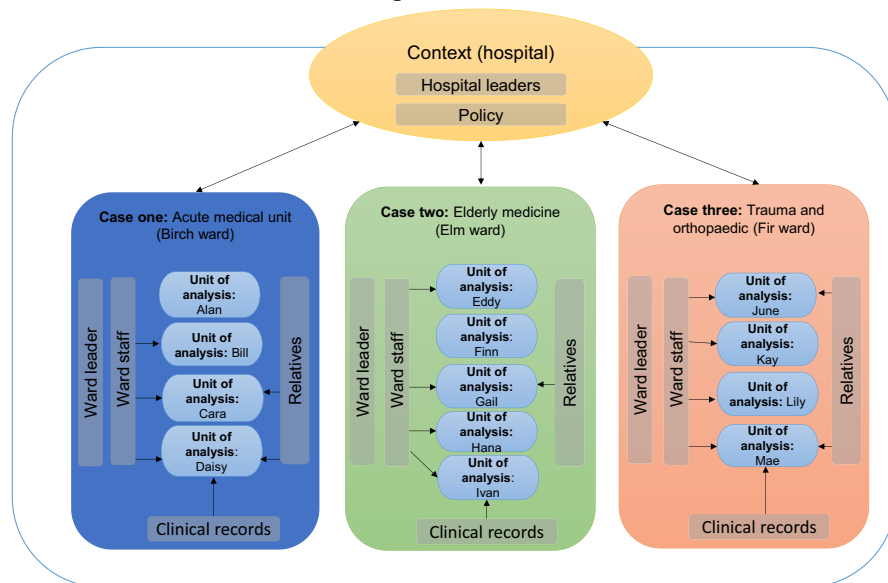


FIGURE 1 Multiple case study design with units of analysis, and data collection*
*all names used are pseudonyms.

were given information sheets explaining the study and aims; ethical considerations are discussed further in section 4.9. They were advised that the researcher was conducting doctoral research under academic supervision. Table 1 displays the participants approached and recruited, the sampling methods and inclusion and exclusion criteria. Demographic details of the older people living with dementia were as follows: aged 70–92 years; five males and eight females; nine were White British, one was Black Caribbean, one was Irish and two identified as any other ethnicity.

4.4 | Setting

The setting was one site of a multisite, inner-city, teaching hospital in England that provides acute care. Acute care can include trauma, emergency, urgent, critical, short-term stabilisation and prehospital care. The hospital had been rated good in national inspections provided by the Care Quality Commission (2022) and could therefore be expected to demonstrate effective person-centred and fundamental care. Three acute wards formed the cases, chosen for this study because they had many admissions of people living with dementia but different care focuses. The pseudonyms assigned to the selected wards are Birch (acute medicine), Elm (elderly medicine) and Fir (trauma and orthopaedics).

4.5 | Data sources/collection

Data were collected by the lead author (SH), a mental health nurse and doctoral student. Organisational level (contextual) and ward-level data were collected concurrently, between January 2018 and August 2018 using observation, interviews and documentary analysis. Figure 2 shows the data collected, and how these interrelated. Interviews were audio-recorded, excluding those with people living with dementia. See Appendix S1 for data extraction tools and interview guides. Prior to

the study commencing the lead researcher introduced herself to ward staff by attending handovers and through an introductory email, which was sent to all staff members by the ward leaders.

4.6 | Component one: Organisational level

Senior staff were approached by email and provided with information sheets, before providing consent. Five individual semi-structured interviews were conducted in a private office or quiet space. These interviews lasting 23–41 min were conducted with staff who held organisational senior positions within the hospital and had oversight into dementia or hydration care. The topic guides were developed based on the research aims and the VIPS definition of PCC (Brooker & Latham, 2016). Additionally, staff were asked to provide policies relevant to hydration or dementia care for documentary analysis.

4.7 | Component two: Ward level

Ward leaders were approached by email and provided with information sheets before providing consent. Ward leaders were interviewed about hydration and dementia care within their wards. Interviews lasted 10–29 min and were conducted in an office or quiet area on the ward. Collection of the in-depth data for each older person with dementia comprised observation of their care, interviews with the person with dementia and their relative (if consented), documentary analysis of their clinical records, and interviews with the staff observed providing their care (if consented).

4.7.1 | Direct observations

Direct observations were completed by the first author, who took the role of observer as participant (Gold, 1958). The researcher undertook

TABLE 1 Participants: approach, sample size, method, inclusion and exclusion criteria.

Participants	Approach method	Participants approached (n=)	Participants consented (=)	Sampling method	Inclusion	Exclusion
Senior staff (Hospital wide)	Email	n=5	n=5	Purposive sampling and snowballing	In a senior and/or leadership position of any professional background, with an expert understanding of key policies, documents and/ or strategies for ensuring quality dementia or hydration care in the hospital	Their role does not have visibility or influence over the wider structure and processes of the hospital
Ward leaders	Email	n=5	n=4	Purposive sampling	In a leadership role of any healthcare professional background, with an expert understanding of the key policies, documents and strategies for ensuring quality dementia care in their ward Likely to be band 7 or above	They are not in a leadership position on the ward
Older people living with dementia (patients)	Initial contact from ward staff, if they agreed to talk to researcher (and had capacity) researcher approached. If they lacked capacity the consultee process was used	n=21	n=13	Purposive sampling	Aged 65-years or older Have a diagnosis of dementia confirmed, or are being nursed by the ward considering that they have a diagnosis of dementia	Have identified dysphagia requiring thickened fluids Require artificial hydration and are not receiving any oral fluid intake alongside this
Ward Staff (Multidisciplinary: nurses, student nurses, HCAs, hosts, doctors, therapists)	Posters displayed and email Face to face at time of observation	n=37	n=28	Purposive sampling	Are an inpatient on the elderly care ward, the acute medical unit or the trauma orthopaedic ward Working on a ward recruited into the study, either as permanent, bank or agency member of staff From any registered or nonregistered healthcare staff group including clinical and catering staff Working directly in any role, for at least one shift, with the patient who is recruited to the study	Are not an inpatient on one of the three wards identified Are under the age of 65 years They have not worked directly with one of the patients recruited into the study

(Continues)

TABLE 1 (Continued)

Participants	Approach method	Participants approached (n=)	Participants consented (=)	Sampling method	Inclusion	Exclusion
Relatives	Initial contact from ward staff by telephone or in person. If agreed, the researcher approached by phone or in person	n=8	n=5	Purposive sampling	Relative or close friend of a patient recruited into the study	Unable to take part in an interview face to face or by telephone
					Has insight into the patient's usual functioning or preferences	Does not speak English

familiarisation visits within the wards, so staff and patients became familiar with her; they were aware that she worked as a nurse in a different area. Each observation episode lasted 4h, between one of these timeframes: 8am–12pm, 12pm–4pm or 4pm–8pm. The aim was to reach a full 8am–8pm period for each older person, covering the nursing day shift. This was not always possible due to patient discharge or transfer. In total, 132h of observation were completed of the 13 older people. A data extraction document was developed to use during the observations, which allowed for unstructured field notes about oral hydration activities, the time and length of interactions, and who was involved.

4.7.2 | Interviews

Interview topic guides were informed by the VIPS framework. Semi-structured interviews were conducted with multidisciplinary staff caring for each older person observed. Ward staff were made aware of the research by poster and email, and were then approached directly during an observation episode and provided with further information leaflets, before consent was obtained. These interviews were brief, as participants were working, and focused on the staffs' views of the needs of the older person observed and specific dementia or oral hydration care provided. Interviews were conducted in a quiet area on the ward with 28 staff and lasted between 4 and 14min. All were audio-recorded except three, where staff preferred notes to be taken; these were written up in detail immediately afterwards and checked for accuracy with the participant.

Interviews with older people with dementia and their relatives explored their views and experiences of hydration care in the hospital as well as their routine, needs and preferences before hospital admission. To address the potential differences in cognitive abilities of older people interviewed, a topic guide was created for the person living with dementia to read, which included using large font and symbols. All interviews followed safe and inclusive research practices for people with dementia (Novek & Wilkinson, 2019), which took on a conversational style and lasted approximately 15min. They were conducted in the person's preferred environment, which was at the bedside for all participants. To reduce anxiety, these interviews were not audio-recorded; notes were taken and typed up when the interview ended.

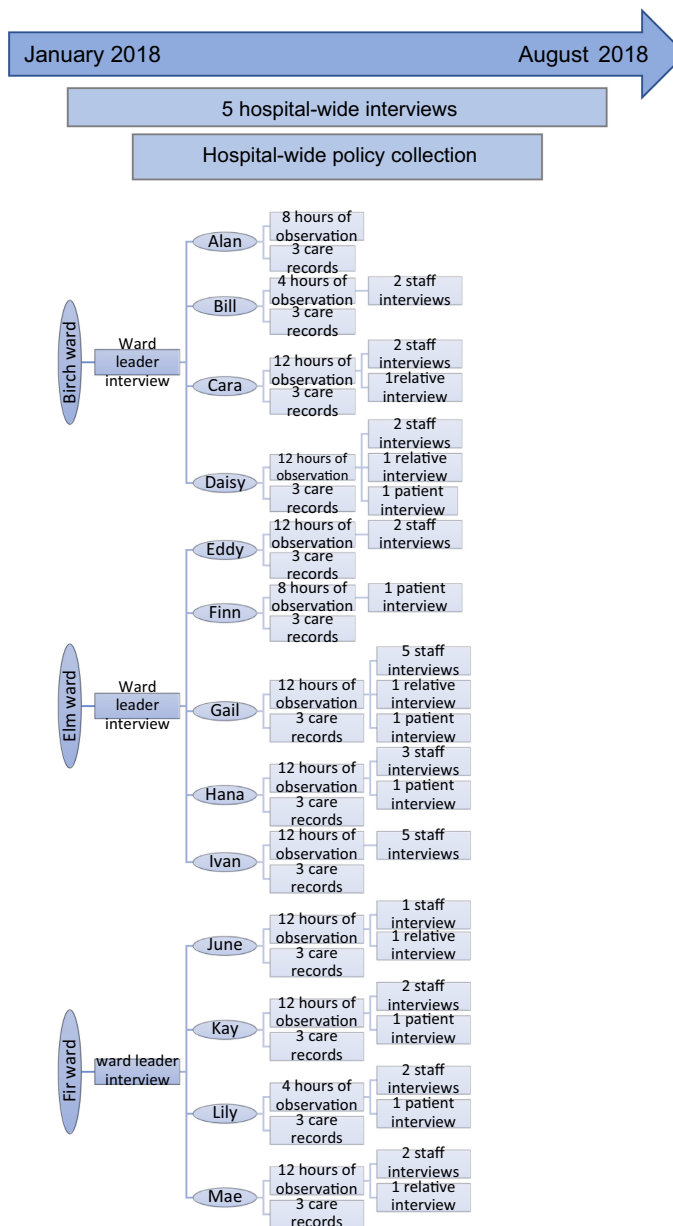
4.7.3 | Documentation

Clinical records are an important aspect of facilitated communication about assessment and care plans amongst the multidisciplinary team working in hospitals. Two data extraction tools were developed to extract information relevant to hydration care from the nursing records and the multidisciplinary clinical records.

4.8 | Data analysis

Data were analysed using Ritchie and Spencer's (1994) framework analysis, commencing with familiarisation with the data set. The

FIGURE 2 Cases, data collection and timeline (NB Figure includes pseudonyms adopted for the cases and units of analysis).



interview transcripts, field notes and clinical documentation were entered into a computer-aided qualitative data analysis software (NVivo 12) and coded using a priori codes taken from the VIPS framework, and the new inductive codes identified. A thematic framework was then developed, through grouping and refinement of the codes, and was then applied to the data set. The 'framework matrix' function on NVivo 12 was used to present the thematic framework, with categories and codes along one axis and the source of the data along the other axis, enabling comparison across and within cases and data sources. Finally, interpretation involved extracting the matrix findings into themes; a typology of staff hydration roles was also developed.

4.9 | Ethical considerations

Ethical approval was gained by the university research ethics panel, and the Health Research Authority Research Ethics Committee

(London Harrow REC reference: 17/LO/1335), which specialised in assessing research involving participants who may lack capacity to consent to research. Research should not exclude people living with dementia, therefore care was taken that people with different levels of capacity to consent could participate, with adherence to Section 32 of the UK legislation, The Mental Capacity Act (2005). Ward staff provided guidance on the mental capacity of older people with dementia who met the study inclusion and exclusion criteria; their capacity to consent to participate was then checked during a formal consent process by the lead researcher. For those who lacked capacity, their next of kin was approached as a consultee, to ascertain if the older person would wish to participate; if so, they were included for observation and if able, an interview. If they expressed any indication that they dissented from the interview this was terminated. Information sheets for all participants and consultees were provided; those who could give informed consent signed written consent forms. Protocols were agreed upon beforehand for how to

raise any incidents observed should any participants be at risk of immediate harm. To report the results, pseudonyms have been used to maintain confidentiality.

4.10 | Rigour

Method triangulation was adopted by using multiple sources of data and data collection methods. The framework analysis assisted with triangulation, as the results from multiple sources of data were viewed on the chart to clearly see data which were complementary or divergent, further contextualising oral hydration care for older people with dementia during hospitalisation. Reflexivity, defined as critical self-reflection (Moorley & Cathala, 2019), was facilitated through a reflexive diary that was kept by the lead author throughout the research process. Additionally, regular discussions took place between the research team who, other than the lead author, were all experienced nurse educators, educated to doctoral level with postdoctoral research experience. Discussions reflected on progress, events and findings and contributed to rigour. Consolidated criteria for reporting qualitative research (COREQ) (Tong et al., 2007) was used for preparing this manuscript. A COREQ checklist, with comments made for each item, explaining if this item is included in the manuscript, tables, figures or in supplementary material, has also been submitted (Appendix S1).

5 | FINDINGS

The results are reported through themes relating to the research questions, drawing on the integrated data sets. Four themes were identified from the multiple data sources: (1) The acute hospital: oral hydration is obscured and not prioritised (2) Overshadowing of oral hydration at ward level (3) Siloed nature of hydration roles (4) Strategies for, and barriers to, delivering person-centred oral hydration care. Pseudonymised participant quotes, observational field notes and data from the clinical documentation are used to illustrate these themes.

5.1 | The acute hospital: Oral hydration is obscured and not prioritised

External factors, including national initiatives, campaigns, quality metrics, audits or financial incentives, appeared to drive hospital-wide priorities and strategy. Lacking a national profile, oral hydration was obscured and not high on the organisational agenda:

... we've never had so much of a push on making sure your patients - and staff - are hydrated. I mean the national initiatives, national campaigns, they're what the organisations really grab [...] but I can't think that we've ever had [a campaign about hydration]

(Hospital Wide Staff4, interview)

Participants perceived that developing a hospital-wide group and strategy focusing on an area of care was requisite to strategy development and implementation at local-level. While a nutrition and hydration policy did exist, the focus was on nutrition and mealtimes, which further obscured oral hydration.

5.2 | Overshadowing of oral hydration care at ward level

Hydration care was similar across the three wards. At ward level, oral hydration was overshadowed by other care aspects, and was outsourced and routinised, rather than person-centred. Staff focused on physical healthcare tasks, yet hydration, a fundamental aspect of physical healthcare, was overlooked. Staff perspectives on hydration and environmental barriers to healthcare further reduced staff involvement.

5.2.1 | Other aspects of care are valued more than hydration

Most staff-patient interactions related to physical care, and hydration was less evident than other aspects of physical care:

I am 1:1 with Cara because of the risk of pressure sores, she needs two-hourly turns and help with feeding, It is also my duty to help observe the clinical care like the blood pressure, recording the BM sugars [blood glucose level] and generally making sure she's comfortable in bed

(Healthcare assistant, Cara, Birch, interview.)

The ward priorities aligned with organisational priorities, which were monitored through quality metrics, such as skin integrity and falls prevention, and did not explicitly include oral hydration.

5.2.2 | Oral hydration is outsourced and routinised

Drinks were provided during routinised trolley rounds by 'hosts,' who were employed by a catering company, subcontracted to provide food and drink. This outsourcing separated hydration care from the role of hospital healthcare staff. Hosts did not deviate from the drinks routine, even when requested:

13.40: The host arrives in the bay and says, 'tea, coffee?' and leaves, the healthcare assistant asks the host to ask Mae again on her way back as she might want one then.

[Once the host leaves the bay they do not return. Mae does not get offered another hot drink]

(Mae, Fir, Observation3, fieldnotes.)

Healthcare staff mainly waited for drinks rounds rather than facilitate drinks outside this routine:

June's relative asks the healthcare assistant if there is any tea. The healthcare assistant replies, 'later.' June's relative says to June: 'When the tea comes, you can have one.'

(June, Fir, Observation1, fieldnotes.)

5.2.3 | Physical barriers at ward level

The kitchen was the domain of the private catering company that employed the hosts:

before, ward sisters could get into their own kitchen, they could make a nice hot chocolate, put loads of milk in for the calories but it's just all gone by the way-side because of all the issues and it's a private firm, and it's wrong on so many levels

(Ward leader, Elm, interview.)

On all wards there was a designated area where staff and patients could access drinks independently, but difficulties included inadequate stock and equipment, or being permanently locked. This affected the confidence of people who wished to be independent with making drinks:

Since I was ill, I don't know if I will still be able to make drinks at home on my own.

(Hana, Elm, interview.)

On the few occasions when staff attempted to make drinks outside routinised drinks rounds, they encountered obstacles, for example no teabags being available (Alan, Observation1, Birch, fieldnotes).

5.2.4 | Attitudes towards hydration

Rather than discussing hydration from a person-centred, health-promoting perspective, staff participants' focus was on avoiding dehydration or delirium, thus viewing hydration through a harm reduction perspective:

I always encourage her to drink because it's very good for them to avoid dehydration, if they are dehydrated, they will be agitated

(Healthcare assistant1, June, Fir, Interview.)

Relatives were more likely to view hydration through a well-being lens and often expressed concern that their relative did not

drink enough, which was sometimes connected to continence concerns:

The dietician says she needs to be drinking two litres a day. So, we're off that target, it's just a fight, a real struggle to get her to drink, one of her reasons is: 'oh, it's going to make me pee all day.'

(Relative, Cara, Birch, interview.)

5.3 | The siloed nature of hydration roles

A ward leader expressed that hydration was 'everyone's role'

Anybody going past can offer a drink, it's not a nursing job, and trying to get that mindset, is important, it's everybody's job.

(Ward leader, Elm, interview.)

However, from observation, staff groups had distinct hydration roles (see [Table 2](#), typology), which were siloed and created a gap in effective oral hydration. Amongst the staff roles, there were variable skills and knowledge of hydration and dementia. There was no expectation for hosts to have any healthcare or dementia training. Nurses noted the differences between their knowledge and skills with other staff:

... I think sometimes if HCAs [healthcare assistants] were maybe more aware of the importance of hydration that might encourage them to kind of work alongside us a little bit more in sort of helping patients with their drinking.

(Staff Nurse, Bill, Birch, interview.)

5.4 | Strategies for, and barriers to, delivering person-centred oral hydration care

The strategies and barriers were communication, direct actions, resources and environmental aspects. These needed to involve the triangle of care, between staff, older people living with dementia and their relatives.

5.4.1 | Communication between staff, older people living with dementia and relatives

Successful communication strategies involved verbal and non-verbal communication, including allowing time, making eye contact, smiling, orientation, speaking directly to the person and getting to their eye level, often combined with actions to support

TABLE 2 A typology of ward staff roles and how they relate to hydration care for older people living with dementia.

Job role	Explanation
Hosts: 'They do not have any responsibility'	Task-orientated; carry out drinks rounds, which were often completed with minimal interaction and minimal choice, in a reductive way
Nurses: 'I need to give you tablets'	Nurses acknowledged their duty and responsibility extended beyond other staff and that they had specific clinical knowledge about hydration. Most hydration care occurred during medication rounds, with medication as the primary aim and hydration a way to facilitate this
Healthcare assistants: 'The front line'	Healthcare assistants described their significance as they spent the most time with patients. They gained knowledge about the person in the moment. They may prompt a person to drink what is within reach, more commonly at mealtimes, but rarely source or deliver drinks. They may not have had formal education about hydration
Doctors: hidden role, minimise risk	Doctors described awareness of the acute risks of dehydration. Interaction with patients was minimal. Occasionally, they documented about hydration in the multidisciplinary team care records; this occurred more often in the elderly medicine ward
Physical and occupational therapists: guided by 'The aim of the session'	Physical and occupational therapists were aware of complications associated with low fluid intake, but this did not often lead to direct care. They may have been unclear about how to record the intervention correctly, or feel their role was to advise nurses rather than directly provide care. Interaction with patients was during the therapy intervention. Hydration was a mechanism to deliver or assess other aspects of care, not the primary goal
Dieticians: 'Refer to'	Nursing staff spoke about referring to dietitians if they identified concerns about malnutrition or low food or fluid intake. Dieticians documented in the multidisciplinary team records. Documentation focussed on nutrition; hydration guidance was linked to food, that is, 'food and fluid intake.' Only one dietician entry provided a calculation of the oral fluid the person should receive. No dieticians visited during any observation periods
Student nurses: frontline learning	Student nurses took a similar role to healthcare assistants, they sometimes prompted drinks which were already present, but did not deliver or offer other drinks
Volunteers	The hospital leaders valued the role of volunteers to support hydration care. There was only one occasion where a volunteer was observed assisting a patient, and this was during a mealtime
Relatives	Relatives had knowledge about their relative's hydration needs and preferences. Healthcare staff expected relatives to bring in the person's drinks preferences if they were unavailable on the ward, which they often did. Relatives did not always feel staff asked about or shared relevant information with them about their relative's hydration
Older people living with dementia	Older people living with dementia had a passive role, hydration care was something done around them or to them, by others. An active role was not often encouraged or promoted, although, if asked, most could provide their preferences and hydration requests

hydration. Staff identified several verbal communication strategies for hydration care, though these were not always observed in practice: verbal encouragement, reminding the person to drink and prompting them:

Just trying to encourage and prompt them and probably, physically bring it down and talking them into giving it a go.

(Healthcare assistant, Bill, Birch, interview.)

However, care interactions were mainly short or task-focused and, in addition, individuals often had impairments which affected communication. Hosts usually walked into a ward bay and said: 'tea, coffee' aloud, without addressing any individual and without associated non-verbal communication. Healthcare staff expressed their frustration:

if someone's asleep or not answering they [hosts] just like, go away, they don't try to wake up or encourage [them], like, 'Would you like something?' they

just leave the patient without anything. There was another [patient] she has problems with her hearing, there was a [host] just like shouting, 'tea, coffee' and [the host] just went away because there was no answer.

(Nurse, Cara, Birch, interview.)

Staff communications were verbal or through multidisciplinary or nursing documentation. Fluid balance charts were not consistently or accurately completed, as acknowledged by nurses, who were often focused on other care aspects:

We have fluid balance charts but a lot of the time they're not filled in accurately especially if you've got a patient like how [Mae...] was today, [...] she can probably go like two hours without having a drink and we haven't noticed because we've been so distracted.

(Nurse, Mae, Fir, interview.)

The language used for documenting oral fluid intake by nurses was limited, for example, 'eating and drinking' or with vague descriptions such as: 'normal amounts' 'encouraged as able' 'tolerated' or 'maintained.' While hosts provided most drinks, they did not document drinks offered or accepted. Healthcare assistants, who spent most time with individuals, did not write in the notes either:

The nurses write all of the notes. So, the nursing assistants often they're the ones that know more about the patient. How much they've drunk, how many times have they tried to help that person, the nursing assistants know that more than anybody, but I don't feel like they're empowered to write down.

(Ward leader, Birch, interview.)

Verbal handovers were used for communication across the nursing team, although they did not result in more targeted hydration care:

8.21am: Amongst other information the nurse hands over to, 'encourage fluid intake'.

(Hana, Elm, Observation1, fieldnotes)

Shortly after, the nurse was observed to be present while the host offered breakfast to Hana, who declined a hot drink; no further encouragement or choices were offered by either staff member (Hana, Observation1, Elm, fieldnotes.)

Staff could write information about a person in the space above the bed, for other staff or relatives but this seldom included information about oral hydration. A symbol was used to communicate a dementia diagnosis, but staff rarely mentioned this when discussing oral hydration for older people living with dementia. As an exception, one host, who had attended a dementia training session, said:

When I do the tea round and I see the flower sign by the bed that means that the patient's got dementia.

(Host, Ivan, Elm, interview.)

Some relatives were asked about the patient's oral fluid preferences but had not seen these documented; others felt they would like more information:

I don't know how much she's drunk, I could see staff are really busy. But it would be nice to be told that she's had some water.

(Relative, Gail, Elm, interview.)

Contrastingly, staff felt relatives should be more involved, demonstrating gaps in the triangle of care and communication:

Family, when they come into hospital, some of them are still keen to help, but some of them, they won't do

nothing, I think everyone should be involved, not just standing and waiting and they will say like, 'oh, she's thirsty I think' but won't offer the drink you know.

(Nurse, Cara, Birch, interview.)

One relative explained MDT members had collected information specific to their role, but this excluded any information about hydration, even though staff were attempting to improve intake:

In terms of drinks, no, no, but actually perhaps it's a question they should ask [...] hydration didn't come up, which is quite strange really, if you think about it.

(Relative, Cara, Birch, interview.)

5.4.2 | Direct actions to support oral hydration

Direct actions to support oral hydration were often used alongside communication strategies and included: finding out drink preferences, observing responses, monitoring intake, pouring drinks, taking drinks to the person, leaving drinks within reach and placing a drink in the person's hand or holding it to their lips. Nurses, healthcare assistants, hosts and on one occasion an occupational therapist took such actions to deliver hydration care. Like communication, action strategies mostly happened alongside other care tasks or during a meal. However, once a host brought a drink, it was often some time before the individual was offered support to drink:

16.00: Host stands in the bay and says: 'tea, coffee, tea, coffee' Kay says: 'tea please.' The host puts tea on the table. [Kay did not drink the tea but had a 1:1 healthcare assistant with her, who only provided one verbal prompt, 16 minutes after the drink arrived]

(Kay, Fir, Observation3, fieldnotes.)

Successful strategies included combining action and communication through a person-centred approach, often at opportune moments, such as when relatives were present:

14.43: The healthcare assistant crouches to Bill's eye level while talking to him, asking if he would like a drink and gently persuades him to have one. Bill agrees to a coffee, the healthcare assistant asks how he takes it and Bill's relative replies: 'milky, no sugar' the healthcare assistant repeats this and leaves, saying: 'I will get that' and also offers his relatives a drink: 'are you sure you don't want anything?' Once he has provided the drink, the healthcare assistant leaves saying: 'coffee, milky, no sugar' and smiles. Bill is drinking coffee in bed talking with his relatives.

(Bill, Birch, Observation1, fieldnotes.)

People with dementia were observed to consume fluids more readily with relatives present. However, staff did not always take advantage of relatives' presence and offer a drink.

Oral hygiene was recognised as affecting oral hydration:

'You can see people build up poor oral hygiene and can develop coated tongues that then can really put people off eating and drinking, that's another thing that we can proactively do as healthcare professionals to try and avoid that building up.'

(Doctor, Elm, Birch, interview.)

Oral hygiene was rarely seen by the researcher, as care taking place behind the curtain was not observed, for patient privacy reasons.

5.4.3 | Resources for oral hydration

Resources on the wards included documentation to record information about the person with dementia, a system to convey whether a person needed help with eating and drinking, and choices of drink and types of cup. However, in practice, these resources were used inconsistently, and staff were often unaware of them.

There was a documentation system to collect information about a person living with dementia, including their preferences; this could support person-centred hydration, for example:

So, we had no idea that she liked black coffee, with two sugars or with no sugar sometimes until [her relative] came in. So, [Daisy] says, 'I'd like a cup of tea' but what she actually means is black coffee, and we didn't know that. The HCA who was looking after her was able to go through that [document recording preferences] with her next-of-kin.

(Nurse, Daisy, Birch, interview.)

Daisy's document was the only one observed in active use. Some staff and most relatives were unaware of this resource, and how it could contribute to PCC.

Nursing staff identified a 'red jug, red tray' system for promoting food and fluid intake:

So, our policy is if they need assistance with eating and drinking, we use the red jug and the red tray [which] are basically one of the indications that the patient will need assistance with eating and drinking.

(Ward leader, Fir, interview.)

However, there was no consistent use of this system with any participants observed. The beverage choices available, and what was offered, differed in practice:

Coffee, hot chocolate, lots of options for herbal tea, squash [are available]

(Host, Lily, Fir, interview.)

However, on all wards, staff reported only tea or coffee was available, and this lack of choice was observed in practice too and reported by an older person living with dementia:

No one has asked which drinks I like, I was only offered water [or] tea, but I like milk especially at dinner that's what I drink at home, I like yellow and red top milk

(Finn, Elm, interview.)

In addition to limited drink choices, there was only one occasion where a choice of a polystyrene cup, or a plastic mug with handle, was offered:

18.00: The host offers a choice of cups to the relative. Gail's relative asks Gail, but she doesn't answer. Gail's relative chooses: 'Oh yes that one' and points to a mug with a handle.

(Gail, Elm, Observation3, fieldnotes.)

5.4.4 | Environmental aspects (social and physical)

Environmental aspects of hydration care were social and physical. Staff approach to interactions and consideration of the person with dementia's psychological needs and engagement, influenced the social environment for oral hydration. Several relatives spoke about making hydration sociable as a strategy to improve hydration:

It would be helpful if the 1:1 with Mae also had a cup in her hand when Mae has a cup of tea, even if they don't drink from the cup [...] this would mean the 1:1 could say 'let's have a cup of tea' rather than, 'you have a cup of tea' and therefore make it more of an event.

(Relative, Mae, interview)

One nurse was observed using a social rather than a task-focused approach to hydration with a patient displaying agitation:

11.20: The nurse takes Eddy for a walk, talking to him the whole time. The nurse offers him a drink on the walk when they are near the water machine, Eddy accepts.

(Eddy, Birch, Observation1, fieldnotes.)

During the walk the nurse successfully encouraged Eddy to drink; later, at interview, the nurse reflected that occupying Eddy with

walking was a strategy to provide fundamental care. This strategic action demonstrated how hydration care and PCC interrelate. By contrast, when Mae was distressed, she had many interactions with staff, but none related to fluid, the nurse reported hydration was:

Put on the back burner

(Nurse, Fir, Mae, interview.)

Older people living with dementia were observed to spend long stretches of time alone, not engaging in social interactions but drifting in and out of sleep, which meant they often missed drinks rounds.

People living with dementia spent most of the time in or next to the bed, so the physical environment mainly related to this space. Sometimes, the immediate environment was not conducive to eating or drinking, with items such as urine bottles, vomit bowls or other litter present on the bed table. These circumstances demonstrated how the clinical environment could conflict with creating a pleasant environment for oral hydration and at times staff seemed unaware of these items' potential impact on the physical environment. Only two Elm staff suggested ways the environment could be improved, which may indicate most staff do not consider it part of hydration care, or feel they cannot influence the environment:

[A] special environment [with] colour-coded cutlery, [...] And you get much more back from them [...rather] than just like a normal bed in a hospital, if you create a proper environment

(Nurse, Eddy, Birch, interview.)

6 | DISCUSSION

The findings provide novel evidence about oral hydration care for people with dementia in acute wards in hospital, a topic not previously explored in-depth. We found that person-centred hydration care for older people with dementia is complex and rarely conducted successfully in these acute wards. A key explanation may have been that hospital organisational priorities had obscured hydration care, as it was not awarded a high status. This obfuscation cascaded to ward level where hydration care for people with dementia was further obscured by the facilitation of drinks rounds being outsourced to a private company. The segregated roles amongst ward staff were a barrier to successful hydration care, leading to a lack of clarity about whose role hydration care is in acute hospital wards. The strategies and barriers to conducting person-centred hydration care within acute hospitals related to communication, action, resources and environmental aspects (CARE), which are positioned around the triangle of care in [Figure 3](#).

Research about person-centred dementia care in acute wards in hospitals had already identified that organisational objectives impact PCC, often negatively, due to limited staff training or organisational priorities focussed elsewhere (Brossard Saxell et al., 2019). This study expands this knowledge by demonstrating an inextricable link

between oral hydration care and PCC for people with dementia when they are admitted to acute wards in hospital and highlighting that this area of care may be doubly disadvantaged, as both oral hydration and dementia care are overshadowed at an organisational level.

The routinised drink round in hospitals and long-term care settings has previously been identified (Godfrey et al., 2012; Jimoh et al., 2019) but our study is the first to highlight how the outsourcing of drinks rounds to hosts, through a private company, poses barriers to person-centred dementia care in hospital wards. Godfrey et al. (2012) found that, at various times, different staff—healthcare assistants, domestics or volunteers—were responsible for the drinks rounds, which led to inconsistencies for older people. By contrast, we found the drinks round was consistently in the hosts' domain, excluding healthcare staff. Whether it is preferable for hosts (if properly trained) to consistently provide drink delivery, or for a variety of staff to perform this duty at separate times, is unclear, as there is insufficient evidence to compare the two approaches. What is now known, is that the routinised approach to drinks in our study was part of the environmental milieu of the ward and healthcare staff were observed to rely on this routine as the way to provide drinks and were reluctant or unable to facilitate drinks outside this time. Staff remained reluctant even when the people with dementia—rarely—spontaneously requested a drink. The reliance on routine has implications for PCC; Brossard Saxell et al. (2019) found that being able to adjust ward routines was a necessary aspect of delivering PCC. We found that the physical barrier to oral hydration delivery, coupled with the routinised mode of hydration delivery, furthers the existing barriers healthcare staff face to providing person-centred hydration care in hospital settings. While completing personal information documents for people living with dementia can support PCC, including choices and preferences for oral fluids (Baillie & Thomas, 2020), this strategy was rarely used at the study site.

Healthcare staff suggested they focussed more on other aspects of physical care, such as pressure ulcer prevention, rather than hydration care. This aligns with the literature on person-centred dementia care, which indicates care is task-focused and aligned with a risk management approach or organisational priorities (Brossard Saxell et al., 2019; Reilly & Houghton, 2019; Røsvik & Rokstad, 2020). In Godfrey et al.'s (2012) study, a hospital healthcare assistant explained that the facilitation of hydration care via volunteers enabled the healthcare assistant to continue 'looking after' the patients, which they expressed would have been prevented if they had to deliver drinks (p.1204). This reveals a belief that hydration care is separate from other aspects of care and of lesser importance. The previous literature, alongside our findings, raises questions about whether hydration is viewed as an aspect of care related to health, or viewed separately as a service to be provided and disconnected from healthcare in some hospitals and care homes. Given the fundamental role hydration has in maintaining physical health and well-being, the findings pose a new question: How has hydration care in an acute hospital seemingly fallen into this incongruent position for the care of older people living with dementia?

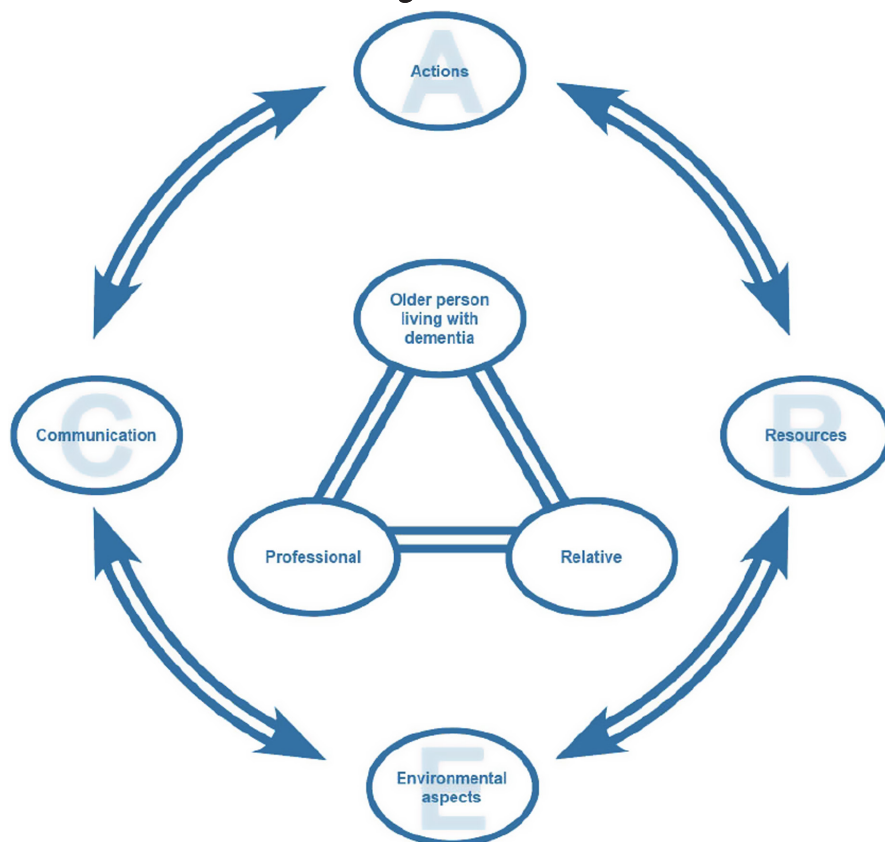


FIGURE 3 A diagram to demonstrate how person-centred hydration care can be facilitated for older people living with dementia in acute hospitals.

Older people in care settings are known to have low fluid intake (Oates & Price, 2017); our study demonstrated that people with dementia in hospital and relatives express insights during interactions about their reduced fluid intake, but these were not always acknowledged by staff. These unheeded insights were compounded by the siloed nature of staff roles and staff reliance on verbal communication, which often ignored non-verbal communication. The perspectives expressed by people with dementia in this study are reflective of previous studies, which found the process of drinking was viewed as a burden by some older people who may be concerned about incontinence (Godfrey et al., 2012).

The task-focused process of drink delivery minimised communication and supports Godfrey et al.'s (2012) findings that social interactions were missed during drink facilitation. Our study highlights the requirement for skilled communication by staff who provide oral hydration care, to enable staff to acknowledge and respond to the individual views expressed by a person with dementia, as these may give insight into their potential individual barriers to oral intake. This study demonstrates that alongside improved communication, within and between the triangle of care, direct actions, resources, and a supportive social and physical environment are all required to support person-centred oral hydration care, or they become barriers to this important aspect of care.

6.1 | Strengths and limitations of the work

The study was carried out in only one hospital, which does limit the findings; however, three acute wards with different care specialisms

were included, improving the range of data collected. Additionally, the use of the internationally recognisable framework of PCC, supports the transferability of the findings, through a framework of reference which is understood by multiple professional disciplines and beyond the hospital, region and country of the study.

This study appears to be the most in-depth exploration undertaken to date of everyday oral hydration care for people with dementia in acute hospital wards. Strengths include a multiple case study approach, which allowed the complexities of oral hydration care for people with dementia to be explored at both contextual and ward level. Multiple data collection methods, contributed to rigour, through data triangulation and the ability to consider the range of influences on oral hydration care within acute hospital wards: the local policies, the clinical documents, observations of care and the views of staff, people living with dementia and their relatives. By recruiting people living with dementia, as individual units of analysis, following Yin's (2018) case study approach, the study yielded a greater understanding of the person-centred oral hydration needs of multiple individuals with dementia.

6.2 | Recommendations for future research

There may be additional staff communication about oral hydration taking place away from people with dementia; future research could capture data from these verbal interactions, from verbal handovers and any relevant multidisciplinary team meetings. Additionally, staff who had less contact with people with dementia during the

observations, such as dieticians, may enhance knowledge about oral hydration care in acute settings and could be included in future research. The findings demonstrated that the specific service model for oral hydration through an outsourced contract to a private company, had implications for hydration care within acute wards in hospital. These findings merit further exploration in future research. It would also be beneficial to explore other aspects of fundamental care within a PCC framework, with a view to implementing interventions for evaluation to improve the biopsychosocial care that people with dementia experience in acute hospital wards.

7 | CONCLUSIONS

This study demonstrates that providing oral hydration—a fundamental aspect of care—in a person-centred way for people with dementia in an acute hospital has multiple organisational, ward-level and individual staff-level challenges. Person-centred oral hydration care for people with dementia in hospital acute wards is a complex activity involving multidisciplinary healthcare and non-healthcare teams. Recognition of these complexities was hidden at an organisational level, which cascaded to ward-level obfuscation. Although there are ways that person-centred oral hydration care can be achieved at an individual staff level, it is likely to require organisational support to implement this consistently. As this support was lacking, person-centred oral hydration care was rarely achieved within the acute hospital wards studied. To improve the biopsychosocial health and well-being of people with dementia, acute hospitals should commit to improving the person-centred delivery of hydration care, through improving communication, direct actions, resources and environmental aspects, within the triangle of care.

8 | RELEVANCE TO CLINICAL PRACTICE

This study presents in-depth evidence about how staff, acute wards and the organisation provided fundamental, everyday hydration care for people with dementia in a clinical setting. The findings demonstrate that while there are a range of barriers, there are also many strategies for improving hydration care for people with dementia in hospitals. Nursing staff with an organisational role could reflect on how hydration care is perceived within their organisation and consider what resources, education and environmental aspects can be improved to support staff who deliver this fundamental care. As the compartmentalisation of ward staff roles can affect fundamental care delivery, nurses should seek solutions to bridge these care gaps within their clinical settings. Ward nurses can apply the strategies of communication, action, utilising available resources, and making social and physical environmental adaptations when facilitating hydration care. This could improve PCC and the biopsychosocial well-being of people with dementia admitted to acute hospital wards.

AUTHOR CONTRIBUTION

Shanlee Higgins was involved in conceptualisation, methodology, formal analysis, investigation, writing original, writing drafts and editing and visualisation. Lesley Baillie was involved in conceptualisation, methodology, writing review and editing. Calvin Moorley was involved in conceptualisation, methodology, formal analysis, writing review and editing. Fiona Nolan was involved in conceptualisation, writing review and editing.

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CONFLICT OF INTEREST STATEMENT

None.

DATA AVAILABILITY STATEMENT

Research data are not shared.

ORCID

Shanlee Higgins  <https://orcid.org/0000-0002-6186-3016>

Calvin Moorley  <https://orcid.org/0000-0002-5969-2465>

TWITTER

Shanlee Higgins  @ShanleeHiggins

Lesley Baillie  baillil2@lsbu.ac.uk

Calvin Moorley  @CalvinMoorley

Fiona Nolan  @fionanolan6

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SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

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