Exploring nurses’ experiences of using hand massage to alleviate anxiety for individuals with dementia in residential settings

Ann Larkin

Supervised by: Dr. Margaret Graham and Dr. Dympna Tuohy

Submitted to the University of Limerick for the award of MSc Research,

November 2017
Abstract

Exploring nurses’ experiences of using hand massage to alleviate anxiety for individuals with dementia in residential settings

Ann Larkin

Patients with dementia living in residential settings may have complex health needs and have reduced capacity to communicate these needs. In such circumstances, attention to presence and touch and more specifically hand massage gains greater significance for their wellbeing. Short periods of calming comforting touch can reduce anxiety. This research explored the experiences of nurses who use hand massage for this purpose in residential settings. A qualitative descriptive approach was employed and data was collected from semi-structured interviews held with eleven nurses working with patients with dementia in five residential care settings.

The findings revealed that hand massage can be effective as an intervention to alleviate anxiety. There was evidence of the benefits for patients with dementia not only as a direct intervention using soothing and rhythmic touch but also in opening doors and creating opportunities for communication between the giver (the nurse) and the recipient (the patient). This research echoes other findings, showing that although people experiencing dementia may lose the capacity to articulate verbally, they retain ability to communicate nonverbally. There was also evidence that the act of giving hand massage benefitted the nurse participants. Engaging in hand massage enhanced their self-awareness and reflection on ways of caring. Being able to “tune in”, be present to the experience of touching hands gave a sense of connection on an emotional and physical level. Participants felt they were caring for patients in meaningful and tangibly beneficial ways. In some instances, hand massage had the effect of calming the collective atmosphere of the room in which the intervention was being given. This sense of atmospheric ease was noted by staff, visitors and families.

Of course, participants experienced challenges in the delivery of hand massage. Integrating hand massage into daily routine activities was met by resistance from some staff. Increased paperwork, audits, safety checks etc. arising from nationally designed standards meant that there was rarely protected time in which participants felt free to stop and offer hand massage. Changes in organisational attitudes and routines are therefore seen as necessary to ensure that the potential benefits of hand massage can be exploited.
Declaration

I declare that the work in this thesis is the work of the candidate alone and has not been submitted to any other University or higher education institution in support of a different award. Citations of secondary works have been fully referenced.

Ann Larkin
Acknowledgements

This research would not have been completed without the support and encouragement of many people. I would like to take the opportunity to acknowledge these individuals.

Firstly, I want to convey warm thanks and appreciation to my supervisors Dr Margaret Graham and Dr Dympna Tuohy for their support and guidance throughout the research,

Sincere thanks to the research participants who generously gave their time to share their experiences and insights.

On a personal note, to my late mother Mai, daughter Claire and brothers and sisters, I must express my deepest appreciation and love for their endless patience, support and encouragement.
Table of Contents

Abstract ............................................................................................................................... i
Declaration ........................................................................................................................ ii
Acknowledgements ......................................................................................................... iii
Table of Figures .............................................................................................................. vi
List of Appendices .......................................................................................................... vi
Glossary of terms ........................................................................................................... vii
Chapter 1 Introduction .................................................................................................. 1
  1.1 Rationale for study .................................................................................................. 1
  1.2 Organisation of the thesis ...................................................................................... 4
Chapter 2 Literature Review ......................................................................................... 6
  2.1 Introduction ............................................................................................................. 6
  2.2 Search Strategy ....................................................................................................... 6
  2.3 The evolution of approaches to nursing ................................................................. 9
  2.4 Dementia ................................................................................................................ 14
  2.5 The role of healthcare professionals ..................................................................... 17
  2.6 Historical and sociocultural context of massage as a therapeutic intervention ...... 22
  2.7 Conclusion .............................................................................................................. 29
Chapter 3 Methodology ............................................................................................... 31
  3.1 Introduction ............................................................................................................. 31
  3.2 Underlying approach and assumptions ................................................................. 31
  3.3 Research design .................................................................................................... 33
  3.4 Research settings and participant selection ......................................................... 36
  3.5 Data collection ...................................................................................................... 43
  3.6 Data Analysis ........................................................................................................ 47
  3.7 Chapter summary .................................................................................................. 57
Chapter 4 Findings ....................................................................................................... 59
  4.1 Introduction ........................................................................................................... 59
  4.2 Opening doors ....................................................................................................... 60
  4.3 Being with ............................................................................................................. 68
  4.4 Challenges ............................................................................................................. 75
  4.5 Summary ................................................................................................................ 85
Table of Figures

Figure 3-1: An example of haiku ........................................................................................................ 56
Figure 4-1: Themes ................................................................................................................................. 59
Figure 4-2: ‘Opening Doors’ Sub Themes .................................................................................................. 61
Figure 4-3: ‘Being with’ sub themes .......................................................................................................... 68
Figure 4-4: Challenges Sub Themes .......................................................................................................... 76

List of Appendices

Appendix 1: Access to Research Site ..................................................................................................... 143
Appendix 2: Communication from Nursing Homes Ireland and Research Officer ......................... 144
Appendix 3: Participant Information Sheet ............................................................................................. 144
Appendix 4: Written consent and reply slip ......................................................................................... 147
Appendix 5: Poster ................................................................................................................................ 149
Appendix 6: Research Participant Invitation Letter .............................................................................. 150
Appendix 7: Interview Schedule ........................................................................................................... 152
Appendix 8: Newell and Burnard Framework ....................................................................................... 153
Appendix 9: NVivo Coding Process ....................................................................................................... 154
Appendix 10: Reflexivity ........................................................................................................................ 161
Glossary of terms

A number of the main terms used in this study can be subject to differing and varied definitions. To ensure clarity, the assumed meanings and definitions of these core terms are set out below.

**Dementia**: ‘Dementia is a syndrome characterised by progressive cognitive impairment and is associated with impairment in functional abilities and, in many cases, behavioural and psychological symptoms. There may be memory loss, usually related to short-term memory, communication difficulties, changes in personality or mood and problems with spatial awareness (Department of Health 2014 p.10). For some dementia can be seen as a disability to be lived with, rather than solely as a disease process (Brooker and Latham 2015).

**Patient**: The term, patients with dementia, is used throughout the thesis. However, for the sake of clarity, this is sometimes shortened to ‘patients’. The term ‘patient’ is a contested term but has been chosen for consistency. Any labelling may influence personhood and the term, patient, may not be future proofed into person-centred care nursing. Milburn & Walker 2008 are cited in Koubel and Bungay (2008) as referring to the term patient as ‘implying illness, incapacity, passivity and lack of decision making’. These labels are not consistent with person centred philosophy but to ease understanding the label ‘patient’ is cautiously used in this study.

**Person-centred care**: An approach to practice established through the formation and fostering of therapeutic relationships between all care providers, patients and others significant to them in their lives. It is underpinned by values of respect for persons, individual right to self-determination, mutual respect and understanding. It is enabled by cultures of empowerment that foster continuous approaches to practice development (McCormack, Dewing et al. 2010).

Person-centred care permeates the frameworks of international healthcare policy, although the challenge of translating its core concepts into practice is challenging (McCormack and McCance 2006). In nursing practice, person-centred care manifests itself in the form of nurse–person interaction. Kitwood (1997) suggested that person-centred care supports the personhood of patients with dementia.

**Anxiety**: As cognitive abilities change and decline, in dementia, behaviour can become the primary source of communication and anxiety is thought to underlie many of the distress
behaviours observed, often associated with poor quality of life. Cohen-Mansfield, Jensen et al. (2012) described the behaviour as a form of language and communication. Dewing (2006) adds a further dimension to this communication by describing anxiety, agitation, distress, different patterns of wandering; as behaviours that patients with dementia use to communicate their feelings and needs. Symptoms of anxiety and symptoms of dementia can coexist and determine whether a direct causal relationship is difficult (Seignourel, Kunik et al. 2008).

**Hand massage**: A comfort intervention that can be integrated readily into routine nursing care activities with the intention of caring through touch, individual attention and presence (Kolcaba, Schirm et al. 2006). It is a form of intentional touch (David Edvardsson, Sandman et al. 2003) and because there are a number of interacting components involved, it is deemed a complex intervention (Craig, Dieppe et al. 2013).

**Residential care**: In Ireland the term residential care unit is used interchangeably with terms such as community nursing unit, geriatric hospital, private nursing home or community hospital. These settings provide a range of services, some of which provide continuing care only, while others provide intermediate care services such as respite or rehabilitation alongside residential care. In general, private nursing homes are staffed by care teams with nurse to care assistant ratios of 1:3 or 1:4. In other settings, nurses do most of the bedside caring, generally with a 4:1 ratio of nurse to care assistant. Care teams in all the sites under study in this research employed both nurses and care assistants.
Chapter 1 Introduction

The purpose of this research study is to add to the existing body of knowledge about complementary interventions which may benefit patients who experience anxiety while living with dementia. The research specifically explores the experiences of nurses who use hand massage for this purpose in residential settings. This chapter outlines the rationale of the study, the policy background, personal motivation and the aims and objectives of this research. Finally, this chapter gives an overview of the thesis content.

1.1 Rationale for study

Worldwide statistics suggest that the number of people living with dementia is in the region of 35.6 million. The number of people living with dementia is predicted to double every 20 years (Prince et al., 2013) with advancing age by far the single strongest defining factor (Cahill et al., 2012). In Ireland, in 2012 there were about 41,740 patients with dementia, 26,000 of whom were living at home. Approximately 4,000 new cases arise every year (Connolly et al., 2014) suggesting that the numbers in residential care are will continue to increase. In Ireland presently, 63% of older people in residential care are in the private nursing home sector, 9% are in the voluntary home sector, and the remaining 28% are in HSE provision (Cahill et al.). Health and social care services for people with dementia in Ireland are largely concentrated on residential care. This projected increase is a crucial consideration when planning services for older people. In Ireland and elsewhere, the demand for residential care is set to rise rapidly as populations age (Wren et al., 2012). It is estimated that over 60% of the residents living in long-term care facilities have cognitive impairment (Cahill et al., 2015). This brings scale of future challenges for care in residential settings into sharp focus (Department of Health, 2012), not least the potential for pressurised residential settings to generate dehumanising experiences of care.

Regulation of the care older people receive in all residential settings is governed by a number of standards and acts, most notably the Health Act 2007 under which the Health Information and Quality Authority (Health Information and Quality Authority (HIQA) was established. The latest documents from HIQA indicate that many centres need to improve their approach to individualised person-centred care planning, specifically Regulation 7 which relates to the management of so called challenging behaviours. In particular, it is noted that staff require
knowledge and skills to respond in person-centred ways (Health Information and Quality Authority, 2016).

In recent years, person-centred practices which foster flourishing relationships between care teams, patients and their families have been introduced into policy and practice guidelines (Department of Health, 2014, Health Information and Quality Authority, 2016, Coyle et al., 2011). There is a widely held consensus that an ethos of person-centred care and culture is beneficial both for patients and staff (Department of Health, 2014, Sjögren et al., 2013, Edvardsson et al., 2008). Person-centred care guidelines emphasise the assessment of individual needs and the use of complementary interventions, where appropriate, before resorting to pharmacological management of distressing behaviours (Pan et al., 2014, Banerjee, 2009).

Care standards and policy initiatives such as the Dementia Strategy are attempting to address potentially dehumanising care experiences (Department of Health, 2014, Authority, 2015). The biopsychosocial model emphasises holistic care and subjective experiences which align with the contemporary patient-centred care paradigm. The Dementia strategy explicitly references person-centred care and seeks to enable patients with dementia to maintain their personhood and calling for patients to be treated ‘with the lowest level of complexity that is safe, timely, efficient and as close to home as possible. It commits to a patient-centred, flexible service’ (Department of Health, 2014, p.12). The strategy also identifies that due to the changing population demographics there is a need for nurses who are knowledgeable and committed to person-centred practices and to a range of interventions to meet the needs of patients including, potentially, the use of hand massage. Effective interventions to alleviate anxiety/distress associated with cognitive impairment/dementia will become increasingly important from a socio-economic and caring point of view (Connolly et al., 2014, Trepel, 2011).

It is notable that there is limited research on how to conceptualise and visualise a residential home, yet it is the very nature of this perception that is crucial to the development of an atmosphere that promotes flourishing for both staff and patient (Robertson and Fitzgerald, 2010, Morgan-Brown et al., 2011). Residential settings are designed for people who are unable to live independently in the community and require some level of assistance to meet their daily care needs. The landscape of these residential care services has been underpinned by some major organisational and regulatory changes in recent years which have had a marked impact on care provision (Health Information and Quality Authority, 2016).
Massage is a traditional nursing intervention and is regarded as a person-centred practice. However, current literature provides only limited reviews of the integration of hand massage interventions into practice. Moreover, research studies have sometimes failed to accurately describe the way in which massage activities are employed and the methods by which outcomes are evaluated. Nevertheless, the studies that have been published indicate that hand massage can have a significantly beneficial effect on reducing anxiety and increasing relaxation in older people (Harris and Richards, 2010, Moyle et al., 2013a). The literature review (Chapter 2) presents evidence of why this is the case.

However, hand massage as a person-centred practice has not been adopted consistently within residential settings, despite the substantial evidence of its benefits in the literature. (Barry, 2008, Kolcaba et al., 2006a, Moyle et al., 2013a, Croghan, 2009, van der Steen, 2014). This knowledge is compounded by the fact that older people are one of the most comforting-touch deprived members of society (Gleeson and Timmins, 2004, Nicholls et al., 2013). Paradoxically those with dependent physical needs and end-stage dementia may be touched without any concern for consent or dignity (Skovdahl et al., 2007). Gaining consent and the preservation of dignity in residential care is a highly relevant focus of person centred practices.

The literature indicates that nurses are the change agents and clinical leaders in older adult settings (Murphy, 2007, Phelan and McCormack, 2016, Martin et al., 2014, Broderick and Coffey, 2013). The literature also suggests that staff create the culture within care units, and patients are dependent upon staff to generate human flourishing and to maintain settings that are therapeutic (Coyle et al., 2011). However, there is a paucity of research relating to nurses’ experiences of using hand massage in general and in Irish residential care settings in particular.

This study provides evidence to suggest that alleviation of symptoms through appropriate and timely interventions may have significant implications for the practice of care. The humanitarian gains may be considerable if hand massage as a person-centred practice is more consistently introduced into the management of dementia (Kolcaba et al., 2006a, David Edvardsson et al., 2003b).
**Personal rationale**

The decision to conduct this research was based on the researcher’s belief that nurses can play a pivotal role in encouraging the practice of hand massage to alleviate anxiety for patients living with dementia. The researcher’s interest in the promotion of hand massage originated from practice that she continually identified while working as a staff nurse in residential care and in her own experience as a massage therapist. Many of the distress behaviours expressed by patients with dementia are considered to be either preventable or can be alleviated by the soothing touch of hand massage.

**Research aims and objectives**

The aim of this study is to provide a comprehensive description of how nurses experience the use of hand massage to alleviate anxiety for patients living with dementia in a residential setting.

Five supporting objectives were identified to aid in realising this aim. The first was to accurately describe nurses’ experiences of giving hand massage to patients with dementia in residential settings. The second was to identify the factors that facilitate the use of hand massage, and the third was to explore the challenges which nurses experience when using hand massage as a therapeutic intervention. The final two objectives concern the identification of recommendations and knowledge guidance relating to the use of hand massage in residential care settings.

There is limited data on nurses’ views of the value of complementary therapeutic interventions in practice (Dewing, 2003, Dewing, 2010, Kolanowski et al., 2010). This research study, therefore, set out to address this gap. The researcher achieved this by engaging with nurse participants to explore their experiences of providing hand massage and analysing the data using a qualitative descriptive approach.

**1.2 Organisation of the thesis**

This thesis has 6 chapters. Following this introduction, Chapter 2 reviews a range literature relevant to the research topic. It situates the research in a brief review of the evolution of nursing practice, particularly the evolution towards person centred care practices. It then goes on to unpack different ways in which understandings of dementia can be captured - as a disease, as a disability and as a human experience. The consequence of each of these for care is
explored. The view then moves on to look at the role of the health care professional, in particular in relation to the care of people with dementia. The final section of the review moves to a more substantial review of literature relating to the use and potential of hand massage.

Chapter three deals with the research methodology. It describes and explains the research design and methods chosen for this study, in particular the qualitative descriptive approach adopted to meet the study. This approach allowed for a broader exploration of the objectives. A qualitative descriptive approach also allowed for an in-depth exploration of participants’ experiences. The limitations of the study are acknowledged.

Chapter four presents the findings from this study. These findings are presented in three themes which capture participants’ experience of the use of hand massage. They are Opening Doors, which describes the experiences of and approaches to introducing hand massage; Being With, which describes the experiences of using hand massage and Challenges, which highlights some of the perceived challenges experienced by nurses in their use of hand massage in residential settings.

Following the findings chapter, chapter five provides a discussion and critical analysis of the findings and situates this analysis within national and international literatures.

Finally, chapter six presents some final conclusions, outlining the contribution of the study and presenting recommendations to enhance nursing practice, nursing education and training and research.
Chapter 2 Literature Review

2.1 Introduction

The overall aim of this study is to explore the experiences of nurses who use hand massage to alleviate anxiety for patients with dementia in residential settings and, in the process, to add to the existing body of knowledge of holistic interventions that support people who experience anxiety and agitation in dementia. In pursuit of this aim, this chapter reviews the range of literature relevant to the research topic. Broadly speaking it addresses the socio-cultural and historical context that may influence nurses’ perception of the value and efficacy of hand massage to alleviate anxiety as well as examine the evidence from the literature on the efficacy of hand massage to meet the needs and expressions of behaviours that trouble patients with dementia. The chapter uses a range of academic and grey or practitioner sources, thereby blending different forms and types of analysis and experience.

The review is divided into four sections. Section 2.2 presents the methods used to search the literature. Section 2.3 then locates the research theme within a historical context of how nursing and approaches to care have evolved, including the evolution of person centred care and nursing. Having laid this important contextual foundation, section 2.4 narrows the literature review to focus more clearly on dementia, examining how dementia is understood, as a disease; a disability; as human experience and as an end of life issue. The logical follow on from this is to discuss in section 2.5, the policies and practices of caring for older people, most especially those living with dementia. The final component of the literature review, at section 2.7, addresses the historical and socio-cultural context of the use of hand massage by nurses in residential settings, including some of the challenges encountered in realising its potential.

2.2 Search Strategy

The research question that underpins this study – ‘What are nurses’ experiences of using hand massage to alleviate anxiety for patients living with dementia in residential settings’? - led the literature search in a number of key directions. It firstly suggested a need to consider, albeit briefly broader literature on the historical evolution of contemporary nursing practice, including the emergence of person centred care as a guiding principle.
Secondly, as might be expected, the literature search focused in on the specifics of dementia, examining different ways in which the disease is understood and the implications of these for the provision of care.

Finally, given the focus of the study on the experiences of nurses on the value of hand massage, the search strategy sought to locate existing research on nurses’ experiences of person-centred interventions such as hand massage, and the use of hand massage/touch as a therapeutic intervention for people experiencing anxiety in dementia. This approach, which defined the scope of the literature review by the research question and its components, was recommended by Newell and Burnard (2006).

A comprehensive review of the literature was conducted using books, electronic databases and relevant grey literature / practitioner sources. The choice of data bases to be reviewed was made following engagement with subject specialists at the University of Limerick Library. As illustrated in table 1 below the literature search utilised a number of broader, non-subject specific data bases; a range of specific medical data bases as well as a number of relevant grey literature sources.

Table 2-1: Databases /literature sources accessed

<table>
<thead>
<tr>
<th>General academic data bases</th>
<th>Academic Search Complete</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Google Scholar.</td>
</tr>
<tr>
<td>Dedicated medical data bases</td>
<td>ClinicalTrials.gov</td>
</tr>
<tr>
<td></td>
<td>CINAHL Plus with Full Text</td>
</tr>
<tr>
<td></td>
<td>PsycINFO</td>
</tr>
<tr>
<td></td>
<td>Cochrane databases</td>
</tr>
<tr>
<td></td>
<td>MEDLINE</td>
</tr>
<tr>
<td></td>
<td>PsycARTICLES</td>
</tr>
<tr>
<td>Grey / practitioner literature</td>
<td>Dementia and Cognitive Improvement Group</td>
</tr>
<tr>
<td></td>
<td>HeartMath Institute</td>
</tr>
<tr>
<td></td>
<td>The Touch Research Institute</td>
</tr>
<tr>
<td></td>
<td>All Ireland Gerontological Nurses Association,</td>
</tr>
<tr>
<td></td>
<td>Department of Health</td>
</tr>
<tr>
<td></td>
<td>Health Service Executive</td>
</tr>
<tr>
<td></td>
<td>World Health Organisation</td>
</tr>
</tbody>
</table>

Working from the research question, a number of primary keywords were identified, including: hand massage, elderly, dementia, nurse, residential care, anxiety and experience were identified.
The relevant databases were then examined to identify other related subject terms utilised by individual data bases. This led to the following general search or query string:

((massage OR hand-massage OR touch OR stroking) AND elderly AND (dementia OR Alzheimer’s OR ‘mental disorder’ OR anxiety OR distress or disease) AND (‘residential care’ OR ‘psychosocial intervention’ OR ‘person centred care’) AND nurse* AND (experience OR attitude OR experience)). To optimise the search outcomes various iterations of this string were run.

Terms such as ‘healing touch’ and ‘therapeutic touch’ were not used because the focus of the review was on massage for relaxation which is a part of traditional nursing care and does not require specialised training.

The searches resulted in a large body of published literature which was initially scanned by journal article, title abstract and article content. This process reduced the volume of literature relevant to the study. A search of reference lists of relevant published papers was also conducted. The search was limited to the years 1995-2016, as 1995 was the earliest published paper found to meet the inclusion criteria.

To limit the results to the most relevant material the following inclusion criteria were adopted:

2. Research studies which addressed nurses’ experiences of implementing and managing person-centred care, and complementary interventions in residential settings.
3. Studies referring to the role of nurses in residential settings.
4. Empirical studies were sub-divided into quantitative (RCT/Quasi-experimental/Secondary data analysis) and qualitative (case studies/action research/practice development/ethnography)
5. Related studies in which participants were men or women with a mean age of 65 years or older.
6. Studies where hand massage was the sole intervention, compared with control groups and those examined in qualitative studies.
7. Studies of combined interventions (e.g. aromatherapy, music) compared with a single-intervention massage group.
The literature search was expanded to include references cited in specifically relevant articles, and these were entered into Endnote. These included seminal works, books, government reports and grey literature. A further search on key authors was also conducted.

The initial searches yielded more than 83 articles. The researcher reviewed the abstracts and determined eligibility by applying the above inclusion and exclusion criteria. Regarding the literature search on massage, many sources of information from complementary integrative health care were considered which enriched the topic. While newer sources were preferred, older works were included for their seminal or enduring merit. Material from non-peer reviewed sources, including evidence from advocacy groups, was included where the content demonstrated relevance and authority. The findings had an international perspective, with sources from Australia, Canada, Japan, USA, Scandinavia, UK and Ireland.

Inevitably there were some limitations to the literature review. Excluding non-English research may have limited the available evidence. Also, most of the studies used in the literature review were from Europe. The studies from within and outside of Europe appear to be equivalent, but this warrants further examination. Also, many of the published studies are based on small samples which made it difficult to compare the findings.

2.3 The evolution of approaches to nursing

As with many professions, the practices and institutions of contemporary nursing have been shaped by norms and values that have evolved over many years. Nursing in Ireland was comparatively advanced from an early age, in fact in the early 1800s Catherine McAuley and her associates established home and hospital visiting nurse services in Dublin thirty years before Nightingale wrote, *Notes on Nursing* (Meehan, 2012). These were autonomous women, but their emphasis of care was not on hierarchical issues with the doctor but the spiritual aspect of care. The notion of ‘careful nursing’ was their guiding philosophy (Meehan, 2012, p.2908). Later, one of these nurses, Clare Moore accompanied Nightingale to the Crimean War bringing with her careful nursing philosophy (Meehan, 2012).

In a further indication of the state of advancement of Irish nursing, in 1832 a nurse from Limerick, Joanna Bridgeman, would also later have a major influence on nursing at the Crimean war by developing a specialised method of stuping (applying moist heat) in an effort to relieve the severe muscle cramps associated with cholera (Meehan, 2012).
It is suggested that nursing care, as initiated by Florence Nightingale, has moved from the provision of basic nursing comfort measures (that incorporated gentle, soothing massage) to a more scientifically based approach with pharmacological interventions and complicated technologies (Sandelowski, 2000a). Prior to the increase in scientifically based care practices, the use of analgesics, and specialisations of massage within physiotherapy departments, the nurse provided basic comfort measures that included massage and stuping.

Reflecting this transition, nursing journals and texts from the 1930s and 1940s place less emphasis on care as comfort, and instead highlight the increased use of technology and pharmacologic treatments. Over time, Sandelowski has argued, nurses have been viewed at times as masters of technology and at other times as mere extensions to it (Sandelowski, 2000b). However, the degree to which technology has both advanced and impeded the development of nursing remains a subject of debate (Sandelowski, 2000a), just as it has raised questions about how care is provided and how the early ethos of care and spirituality in nursing may have become displaced.

Perhaps spurred on by the increased reliance on technology and pharmacological responses, and informed by a body of literature which suggests an increasing insensitivity to patients’ emotional welfare within contemporary nursing work culture (Kapur, 2014), the notion of person-centred care is again gaining traction. Person centred care can be understood as an approach to practice established through the formation and fostering of therapeutic relationships between all care providers, patients and others significant to them in their lives. It is underpinned by values of respect for persons, individual right to self-determination, mutual respect and understanding. It is enabled by cultures of empowerment that foster continuous approaches to practice development (McCormack, Dewing et al. 2010). Person-centred strategies must enhance the capacity of the nurses to be more visible and transparent in their caring roles (Mitchell and McCance, 2012).

Patient-centred practices have been enriched by the psychology based contributions of Carl Rogers and Abraham Maslow, amongst others. Their contribution to the notion of ‘humanistic psychology’ emphasises that ‘people are unique and multidimensional beings, and that these spiritual and psychological aspects and psychosocial and spiritual dimensions are as important as physical health (Rogers, 1995a). Indeed, Rogers was the first to coin the term person-centred care in his client centred counselling work. Kitwood (1997) adopted these ideas to the dementia care settings. The development of the person-centred framework by (McCormack
and McCance, 2006) builds on this interconnection between caring and person-centeredness. Connecting these concepts through the creation of an enriching environment may directly impact the trajectory of dementia (Jankowsky et al., 2005).

However, being person-centred within contemporary and performance dominated health care systems brings tensions and challenges. McCormack et al. (2011) suggest that while many nurses experience ‘person-centred moments’, the challenge is to transform this into more sustained and sustainable ‘person-centred cultures’, not just isolated opportunities. This can be facilitated through emancipatory practice development in which nurses develop a more critical perception of their world of work and liberate themselves from ritualistic and oppressive practices, echoing educationalist theorist Paulo Freire (Mooney and Nolan, 2006).

Such emancipatory practice however, requires consciously developed emotional intelligence and psychological safety nets to enable nurses to be truly present to an individual experiencing anxiety, capacities which need to be built into the competencies of the nurse in care settings. This, however, is not without complication and indeed, competing influences. Psychologically abstract concepts such as compassion and empathy stimulate society and humanise relationships (Robertson, 2013) but have to exist within the worlds of regime, rosters and rote. They also have to be part of the process of training and forming nurses. However, this does not always happen. Drawing on the findings of a phenomenological study which sought to understand the experience of final year nursing students of learning through reflective processes, some of the participants were satisfied to describe how reflective activity had enabled them to develop and justify a ‘traditional’ emotional detachment (I-it) from their care (Rees, 2013). A capacity for detachment as opposed to patient centeredness is the result in this particular case.

This experience brings in focus the multidimensionality of caring and nurses’ relationship with care. Leininger (2006) a nurse anthropologist, traced caring concepts over four decades and challenged nurses worldwide to reflect on the essence of caring practices (Leininger and McFarland, 2006). Other nursing authors such as Watson and Benner focused on the centrality of caring (Norman, 2012). In particular, Watson (1987) focused on authentic caring relationships minimising task orientated roles and maximising relationship developing ones (Norman, 2012), all core elements of a person centred approach to caring. However, it is suggested by some that the model of reflective practice introduced into nursing in the 1990s appears to have failed to become more deeply embedded (Mackintosh, 1998). However the
concept of reflection is included in most professional standards of practice (Goulet et al., 2016). According to Cotton (2001), the idea and practice of reflection appears not to be valued within organisational hierarchy, except as a tool of reporting on critical incidents (Gustafsson et al., 2007). Minimising the value of reflection may lead to minimising the value of relationship building and inhibit the potential to develop a more strongly person centred approach.

Of particular relevance to any discussion on person centred care is the idea of human flourishing, supported by a vast body of literature on the use of interventions to produce human flourishing outcomes (Titchen and McCormack, 2010). Amongst this body of work is a series of studies geared towards enabling human flourishing through the body, creative imagination, nature, beauty and the spiritual as well as through the critical mind. Practice development invites one to engage in inquiries into one’s flourishing at work. (McCormack and Titchen, 2014), in turn, enable a person-centred philosophy to permeate residential settings. The ability to reflect and see with the eyes and the heart are prerequisites for person centred care (Senge and Scharmer, 2011).

**Person-centred nursing in residential settings**

While person centre care is challenging in a variety of care settings, it is particularly so in residential contexts where a patient may have moved from the psychological security of their own home into a new, possibly permanent and potentially frightening living environment. (Coleman et al., 2002). Inevitably, moving into residential care causes distress for the patient. The patient needs to develop emotional bonds with their new place of residence to enhance psychological and emotional well-being (Van Oel and Boer-Lootens, 2015). Residential care has of course evolved from institutional custodial care approaches delivered by the state and by religious and voluntary organisations, to the most recent model of *cash for care* (home care packages) in which individuals are cared for in the home (Timonen and Doyle, 2008). Beyond the challenges facing individuals, institutions too are confronted with the need to create environments in which person centred care can flourish. Creating healthcare environments that are conducive to providing and promoting optimal patient and staff outcomes requires a change in the thinking that govern the existing nursing culture (Tillott et al., 2013). This is especially true if person centred care ideals are to be realised in residential settings.

Clearly, this is not so easy in practice. It can be seen from the literature reviewed above person-centred care focuses on the individual needs of a person rather than on efficiencies of the care
provider. As such it builds upon the strengths of an individual and honours their values and choices. In practice, within residential settings, achieving such an ambition is not quite so straightforward. In a systematic review on the effects of person-centred care on residents and staff in aged-care facilities, the *Eden Alternative* was the only identified intervention that articulated a framework for a person-centred approach to caring for patients, while also improving staff working conditions. The Eden Alternative is about living in a natural, healthy habitat in a homelike environment (Thomas, 1994, Brune, 2011, Downes, 2013, O. Siegel et al., 2012). It introduces pets, plants, and children into a nursing home setting which, while possibly leading to an increased rate of falls and infection control issues, ultimately contributes to improving the overall quality of life. It has been concluded that such a person centred, less routinized approach and principles can lead to meaningful and important benefits for people with dementia (Downes, 2013).

In general terms, for patients living with dementia, outcomes may be improved if the present moment is made as pleasant as possible through therapeutic engagement (Irish et al., 2006). Incorporating selected therapies into a plan of care provides multiple opportunities for nurses to demonstrate caring and to create calm, present moments in which patients can flourish. It is argued that training in therapies such as hand massage is feasible in the work place and can lead to reduced stress for patients and, ultimately, for staff, (Tang et al., 2010). This may produce a positive cascading effect which may enrich the entire practice environment. Kelly et al. (2014) concurred with Tang et al. (2010) by confirming that an enriched work environment, such as changing from a traditional to a household model nursing home, was found to increase relationship building. The enriched environment occurs through interaction and social engagement of residents, staff, and visitors within communal living areas (Hanson Michele, 2014). It allows for more delicate interpretation of patients’ behaviours. For example, using a Life Story approach helps nurses to make the link between a patient’s past and present, giving them a greater awareness of the person’s preferences for care. It also increases understanding of the meaning of behaviours and expressions (McKeown et al., 2010, Thompson, 2011). However, it needs a more person centred care environment if it is to fully incorporated into the suite of care processes, particularly those designed to meet the realities and needs of patients with dementia. Some of these needs are explored in the next section.
2.4 Dementia

The last section addressed the challenge of providing person-centred care in a residential setting. This challenge is heightened in settings where caring for people living with dementia is the norm. This section now moves on to look at how dementia is viewed in different ways, as a disease, as a disability, and as a human experience.

2.4.1 Dementia as a disease

Traditionally, dementia was solely understood as a disease, typically characterised by ‘a loss of cognitive ability. Andrews (2011) describes it simply, as an impairment of memory, impairment of reasoning and impairment of learning. However, in relation to dementia, there is an increase in stress due to the reduced capacity to cope. Andrews suggests that this stress can manifest into anxiety, agitation, anticipatory grief and anticipatory anxiety (Andrews, 2011).

Dementia can be caused by many conditions, the most common of which is Alzheimer’s disease. Alzheimer’s accounts for 60 - 80% of recorded dementia (World Health Organization, 2013). Other common forms include vascular, Lewy body, and front temporal dementia. It is important for nurses to know the underlying cause of dementia as this helps to clarify which symptoms may predominate (Andrews, 2011).

When dementia is seen as a disease, there is a tendency to respond with medication (Hungerford et al., 2014). However, the limited efficacy and adverse effect of antipsychotics leave doctors in a difficult situation given the prevalence of neuropsychiatric symptoms and a lack of pharmacological alternatives for treatment (Kales et al., 2011). It is suggested that out of the 180,000 people being treated with antipsychotic medication each year in the UK, only 20% will derive some benefit (Banerjee, 2009). This has led to a greater interest in complementary approaches. Achieving a balance between biomedical and more humanistic models may be the ideal solution (Brownie and Nancarrow, 2013).

In the UK, enhanced complimentary interventions that impact on the practices of prescribing doctors can also lead to reductions in the use of drugs as there is a growing knowledge that when such medications are given to the frail and older people, they can induce a lethargy that can mask symptoms of other afflictions (Fossey et al., 2006). Dementia with Lewy body, for example, must be excluded before commencing antipsychotic drugs (Cahill et al., 2010).
Antipsychotics are also expensive, not only having an impact on patients, but also raising the cost of care. For example, in the US, a commonly used drug, can cost €300 a month (Mead, 2013). Clearly, if lower cost, but effective alternatives or complementary approaches are available at a lower cost, it makes sense to explore them.

2.4.2 Dementia as a disability

By contrast with the idea of dementia as a disease, organisations such as the Dementia Services Information and Development Centre (DSISC) are evolving an improved understanding of dementia as a disability (Cahill et al., 2012). Traditionally, the dominant understanding of disability itself has been informed by a medical model where and treatment proceeded accordingly (Murphy and Welford, 2012) where it is the disability as opposed to society’s reaction to it that takes centre stage. More recently, however, across a range of disabilities, a social model of disability has emerged. In such an approach ‘disability is considered in the context of interpersonal and physical environments, cultural attitudes and social structures’ (Murphy et al., 2009, p.607). The social model of disability concept is continually being developed to optimise adjustment for people diagnosed with dementia (Brooker et al., 2017) underpinned by suggestions there may well be a place for cognitive rehabilitation in the early stages of Alzheimer’s disease (Robertson and Murre, 1999, Cheung et al., 2011). The approach of the International Classification of Functioning, Disability and Health (ICF) is worth recalling, in this regard, suggesting that rehabilitation is a dynamic and iterative process [and] involves a common goal to achieve and maintain optimal human functioning (Stucki et al., 2007). This paradigm shift from disease to disability may be a milestone for the future of dementia care potentially leading to a new culture of care, requiring carers to see dementia not just as a disease but as a disability, leading to a new way of viewing how dementia and those who live with it are treated and viewed by broader society.

2.4.3 Dementia as a human experience - out of mind or out of spirit.

It is challenging to convey an understanding of dementia to people who may not have any direct experience, understanding or concept of the disease/disability, be it the broader public or carers in residential settings. Dementia may be associated with an outdated idea about senility and madness or some dismissive idea that ‘nothing can be done’ (Kitwood and Bredin, 1992). Understanding how patients with dementia experience themselves and their surroundings is essential in the development of appropriate care models. Caddell and Clare
(2011) systematically reviewed identity interventions for patients with dementia. The review concluded that there are many avenues which could be further explored apropos supporting self and identity. They suggest that if the autobiographical memory is able for stimulation, then reminiscence therapy and meaningful activities may be valuable (Phinney et al., 2007b). Equally, if the analytical mind is not to the fore, then artistic or touch interventions may be more appropriate (Hansen et al., 2006b, McAdam, 2012). However, if the routines and care culture of residential care settings are not open to such practices, then their potential can never be realised.

The potential for hand massage to help the mind body connection has an obvious place as a therapeutic tool. When faced with challenges, physical, emotional or others, the human mind has an ability to separate itself from its immediate reality and to mentally relocate to another time, place, or outlook (Irish and Piguet, 2013). However, people with cognitive impairment may not have this luxury and, as a result, people experiencing dementia may be effectively tethered to the present moment, unable to draw on the reservoir of memory or the comfort of recognition to deepen their resilience in coping with the challenges of dementia. However, research has concluded that even those who are cognitively impaired as a result of probable advanced dementia can still communicate opinions and preferences about what is important to them, using both verbal or non-verbal means (Caddell and Clare, 2011, Lillekroken et al., 2015). Inevitably, apathy, depression and most especially anxiety – the core theme of this research - are common features of advanced dementia. Consequently, more careful attention to how those living with dementia within residential settings can be more socially included needs more careful consideration. From a research perspective, it is also suggested that better understandings of the unique needs of this vulnerable group of people need to be generated and emphasis on the importance of nurturing the individual resources (Diaz-Ponce and Cahill, 2013, Lillekroken et al., 2015).

In contrast with the previous presentation of dementia as a disability, Kitwood (1997) insisted that people experiencing dementia should not be considered disabled. Dementia has bypassed their analytical abilities, the individual has been liberated from their ego, and the person has returned to instinctive primitive aspects of being which is much older in evolutionary terms (Dewing, 2006). In advanced Western societies, in which there is a weak sense of community dementia can generate fear and unease (Kitwood, 1997). As a result, western societies may turn those living with dementia into non-persons, who are minded or warehoused in nursing homes.
However, rather than contradict the disability description this actually echo the tenets social model of disability argument, especially when divisive, disabling language to describe the behaviours of people with dementia. Behaviours that challenge are filtered through the lens of pathology (Dupuis et al., 2012). Alternative discourses challenge what is known and provide new possibilities.

2.5 The role of healthcare professionals

As well as presenting challenges to the nature of residential settings, the projected scale of the impending dementia crisis poses challenges to the role and responsibilities of health care staff. International studies show that, overall, there is insufficient knowledge of ageing and older people among a variety of healthcare personnel (Topaz and Doran 2013). Predictors of nurses attitudes about aging are multifaceted and shared understanding can never be assumed (Liu et al., 2013). Preference to work with older people and knowledge of ageing appear to be associated with education in gerontological nursing together with positive practice learning experiences (Liu et al., 2013). In an earlier study on UK and Australian nurses, Getting et al. (2002) explored the relationship between views on self-ageing and attitudes towards older people. In the above study nurses in general devalued and underestimated the capabilities of older people. Individuals with dementia may be perceived as exhibiting all the most feared aspects of the ageing process (Batson et al., 2002) and it is recognised that stigma associated with dementia accentuates and deepens the distress experienced by the person with dementia (Milne, 2010).

An indicator of impoverished as opposed to enriched care provision may be provided by the use of language in health care settings. Language can often be paternalistic and negative and may reflect negative attitudes that are a precursor to ageism (Liu et al., 2013). The power of words and the link between words and attitudes are very important (Draper et al., 2013) and in the context of this study may well indicate a predisposition in favour or against the use of complementary approaches such as hand massage. Language can socially identify a person and position them within a stereotype. It is important therefore to continually question understandings of the factors that influence how engagement with ageing and older people occurs as this offers an opportunity to influence workplace culture (McCormack et al., 2010).

In this regard, it is worth noting the development of an innovative experimental project called Taking Care with Words which created a space where nursing staff explored through creative
writing the power of language in their interactions with older people. The designers of the project concluded that innovations like this sensitise workers to the importance and power of language (Draper et al., 2013). From this project, it is evident that the everyday and dominant language employed to describe dementia itself influences perceptions of dementia and creates a complete and total “loss of self” (George, 2010). Thus, it is suggested, conscious adjustment of the use of language can ‘reshape thoughts, attitudes and actions towards ageing and mental health (Kleinman, 2008).

It is useful therefore to critically examine the context of nursing practice and notions of idealised and unrealistic practice. Literature shows the value of the interpersonal components of caring that make up the nurse/patient relationship (Arnold and Boggs, 2015). In an international study to explore nurses’ experience of strain in dementia care in Sweden, Australia and UK, nurses described the complexity of their situation. They wanted to do more but did not have the resources, opportunities or abilities, emphasising the tension between what they wanted to do and what they actually could do (Edberg et al., 2008), pointing to the complexities faced even by nurses well-disposed to use and apply theories and practices of compassionate care in contemporary healthcare settings (Crawford et al., 2014).

The stated desire of health care systems to enable compassionate working is often at odds with the perceived need to optimise the use of resources and encourage time-efficient care. Lack of compassionate practice is sometimes presented as the responsibility of the individual practitioner, but the engagement of the individual practitioner is informed by organisational structures and processes. Health care practitioners, to some extent at least, are products of their environments (Crawford et al., 2014). While the literature strongly supports person-centred care as the way forward for patients with dementia, there is a need to acknowledge the challenges that person-centred planning and care can present for professionals. Research has explored nurses’ experiences of care of the older person with dementia in an acute hospital setting and recorded views on the limitations imposed on them by the structural nature of the care setting (Nolan, 2007).

Nurses form the largest group of health care professionals, and they are ideally placed to influence and shape how people think about dementia; to redress the balance in relation to dementia; to clarify what this condition represents for society, and how it is perceived (Van Gorp and Vercruysse, 2012). The roles that are undertaken by nurses working in older adult settings are changing; more challenging but also more fulfilling (Dewar and Nolan, 2013). The
general thrusts of these changing roles are an increase in autonomy and responsibility of the nurse (Phelan and McCormack, 2010). Nurses are the main potential change agent in evolving healthcare, yet what forms the nurse? The conditions needed to enable nurses to flourish and deal with the multiple challenges of individual, group, work environment and culture and organisational change can be facilitated through emancipatory practice development in which nurses are empowered to develop a more critical perception of their world of work (McCormack et al., 2007). Nurses can become leaders and facilitators who can change oppressive aspects of practice when they are allowed to use the Freirean approach and develop an awareness of personal power and responsibility (Sorensen et al., 2008, Dwyer, 2011, Doody and Doody, 2012a). Within such an approach, the needs and perspective of those on the frontline must be accessed and taken into account to enhance service delivery (Dowling et al., 2007, Krieger, 1975). Unfortunately, strategic visioning exercises are too rarely supported with the necessary education, resources and finance.

James Macgregor Burns (1998) was one of the first to promote the idea of transformational leadership, stressing engagement between leaders and followers also based on the Freirean philosophy and engaging all stakeholders. Building on the theme of nurses as stakeholders who should be consulted and listened to. Sorensen et al. (2008) recognise the unique insight of nurses and suggest that a nurse’s emotional intelligence gives an advantage for enacting and embedding a moral type of leadership in healthcare. This study found that nurses adopted a relational way of being, guided by an inner knowing and their wish to do well. But parallel to this guiding morality, it is argued that a form of ‘learned helplessness’ exists which when combined with the use of socially structured defence techniques hinder nurses’ involvement in practice development (Cooper et al., 2013, p.536). A study by Menzies (1960), looking at the possible origins of this defence mechanism, suggested that the human state requires us to manage our anxiety to avoid it overwhelming us and that if the emotional elements of nursing are not managed, that anxiety can cause emotional exhaustion and burnout. The notion of the use of ritual as a protection and containment against anxiety is one strategy used in nursing (Philpin, 2002)

Given its particular complexities, is not surprising that care of the older person should increasingly be presented as a nursing speciality, with distinct knowledge and skills and requiring an associated career structure. However, provision of care for older people does not always enjoy the same status within nursing as other specialisations (Phelan and McCormack,
2012). For example, it does not have the same recognition as intensive care which may imply that this population are not considered as worthy, however subliminal this may be (Downes et al., 2013). For patients with the types of cognitive impairments associated with dementia, the ability of nurses to understand their individual needs assumes greater significance as do their knowledge, skills and disposition. When they did not have the support, opportunity or ability to do this, it caused strain (Edberg et al., 2008).

The Menzies study also highlighted that nurse training in the past few decades focused on the efficiency of task performance partly to evade the inherent anxiety of nursing work. Equally, it is suggested that emotional labour in nursing has become marginalised due to organisational changes and organisational priorities (Theodosius, 2008). However, there is a danger that emotional labour requiring suppression of feelings, in turn, creates a necessary management of emotions, bringing with it potential negative consequences for workers (Sloan, 2012). With such ‘management’ social, cultural rules, formal and informal, determine how to manage emotions in public arenas; what emotions one should express and the degree and nature of that expression (Theodosius, 2008). A worker’s positive sense of self-efficacy in such a context is shown to reduce the negative effects of internalising the emotion (Sloan, 2012). That is if one has a strong sense of self; if the focus of control is internal, then confidence and self-efficacy are stable (Glasser et al., 1988). Emotional intelligence has already been introduced as an essential aspect of aware caring. Models of learning that focus on the centrality of emotional intelligence emphasise that a person’s identity and belief system will determine whether competencies and skills can even be practised (Sheard, 2013a). Confidence and resilience to find a solution or to live with uncertainty are core skills (Lundman et al., 2010, Eriksson and Lindström, 2006).

These points to the growing need for nurses to be enabled to develop and operationalise personalised interventions for patients with dementia. One key step towards realising such an ambition may be to deepen understanding of nurses’ perspectives on what dementia entails and how it affects everyday life. Decision making in nursing has changed radically with nurses expected to make choices based on current evidence (Doody and Doody, 2012b). The literature supports the wisdom of practice if that wisdom is linked to purpose, feasibility, appropriateness, meaningfulness and effectiveness (Pearson et al., 2007). If a practice fits these criteria, whether the evidence for it is derived from experience, expertise, inference, deduction or the results of research, it is regarded as a form of evidence (Pearson et al., 2007). For
example, the literature indicates that nurses play a key role in decision-making processes about physical restraint for individual’s experiencing agitation and/or aggression (Goethals et al., 2012). In their research Goethals et al. (2012) revealed that nurses’ decision making was primarily focused on 1) safety and, 2) a perception that there was no alternative. Nurses who were willing to take risks avoided using restraints, even if there was a risk that a patient might fall. However, this created a moral dilemma. Garity (2009) highlighted that nurses continue to report moral distress when facing ethical dilemmas in the clinical setting. Clearly then, there is no shortage of challenges for nurses and nursing in the compassionate management of care for patients with dementia.

Motivation plays an important role in the willingness and capacity of nurses to take on these challenges. The history of nursing and a reflection on the role of emotional literacy in nursing practice can shed some light on the essential components that may help or hinder the achievement of higher levels of motivation and creativity in nursing (Freshwater and Stickley, 2004) Poor motivation in workers is has many components. However, emotional well-being and motivation are intrinsically linked with the ability to partake therapeutically with the patient (Freshwater, 2002, Wilson and Carryer, 2008). The value of emotional aspects of care, such as relationship, friendship and dignity are by their nature somewhat vague and both person and context specific. They are also difficult to legislate for (O'Brien et al., 2011). These elements of care are often the product of distinct cultural and environmental factors, often evident and palpable in enriched environments, but harder to detect within impoverished care environments (Brooker and Latham, 2015).

The emergence of such impoverished care environments are facilitated by the absence or inadequacy of reflexive practice. Sheard’s core teaching in dementia calls on the carer to ‘know thyself’ and engage in reflective practice self-inquiry and self-assessment before assuming that caring skills are person-centred. A foundational study in Ireland on the clinical judgment and decision making of psychiatric nurses revealed participants’ judgments to be non-reflective and habitual. Participants expressed confidence and certainty even where body language indicated clinical situations which were obviously characterised by uncertainty (Clinton, 2010). This study’s findings are disturbing, particularly if there was such a discord between participants’ inner and outer reality. In such circumstances, the emotional ability to engage in person-centred practices such as hand massage is surely put in question.
2.6 Historical and sociocultural context of massage as a therapeutic intervention

The use of massage as remedial treatment dates to ancient Greece where bathing and massage in bath houses were combined. The Romans inherited the tradition, and Galen, a famous Roman physician, wrote extensively on the therapeutic benefits of massage (De Domenico, 2007). There is also a rich literature on massage from the 19th and early 20th centuries. Pehr Henrik Ling (1776-1839) is arguably the most famous physician from this era, and his work remains an important influence on the profession of physiotherapy (Goldstone, 2000).

2.6.1 The role and benefits of hand massage

This section explores the role of massage as a therapeutic intervention. It initially explores the role and perceived role of touch and massage in a medical / care context after which some initiatives trailing the efficacy of hand massage are reported. Finally, the challenges facing the use of hand massage are identified and assessed.

Caring touch may be the most important of all non-verbal communications, but in the reality of institutional settings touch is confined to procedures and tasks (Pedrazza et al., 2015). For a variety of reasons, older people are deprived of touch (Gleeson and Timmins, 2004, Field, 2014a). Equally noted and paradoxically, keeping in touch by using touch has the potential to empower professionals to act and to find satisfying solutions to the challenges faced in caring for older patients and, in the context of this study, to particular challenges of relieving anxiety amongst patients with dementia (David Edvardsson et al., 2003a). Many experienced nurses are aware that close touching interactions help patients feel safe and comfortable during times of distress. The unrelenting pressures on contemporary health care systems suggests that a future nurses role will be supporting family members in the development of caring competencies and including family in all elements of care (Allen, 2007).

An aim of hand massage as an intervention is to improve daily practice among professionals who provide support to patients and families living with dementia. Complementary interventions are most effective when moulded to the individual needs of the person and family (Olazarán et al., 2010). A greater understanding of the use of had massage the sensory ability of touch could yield much to the fullness of life in dementia care because touch may be the most important form of non-verbal communication (Gleeson and Timmins, 2004, Goldschmidt and Van Meines, 2011).
However, in the case of people living with dementia there may be a reduced understanding of the situation and what is perceived as comfortable will inevitably vary. In such circumstances, touch might well cause an increase in stress, which caregivers must be aware of and be sensitive to (Skovdahl et al. 2007).

Although massage has been an integral part of nursing throughout history, there is a scarcity of research into the specific benefits of massage for older people, even though the older adult population are one of the most touch deprived groups in most societies (Field et al., 2007, Field, 2014b). At a more general level, positive effects arising from the use of massage with patient have been identified in the relevant literature. These include improvements in the quality of patients’ relaxation, sleep, immune system and in the relief of pain and anxiety (Osaka et al., 2009, Hicks-Moore and Robinson, 2008, Hernandez-Reif et al., 2000, Kapoor and Orr, 2017).

Looking more specifically at the research on hand massage concerning dementia, a Cochrane review of studies on touch, including massage, furnished some data that supported the use of hand massage although there was insufficient evidence regarding its efficacy (Hansen et al., 2006b). A review by Harris and Richards (2010) examined the effects, both physiological and psychological, of slow stroke back massage and hand massage. This review identified six experimental studies, and one qualitative study which investigated the effects of hand massage on relaxation among older patients with dementia. All experimental studies showed either statistically significant improvements or trends towards improvements in vital signs, with heart rate the strongest vital sign indicator of relaxation, thereby suggesting that massage can play a role in reducing stress and anxiety. A later literature review by Moyle et al. (2013a) found only one study of adequate methodological quality upon which an assessment of benefits could be made. However, this prospective study, in which each participant was given 10 to 15 minutes of massage to head, shoulders and hands, reported significantly reduced levels of agitation in 52 cognitively impaired residents in two long term care settings, evidencing the positive benefits of massage. It is noteworthy in the Hansen, Jorgensen Cochrane review; studies indicating the beneficial effect of combined interventions seemed to have the same effect as that of one intervention alone (Hansen et al., 2006b).

While the benefits of massage can be pointed to, its practicality within the routinised world of care remains an issue. The most noteworthy element in a series of studies by Snyder et al. was to make the implementation of hand massage more practical and appealing to nursing staff by
reducing their hand massage protocol from 10 minutes to five minutes. 10 minutes was considered too long (Snyder et al., 1995).

As already said hand massage is deemed a complex intervention (Craig et al., 2013). However, just because it cannot be evaluated objectively does not minimise its effectiveness. The methodology for evaluation of complex interventions in applied dementia care research is thought to be in need of change (Vernooij-Dassen and Moniz-Cook, 2014). The new objective is to differentiate between genuine effectiveness and implementation error. This implementation error may be a consequence of practical difficulties in conducting applied research in routine care settings.

Kolcaba et al. (2006b) used The Theory of Comfort to support hand massage as a comforting intervention, suggesting that when comfort is enhanced, individuals are strengthened to engage. This comfort can be physical, psychological and/or spiritual. The Snyder et al. (1995) studies mentioned above used the Progressively Lowered Stress Threshold Theory (PLST) as a framework to understand the benefits of hand massage. The PLST suggests that massage is a mechanism that decreases stress response by inhibiting the endocrine system from producing stress hormone which can then induce relaxation. Remington 2002 found a decrease in agitated behaviour (rated using the modified Cohen-Mansfield Agitation Inventory scale CMAI scale) which was greater in the group receiving hand massage than in the group receiving no treatment. (Remington, 2002)

Beyond the direct impact on anxiety, some neurological evidence supports the conclusion that the sensitive use of touch can be beneficial when adults are distressed. Coan et al. (2006) found that simple hand-holding produced positive neural responses to threat. Personal, high-quality relationships yielded more ‘comfort’, yet brain imagining and participant responses indicated that even hand-holding from strangers yielded some emotional comfort (Coan et al., 2006). Supporting this conclusion is the fact that neuroactive hormones, especially oxytocin, are known to mediate trust between people (Zak and Fakhar, 2006). Massage is known to increase oxytocin production (Morhenn et al., 2012), again reinforcing the conclusion that hand massage can have a beneficial role in reducing anxiety amongst patients with dementia.

---

1 The purpose of the Cohen-Mansfield Agitation Inventory (CMAI) is to assess the frequency of manifestations of agitated behaviours in elderly persons. The CMAI was developed for use in the nursing home.
2.6.2 Quality initiatives which include hand massage

Having introduced evidence of the benefits of massage, this section now proceeds to examine instances where massage has been deployed in care situations. In most instances, hand massage is introduced as part of a broader suite of person centred approaches.

Hand massage is a component of several interventions used internationally. In the USA, the concept of person-centred care has become common. The term, nursing intervention has been replaced with the phrase caring-healing modalities (Hill et al., 2011). The Beatitudes Campus in the USA aims to offer patients with dementia a comfortable decline with a palliative approach to care (Mead, 2013). This includes providing their patients with pleasurable moments including hand massage. A main focus is the engagement for patients no matter how advanced the dementia, and the reduction/elimination of anti-psychotics. Namaste Care is another US programme which tries to offer 'meaningful activities to patients of care homes also who are living with advanced dementia. The focus of the activities is on calming and soothing using a variety of stimuli including sound, touch, smell and taste. A study of this approach involving 86 care home residents with advanced dementia found that they were looked after in an ‘unhurried manner’, with a compassionate touch approach to care (Duffin, 2012). Health care staff were taught the benefits of ‘putting residents’ hands and feet in warm, lavander-scented water, and clipping their nails in a room with soothing music and low lighting’ (Duffin, 2012, p.16). The Namaste ideas are also being tried in the UK, and several organisations are piloting the principles to see how well they work. At this stage, there is anecdotal evidence that the system produces better work outcomes for staff arising from a strengthened sense of teamwork, and better outcomes for patients as staff are enabled to provide better care (Duffin, 2012, Stacpoole et al., 2015). In the UK also, the Feeling Matters Most model of dementia care involves the creation of a home which is engaging with opportunities to reminisce, touch and feel (Sheard, 2013a, Sheard, 2013b). It includes turning staff into ‘butterflies’ – helping staff draw on their emotional intelligence in a wide variety of ways, to engage and occupy patients in the immediacy of the moment. Studies in Australia indicate that specialist palliative care inclusive of the therapies mentioned above can be beneficial in dementia (Hughes et al., 2010). In the same vein imaginative additions such as the Productive Ward Innovative-releasing time to care (Wilson, 2009, White et al., 2014). After the five year review by White et al. (2014). Key interdependent characteristics identified as having direct impact on the implementation of the Productive Ward was an engaging communication strategy with appropriate training and
support, project planning and a leadership team that enables and empowers others (White et al., 2014).

*Dementia Champions* (Cahill et al., 2012), *Changing Minds Program* (foundation, 2013), the above mentioned *Feelings of Mattering model of care* (Sheard, 2013b) and the *Eden Alternative* (Brune, 2011) are presented as examples of increasing creativity in nursing care. All these programmes involve the creation of creating life affirming, person-centred, inclusive human habitats (Brownie and Nancarrow, 2013) and all include hand massage. Many contributors to nursing journals now converse about a ‘*slow nursing*’ philosophy (Gallagher, 2012, Sellman, 2007) inviting practitioners to reconsider the possibility of slowing down their caring practices and to recognise that work matched with more acute awareness of patient needs may increase efficiency. Care aimed at improving emotional well-being for adults experiencing dementia termed *emotion-orientated care* has been introduced in the Netherlands and Belgium, for example are *validation therapy* (Feil, 1992) *reminiscence therapy* (Norris, 1986, Woods et al., 2005) and *sensory tactile stimulation* in its many forms (Skovdahl et al., 2007), one of which is hand massage.

Hand massage is also incorporated into other psychosocial interventions, for example, Sonas APC is a popular multi-sensory intervention used in Ireland, the UK Australia Hutson (2014) argued and in America (Hamill and Connors, 2004). However, Hutson et al. (2014) argue that this programme is Irish-designed and its suitability may be confined to Celtic cultures. A study examining the effect of integrating this emotion-oriented care on nursing home residents with dementia and nursing assistants showed it to be more effective regarding the emotional adaptation in nursing homes of persons with a mild to moderate dementia.

The essential essence of all these quality initiatives is their naturalness and ease of integration into most care settings. The result appears to be better work outcomes for staff and better outcomes for patients as staff are enabled to provide better care.

### 2.6.3 Implementation challenges

Having identified the recognised benefits of hand massage and having illustrated from existing literature examples of hand massage being integrated with packages of person centre care, this section now completes the literature review chapter by highlighting some of the most pressing challenges that are likely to impede the more widespread use of hand massage within care settings.
Developing appropriate skills and dispositions

In a study by Murphy and Welford (2012) on the development of a framework for an educational programme for nurses and carers for the integration of complementary interventions, participants regularly referred to 'others', i.e. colleagues, who exhibited negative dispositions towards such approaches. This suggested that the value placed on such interventions were likely to be questioned.

The need for further education in the care of the older person has been identified in the national dementia strategy (Department of Health, 2014). In addition, a key recommendation in the 2013 report of the Francis Inquiry is that organisations must develop a set of core values and standards (Kapur, 2014), as displayed by Dewar and Nolan (2013) in their Appreciative Inquiry and Caring Conversations, which describe methods used for organisational improvement. Dominant discourses shape how behaviours are understood in the dementia care context, and the approaches used to respond to behaviours follows (Dupuis et al., 2012). The literature suggests that there is a need to compare complementary treatments, with pharmacological interventions (Vasse et al., 2012, Moniz-Cook et al., 2008) thereby providing stronger evidence for their efficacy and relevance.

Integrating different approaches to education leads to lower levels of subjective burden in caregivers and education determines the strategies the caregiver chooses to manage distress behaviours (De Vugt et al., 2004). Disposition is of course affected by nurses own understanding of the nature of dementia. In the latest audit on dementia care in acute hospitals, it was acknowledged that the design and delivery of care predated the evolving understanding of the needs of people experiencing delirium or dementia (de Siún et al., 2014). Adapting to the hospital environment may increase symptoms of anxiety for an individual experiencing cognitive impairment. Currently, first line treatment is medication. If treated by pharmacology the trajectory of the illness is changed negatively (Banerjee, 2009). However, first line treatment with non-pharmacological approaches and intense assessments are advocated (Department of Health, 2014, Cohen-Mansfield, 2013). Integration of complementary treatments alongside traditional medical approaches may produce enhanced outcomes for patients, nurses and the overall care environment and may again have a longer lasting impact on nurses’ disposition.
Alongside disposition, basic skills in meeting the needs of people with dementia may require some level of attention. In the care environment, there is a renewed focus on fundamental care. This focus is underpinned mostly by growing evidence of recurrent failures to attend to people’s fundamental care needs (Kapur, 2014). In the older nursing texts fundamentals of care used to be defined in terms of safety, nutrition and elimination, rest/sleep, mobility and personal hygiene (Henderson, 1997). Concepts such as comfort, pain management, privacy and dignity are later additions to the fundamentals of care (Corbin, 2008). Interpersonal skills and attention are essential for relating these later addition fundamental care aspects with patients (Arnold and Boggs, 2015). Too often staff are expected to rely on common sense, instinct, tacit knowledge and life skills acquired through experience to support patients. These may or may not be present. The paradox is that these so called fundamentals of care are anything but basic and in no way are they straightforward skills to acquire (Kitson, 2010, Kitson et al., 2013). The presence of these emotional attributes are discussed in the next section. Research on the use of effective interventions such as massage may help to redirect attention towards the mind/body complex and, in the process, reinforce the value of fundamental, compassionate touch therapies in nursing practice today (Childre and Martin, 2011).

Reasserting the place of emotion

The rationale for this study is to explore nurses’ views, experience, attitudes and behaviours in the use of one therapeutic method, i.e. massage in a clinical setting. Inherent in this is consideration of emotion. Many authors concur that to develop real relationships with patients and thereby promote human flourishing, an individual must source their creative imagination, tacit knowledge and self-empathy (Arnold E, 2003, Rogers, 1995b, Titchen et al., 2011, Thorne, 1991, McCabe and Holmes, 2009, Meehan, 2012). To some extent, nurses may be seen as going on a spiritual journey with the person living with dementia, requiring them to bypass their own analytical brains, time-travel into their dimension and meditate on those moments at which everything seemed to change. Thus, the relationship with the patient became qualitatively different and authentic (Dewing, 2006).

The study and practice of compassionate presence are also relevant to support emotional well-being. There is compelling evidence that what esoteric practitioners observed for thousands of years is true, the subtle biological and bio-energetic pulsations of people in relationship influence each other, possibly connecting through electromagnetic fields (McCraty, 2005, Radin, 2009, Sheldrake, 2005). These authors also suggest that energetic information, such as
gratitude, appreciation, love and compassion is energetically transferred. Bypassing the analytical brain into this arena of non-verbal communication has un-investigated potential. This principle may be the heart of understanding non-verbal communication and the potential of hand massage as a healing intervention, further emphasising the relevance of the mindset of the nurse and their ability to care, to be present, and allow this energetic exchange to flourish.

The physiology of positive emotions and the role played by communicating from the heart has exciting implications for holistic nursing. An increased ability to be empathetic and an increased sense of personal power are intimately linked. It is now well-established that the heart is far more than a simple pump (Armour, 2008). A new critical consciousness about working from the heart has developed although it is evident that working from the heart and connecting through the act of hand massage may not be simple. Touch can evoke emotion that can complicate caring for the nurse. An enriched environment enables compassion to surface (Robertson, 2013), thereby enabling caring to be nurtured and developed to its fullest extent. McCormack et al. (2007) point out that compassion is a skilled interpersonal and relational process from which staff can gain energy and satisfaction.

2.7 Conclusion

The purpose of this study is to highlight nurses’ views, experience in the use of one therapeutic method, i.e. hand massage in a clinical setting, for the alleviation of anxiety in older adults with dementia. This chapter has located the research question within the historical evolution of nursing practice, and within the discussions of how a more person centred care focus can be achieved. More specifically, it has examined the added complexity of providing such care to people living with dementia, highlighting the different ways in which dementia can be understood and the impact this can have on approaches to care. The chapter also shows how consideration of the care of people living with dementia is an issue of growing importance, given the growing numbers of people living with dementia both in Ireland and worldwide. This study’s focus is on the delivery of person-centred care through the hands of nurses, as one in a number of care responses. Despite its intuitive appeal, this approach to care is still somewhat marginalised and requires further research. However, the evidence presented in the chapter is sufficient to justify that an exploration of hand massage may have an important role to play in the provision of such care. Such a role derives not just from its direct impact on anxiety reduction but on its potential to re-establish the basics of closer, human caring and connection, at a physical and emotional level. There is evidence that it offers exciting possibilities to
positively influencing the dementia experience through a refocusing of attention towards person-centred care practices. In the next chapters, these possibilities will be explored in a number of residential care settings in Ireland.
Chapter 3 Methodology

3.1 Introduction

The aim of this chapter is to describe the methodology used to explore the central research question of this study, namely ‘What are nurses’ experiences of using hand massage to alleviate anxiety for patients living with dementia in residential settings’?

This chapter is organised as follows. Section 3.2 outlines the underlying approach taken to carrying out the research and the rationale underpinning the choice of approach to research design and analysis. The importance was highlighted by Newell and Burnard (2010) who emphasised the need to create logical links between a research question and the methodology used. This research draws on a constructivist/interpretive worldview, and the justification for this choice is explained, making explicit the philosophical assumptions underlying the methodological choices for this study. In the section on research design (3.3) the rationale for placing a qualitative approach at the core of the research design is described. Such an approach allowed for a broader exploration of the research objectives and a deeper insight into nurses’ experiences.

The settings in which the research was conducted are next described in section 3.4, outlining both the research locations as well the process for selecting participants, access and ethical approval. Section 3.5 proceeds to describe the approach taken to data collection, including collection methods, piloting of the data collection, data analysis and the rigour of the study. This section also includes consideration of relevant ethical considerations pertaining to this study. The penultimate section 3.6 details how the study data were analysed, explaining how data was captured and structured for analysis and the various choices involved in such a process. The methodological limitations to this study are discussed in the final concluding chapter.

3.2 Underlying approach and assumptions

The purpose of this section is to set out some of the underlying approaches and assumptions to research and to present the approach that has guided this study. It briefly examines the different research paradigms, the theoretical frameworks or analytical lenses, through which the world may be viewed, and human experience understood (Holloway and Galvin, 2016).
It is the specification of the paradigm that sets down the intent, motivation and expectations for the research. Without identifying a paradigm as a first step, there can be no basis for subsequent choices regarding methodology, methods, literature or research design. There are a number of paradigms in social sciences research, with positivist, interpretive-constructivist, critical theory and participatory being the main approaches used in nursing research (Denzin and Lincoln, 2008, Weaver and Olson, 2006). Simply put the goal of positivism is to consider only what is observable and directly measurable. The view of the world is considered deterministic and reductionist (Creswell, 2013). The world is ‘real’, ordered and regular (Young, 2008). Truth is universal. Theory is established deductively through scientific statistical testing of the hypothesis (Guba and Lincoln, 1994). Positivism is closely aligned with quantitative research. Building on the once dominant positivist perspective, the post-positivist paradigm maintains that reality can never be completely known. The epistemology of post-positivism is objective, and knowledge is sought through replication (Weaver and Olson, 2006). The principles of post positivism emphasise the importance of multiple measures, observation and consensus of opinion (Houghton et al., 2012).

Health research often emphasises the measurement of the appropriateness and effectiveness of interventions (Bowling, 2014). In this research, the use of complementary interventions for patients living with dementia in residential settings has been identified as difficult to measure due to the current lack of appropriate tools (Vasse et al., 2012). While there is value in measuring outcomes quantitatively, there is also a need to allow the exploration of human stories to make sense of reality and to develop theories (Morse and Field, 1996). Thus, qualitative approaches which share a philosophy of person-centeredness (Todres et al., 2009) and a focus on methods that explore the in-depth nature of human experiences are necessary.

Beyond positivism and post positivism, therefore, other ontological approaches reject the idea that what we know is only that which is observable and directly, quantitatively measurable. A critical social theory approach emphasises the study of social institutions and aspects of power. Within the realm of nursing, for example, the ability of nurses to recognise and potentially challenge social structures in the provision of holistic care is central to critical enquiry (Mooney and Nolan, 2006).

Such an approach does not lend itself to mere observation and measurement and requires more in depth qualitative analysis and interpretation, such as that provided by the constructivist/interpretive approach. The constructivist-interpretivist paradigm is premised on
the belief that knowledge is socially constructed. Guba and Lincoln (1994) describe the constructivist/interpretivist paradigm as having relativist ontology in which truth is not absolute but consists of multiple realities constructed by individuals. It is context specific. Knowledge is jointly created through this interaction between researcher and participant. It embraces and emphasises the importance of the interactions among researcher, research setting and research participants. In a constructivist/interpretivist framework, understanding is embedded in a person's interpretation of the world. As such, it not only captures the participant’s view of the situation being studied and also acknowledges that the researcher’s beliefs, values and interpretation affect the research (Creswell, 2013). This understanding makes the researcher a participant in the research as well as an interpreter of the data. Unlike positivist approaches, the constructivist/interpretivist approach generally relies on qualitative methods of data collection (Silverman, 2013).

3.3 Research design

A research design is a framework used for the planning, implementing and analysis of a study (Burns and Grove, 2010). A research design connects an ontology with an appropriate set of research methods (Wahyuni, 2012). Having explained the rationale for embracing a constructivist/interpretivist approach and its emphasis on qualitative research this section now outlines in greater detail the nature of the qualitative approach adopted.

The focus of this study is on individual experience and perspective. Thus, the study is ontologically rooted in the constructivist/interpretivist approach recognising that reality is never fully and definitively known (Speziale et al., 2011, Munhall, 2012, Rolfe, 2006). It is ever changing and reproduced by people as they act on their perceptions of reality, in the process changing and reconstructing reality (Welford et al., 2011). The epistemological position adopted recognises the reality of subjectivism, acknowledging that each participant has a unique perspective and experience. Subjectivity, while bringing bias to the research environment, also allows sensitivity, intuition and an awareness of self (the researcher) as a research instrument (Janesick, 1998). Critical awareness of and conscious reflection on self and one’s motives are seen as essential tools for management of bias in the research arena (Morse and Field, 1996).

Creswell (2013) suggests that a qualitative methodology, with its emphasis on the human experience, allows for a richer, more meaningful experience that contextualises the personal
and social factors affecting the nurse participants’ experience. There are a number of different approaches commonly used in nursing research to undertaking qualitative research including ethnography, phenomenology, grounded theory and the qualitative descriptive approach (Pope et al., 2000). Ethnography, which it is closely associated with cultural anthropology, explores behaviour from the cultural context in which it is embedded. It is often conducted over a long period and involves extended periods of direct observation. Given that the purpose of this study is not to explore a purely cultural perspective but to describe a broad perspective encompassing multiple factors (institutional; professional; human interaction, to name a few), ethnography was not considered to be the most appropriate approach. Moreover, it was not possible to conduct extended observations within the type of research site implicit in this study.

Phenomenology involves the study of experience and consciousness and is associated with the philosophical movement founded by Edmund Husserl. It explores the lived experiences of participants, emphasising the importance of judgement, perception and emotions. There are many perspectives of phenomenology. However, Husserl is said to be the father of phenomenology, with descriptive phenomenology being used to describe his philosophy. Husserl argues that the “lifeworld” (Lebenswelt) is understood as what individuals experience pre-reflectively and describe thus, without resorting to interpretations (Dowling, 2007). Heidegger, once a student of Husserl, moved phenomenology towards an interpretive approach. This interpretative approach is said to be useful in examining contextual features of experiences and exploring the concept of being in the world (Reiners, 2012). However, it is suggested that phenomenology research results in the illumination and explanation of human experience and its meaning. Therefore not considered the most appropriate method for this study (Van Manen, 2016).

Within qualitative research, grounded theory is used to explore the underlying processes that inductively build theory (Strauss and Corbin, 1990, Creswell, 2012). Thus, its aim is to develop or perhaps discover theory from the data gathered. As the purpose of this study was not theory creation, grounded theory was not selected as the research method.

To meet the aims of this research as described in the introduction, a broader, qualitative descriptive approach has been adopted. According to Sandelowski (2000c), a broader qualitative approach emancipates the researcher allowing them to be free from the constraints associated with more traditional methods which also seek to explain phenomena and generate
theory (Lambert and Lambert, 2012). The rationale for using a qualitative descriptive approach is set out in the next section.

3.3.1 Rationale for using a qualitative, descriptive approach

This study uses a broad qualitative descriptive approach chosen to elicit deep, rich and practitioner led understanding to guide future decisions that will apply evidence to the lives of real people (Thorne et al., 2004). Data collection in qualitative descriptive studies are directed toward discovering the who, what, and where of events or experiences (Sandelowski, 2000c). Qualitative descriptive stays close to the meaning of what participants say with little inference or interpretation (Sandelowski, 2000c). Participant’s words as the basis for the clarification of meanings are key. This is believed by the researcher to achieve most effectively the objectives of this nursing inquiry, given that the purpose of this study is to concentrate on describing nurses’ experience. The justification for this is set out below.

Qualitative descriptive research has developed from the fields of anthropology and sociology (Holliday, 2007) and seeks to understand the complexity of human activity within cultures and societies. Describing nurses’ experiences of providing hand massage to individuals experiencing anxiety in dementia in residential settings is one such activity. This thesis aims to provide such an understanding and contribute to the knowledge of hand massage practices within the cultural and social context of residential settings by using a qualitative descriptive approach.

A qualitative descriptive approach is one of the most frequently employed methodological approaches in the practice disciplines (Sandelowski, 2000c), particularly when direct descriptions of phenomena are desired (Milne and Oberle, 2005). The values and influence of the researcher are an integral part of qualitative description, and rich straight descriptions of an experience of the event are used to analyse the data (Sandelowski, 2010). Within qualitative descriptive studies the emphasis is on ‘discovering the nature of specific events under study’ usually using some level of structured but open-ended interviews or collective focus groups. Qualitative descriptive studies are ‘purely data derived’ that is, the procedure for coding data emerges during the study (Lambert and Lambert, 2012).

Whereas other qualitative approaches often aim to develop concepts, analyse data and engage with existing theories, the final product of qualitative description is a description of participants' experiences in a language similar to the participants' own language (Neergaard et
Qualitative descriptive studies are not atheoretical but may be considered to be the least ‘theoretical’ of the research methods (Sandelowski, 2010). Qualitative descriptive involves low-inference interpretation; so even though the description is the main aim, it is acknowledged that some level of interpretation is always present. Inevitably, the presentation of descriptions will depend on the perceptions, experience, inclinations and disposition of the researcher (Neergaard et al., 2009).

In short, it is suggested that ‘a qualitative descriptive approach needs to be the design of choice when a straight forward description of a phenomenon is desired’ (Lambert and Lambert, 2012). The relative novelty and limited development of hand massage as an intervention lends itself well to a such a method as it allows for emphasis nurses experience and the contributing factors to the development of this complimentary intervention (Barroso and Cameron, 2012).

3.4 Research settings and participant selection

This section describes the specific settings in which this research was carried out and outlines how participants in the study were selected.

3.4.1 Research settings

The settings for the recruitment of participants for this study comprised older adult residential settings, namely three Health Service Executive (HSE) hospitals and two private nursing homes providing 24-hour nursing care to an inpatient population.

There were designated dementia units in two of the research sites but the number of patients experiencing dementia far exceeds the complement of these units, and so many individuals are cared for in other, more general residential care units within these two sites. Some nurses who were interviewed worked in designated dementia units where adults living with dementia are being cared for, while others worked in general residential units. The settings are staffed by registered nurses, health care assistants and multi-task attendants. To meet the aims and objectives of the research, the five selected sites provided an existing hand massage service (integral to routine activities or coordinated by local staff). It was important to set the research in facilities in which there was an optimum chance of encountering participants who would contribute to the study (Boeije, 2009) and where the views and experience of nurses offering hand massage could be obtained.
3.4.2 Selection of participants

The sampling approach used in qualitative analysis focuses on the elicitation of meaning, so it was important to gather data from nurses with direct knowledge and experience of hand massage (Sandelowski, 2010). The qualitative approach relies on small sample sizes to attain rich, thick data. This type of sampling is called *purposive*, i.e. the sample comprises participants who can offer information or views on a given topic, with each of the participants having knowledge on the topic (Newell and Burnard, 2006). To add value to this study, it was important to set the study in an area that optimised the chances of encountering participants who could contribute effectively to the study (Boeije, 2009).

To ensure that potential participants selected could contribute to the study aims participant inclusion and exclusion criteria were identified. Inclusion criteria specified that participants:

- Be registered nurses working in a residential care setting
- Had experience in the use of hand massage directly or indirectly in these care settings;
- Work closely with patients on an everyday basis, either directly involved in the care of the older person with dementia, or who supervised and directed health care assistants in the use of hand massage;
- Have at least one year of clinical experience within the past five years within an older person care setting.

There was a single exclusion criterion, namely that agency nurses would be excluded from this study. This exclusion criterion was justified as agency nurses may not be as deeply familiar with the research setting and may not have cared for older people in a specific long-term setting on an ongoing basis.

*Gaining access to participants*

The Directors of Nursing (Gate keepers) within the three Health Service Executives (HSE) and three non-HSE sites were contacted with a request to access the site for the research study (Appendix 1). *Nursing Home Ireland* indicated that each nursing home would have its own ethical practices in place (Appendix 2). All the HSE sites agreed to participate. Of the non-HSE sites approached access was granted in two while one declined to be involved.
Five Directors of Nursing agreed to be involved, and an information pack was forwarded to them. These packs included participant information sheets and consent forms so that the directors would be aware of the information being presented their staff (Appendices 3, 4). Arrangements were made for an initial visit to provide further information to the Directors and answer any questions about the proposed research process.

To provide an entry point to the study for potential participants, hand massage workshops for nurses and carers were facilitated at each of the research sites. These took place over four months. Workshop posters providing initial information about the study (Appendix 5), were also displayed in staff tea rooms well in advance of the workshop to attract the interest of all potential registered nurse participants.

Once interested participants indicated an interest they were sent a letter of invitation, (Appendix 6) information and a consent form (Appendices 3, 4 and 6). Within a week they received a follow-up telephone call. This gave adequate time to consider. Nurses willing to participate were offered interviews at a location that was convenient to them, either in the workplace or elsewhere. As a result of this process, 11 participants were identified in line with the participant inclusion criteria. Participants also had the opportunity to verbally discuss the study with the researcher before consenting to take part and at any stage of the research process. Their work experience ranged from three to approximately twenty years of exclusive experience in the setting of long-term care for older people, as a staff nurse, to activities nurse to the clinical nurse manager. All participants were female. A summary of the study participants, their level of experience and role in the care setting is provided in table 3-1.

<table>
<thead>
<tr>
<th>Participant Identifier</th>
<th>Years of experience in residential setting</th>
<th>Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>20</td>
<td>Staff nurse</td>
</tr>
<tr>
<td>2</td>
<td>10</td>
<td>Clinical nurse manager</td>
</tr>
<tr>
<td>3</td>
<td>25</td>
<td>Activities nurse</td>
</tr>
<tr>
<td>4</td>
<td>10</td>
<td>Staff nurse</td>
</tr>
<tr>
<td>5</td>
<td>11</td>
<td>Manager</td>
</tr>
<tr>
<td>6</td>
<td>5</td>
<td>Activities nurse</td>
</tr>
<tr>
<td>7</td>
<td>10</td>
<td>Staff nurse in dementia unit</td>
</tr>
<tr>
<td>8</td>
<td>17</td>
<td>Clinical nurse manager in dementia unit</td>
</tr>
<tr>
<td>9</td>
<td>7</td>
<td>Staff nurse</td>
</tr>
<tr>
<td>10</td>
<td>11</td>
<td>Staff nurse in dementia unit</td>
</tr>
<tr>
<td>11</td>
<td>3</td>
<td>Staff nurse</td>
</tr>
</tbody>
</table>
3.4.3 Ethical considerations

Ethical approval was sought from the HSE Ethics Committee and was granted in November 2014. This approval was applicable for all the research sites as the two non-HSE sites accepted approval from the HSE Ethics committee and granted access.

Ethics is a branch of philosophy that deals with decision making, including choices, right and wrong (Marianna, 2011). Qualitative research generates specific ethical challenges because of the potentially close relationship that researchers may form with participants (Holloway and Wheeler, 2013). A core part of research practice is the ethical framework which guides it. The Code of Professional Conduct and Ethics for Registered Nurses and Registered Midwives is this framework document (Nursing and Midwifery Board of Ireland, 2014). In Ireland, a guidance document regarding the ethical conduct of nursing and midwifery research had previously been developed by An Bord Altranais (2007), the statutory body responsible for the registration and education of nurses and midwives. This document identifies a number of core ethical principles to be addressed when carrying out research, namely: respect for persons/autonomy; beneficence; non-maleficence, justice/fairness; veracity; fidelity and confidentiality. In addition, the guidance document also identifies informed consent is an important consideration to be addressed when undertaking research (2007, p.9)

Respect for participant autonomy

The researcher must strive to respect the participant’s autonomy. The key elements of respect for a persons autonomy include the right to self-determination; the right to full disclosure. The availability of the researcher to explore and clarify any queries or concerns that potential participant may have is essential and the right to withdraw at any time without consequences (An Bord Altranais, 2007, p.7). The right to self-determination was achieved by stating in writing and verbally that participation was voluntary. The right to ask questions, to refuse to give certain information and to terminate their participation at any time without the risk of incurring any penalty or prejudicial treatment are all aspects of self-determination. This information was stated in the information pack. All potential participants were given informed consent forms to sign before participating in the study. In line with best practice, those that consented were given additional informed consent information on the day of the interview (Appendices 7 and 8) to assure them of their power of free choice and voluntary participation (Parahoo, 2014).
**Beneficence and non-maleficence**

While the principle of nonmaleficence places an obligation upon the research to do no harm, beneficence means ‘to do good’ and ‘positively help a person’ (An Bord Altranais, 2007, p.8); taken together they impose a duty on the researcher to minimise harm and to maximise benefit for the participants.

It is further envisaged that the research should be of benefit to participants and broader society (Zimmerman et al., 2014). The findings in this study gave voice to the experiences of participants and may positively influence the sustainability of hand massage within the research settings. One means of endeavouring that good is created and harm avoided is to practice constant self-awareness and mindfulness during the research process, where the researcher is in a state of care and acceptance (Bentz and Shapiro, 1998). This honoured the person and the process of engagement.

Neither the researcher nor the participant could anticipate everything that might unfold as a result of the interview and the researcher was conscious that addressing issues to do with hand massage which involves touching and being touched, had the potential to generate a range of feelings and reactions. The mindful and responsive interviewing style employed in this study produced a gentle style of acceptance (Rubin and Rubin, 2011). This attitude allowed the participants to feel psychologically safe during the interview process. When two participants became emotional during their interview, I created a pause, turned off the tape recorder and repeated my ethical and personal need to minimise intrusion. I explained that in my efforts to hold to the ethic of care, anxiety to get it right can cause me to lose sight of a participant (Peredaryenko and Krauss, 2013). Both participants were asked if they were happy to continue and they agreed to proceed. As a result of this mindful research practice and through regular ‘checking in’ with participants it is confidently concluded that there were no adverse effects encountered from asking participants about issues to do with hand massage.

**Justice and fairness**

The principle of justice means that participants are entitled to fair treatment before, during and after this study (An Bord Altranais, 2007). This valid expectation of fairness was made explicit to all participants in the information provided prior to the interview (Appendices 7 and 8). Participants had an opportunity to verbally discuss the study with the researcher at any stage during the research process and were assured that identifying information would not be made
available to anyone other than the researcher and research supervisors. They were also informed that their contributions would be faithfully reported and not distorted in any way.

*Veracity*

The principle of veracity involves ‘concepts of truth told about the research study and the absence of deception’ (An Bord Altranais, 2007, p.8). Every effort was made to make the purpose of this study explicit to all involved. All participants during this study were informed of its purpose by written and verbal means prior to its commencement, and this was reiterated at the beginning of each interview.

*Fidelity*

Fidelity involves the idea of trust (An Bord Altranais, 2007). The researcher was conscious of the privilege afforded at all times and committed to protecting participants before, during and after the study. As a result of this mindset being communicated to participants, it was possible to foster a trusting relationship during the interview process, which (in the opinion of the researcher) ultimately led to a mutually enriching experience. This was achieved by ensuring confidentiality and anonymity thereby removing any risks for participants and facilitating autonomy of thought (Munhall, 2012).

Maintaining the trust and dignity of the participant is paramount (McIntosh and Morse, 2015). During the interviews, it became apparent that most of the participants had personal views and experiences that they wished to express. Therefore, it was important to seek permission from each participant at regular intervals throughout the research process by re-iterating the voluntary nature of the study and the participant’s right to withdraw from the interview at any time.

*Confidentiality*

According to An Bord Altranais (2007, p.9), the researcher has a responsibility to participants to ensure privacy and confidentiality meaning that any information made available to the researcher by participants ‘must not be made available others without their consent’. Researching with a small, distinct group of nurses at their workplaces made the aim of ensuring confidentiality more complex. In the discussion, most of the participants wanted their identities to be anonymised, although two participants did not mind being disclosed. However, all contributions have been anonymised.
To do this, prior to data transcription and to protect the identity of participants, recordings were given code numbers. The corresponding transcripts were also given code numbers to protect the identity of participants. The master list of participants’ names with these code numbers is stored securely separate from all other data in a locked filing cabinet in the locked office of the researcher. All electronic data files were password protected and stored in accordance with the Data Protection (Amendment) Act 2003.

In line with the University of Limerick guidelines, electronic and hard copies of the coded anonymised data will be retained for seven years. All hard copy data including written transcripts are securely held under lock and key in the researcher’s office. The researcher is the sole key holder to this office.

Computerised data files including transcripts of digital recordings were password protected on the researcher computer. Digital recordings were permanently erased immediately after transcription. No-one but the researcher knew the source of the data, ensuring that confidentiality was maintained.

**Informed Consent**

Finally, within any research carried out under ethical principles, the purpose of informed consent is ‘to protect research participants and allow them to make informed choices’. It is further suggested that achieving informed consent involves four key components: disclosure of information, comprehension, competency and voluntariness (An Bord Altranais, 2007:9).

All participants in this study were informed of the purpose of the study verbally and through the provision of an information sheet (Information Sheet Appendix 3)\(^2\). They were also informed about their right to refuse to participate and to withdraw from the study at any time without prejudice (Information sheet and Consent form, Appendices 3 and 4). Recognising the dynamic nature of consent giving and to ensure that there was sufficient time to allow for full comprehension of the information provided, time to consider and make an informed choice of

---

a week to ten days was factored in to allow the nurses sufficient time to process their thoughts about participating in the study.

Following a further review of the information sheet before each interview, informed consent was obtained immediately before the commencement of each semi-structured interview (Appendix 4). Having been advised in the information letter that interviews would be audio recorded, participants were advised that the digital recording device could be stopped at any time and they did not have to answer any questions that they were not happy to answer. The participants were reassured and asked at regular intervals during the interview if they were happy to continue and were advised that they could withdraw at any point without fear or favour. The autonomy and dignity of each participant were upheld throughout the study (Kraft et al., 2017). In summary, this research project was designed and carried out in full cognisance of An Bord Altranais guidance for the ethical conduct of research within the field of nursing practice.

3.5 Data collection

Data collection is the systematic gathering of information relevant to the aims and objectives of the research (Burns and Grove, 2010). It is also suggested that nature of the research question determines the data collection method (Doody and Noonan, 2013, Ormston et al., 2014, Merriam and Tisdell, 2015). Equally, the choice of research paradigm and methodology also impacts on the choice of data collection instrument. This section describes and justifies the approach taken to data collection in this study.

3.5.1 Collecting data in a qualitative study

Data collection in qualitative research involves gathering narrative data from participants through interactive conversational processes. One such process involves the use of interviews as a way to engage in conversations. A range of interviewing techniques can be used, including structured, semi-structured and unstructured interviews (DiCicco-Bloom and Crabtree, 2006, Doody and Noonan, 2013). Unstructured interviews are open-ended and non-directive (Silverman, 2013), typically focusing on one or two broad questions. Structured interviews lie at the other end of the spectrum. In a structured interview, there is a complete script that is prepared beforehand with no room for improvisation (Merriam and Tisdell, 2015) These types of interviews are often used in qualitative surveys where the interviews are not necessarily conducted by the researcher. Structured and unstructured interviews were not considered...
appropriate for this study because there is no room for exploration or deviation from the exact topic (Seidman, 2013).

By contrast, semi-structured interviews are flexible, consistent with qualitative research methods and congruent with the aims and objectives of this study. In a semi-structured interview, the researcher and participants are engaged in a mutual experience to gain real insights into the participant’s world (Higgs et al., 2009). Polit and Beck (2004) suggested that in the semi-structured interview, the researcher has a list of topics to cover rather than specific questions to ask. This flexibility in semi-structured interviews adds to the effectiveness in exploring relatively new or uncharted areas such as the experience of nurses using hand massage to alleviate anxiety.

Rubin and Rubin (2011, p.15) discuss semi-structured interviews in terms of “responsive interviewing” which in their view draws on interpretive constructionist philosophy. The researcher elicits depth and detail about the research topic by following up on answers given during the interview. They are firm on the dynamic nature of qualitative interviewing and stress that ‘qualitative interviewing is not simply learning about the topic but also learning what is important to those being studied’. The flexibility of this approach allows for the discovery of what is important to participants and which may not have been previously considered by the researcher. Face to face; semi-structured interviews facilitate the participants to share control of the interaction between the interviewer and interviewees so that the meanings will eventually be a joint effort of both parties (Polit and Beck, 2017, Boeije, 2009). Boeije (2009) highlights the reciprocal benefits of interviews, where interviewer and participant are engaged in a mutual conversation, justifying the use of semi-structured interviews within the interpretive constructivist framework of this study.

While the qualitative, semi-structured interview is an excellent means of gathering data, it is not without difficulties (Thorne, 2016). One drawback is that novice researchers are often unable to identify where to ask prompt questions or probe responses, or explore relevant data (Doody and Noonan, 2013). By participating in an interview, both parties are implicitly agreeing to abide by certain norms. What is said is seen as a reflection of what actually happens in practice rather than a social construct produced by two people (Thorne, 2016). The challenges of dementia as experienced by participants were powerful. It took a good
deal of self-control for me to not be overly involved, sympathetic and offer words of reassurance and agreement (Ashton, 2014). The interview can be looked on as an artificial encounter which involves asking participants to create or give opinions under time pressure (Silverman, 2013). There may be concerns regarding how much the researcher can be trusted. The participant may choose not to divulge information that he or she may consider sensitive (Rubin and Rubin, 2011, Silverman, 2013). Also, participants are sometimes known to respond in a way that creates a positive impression (Doody and Noonan, 2013). An awareness of the qualitative interview as a powerful tool and an awareness of the potential problems and pitfalls in its use gives a heightened appreciation of its strengths and weaknesses (Myers and Newman, 2007, DiCicco-Bloom and Crabtree, 2006).

3.5.2 The data collection process

The process of data collection for this study commenced once ethical approval for the study was secured. From November 2014 to May 2015 interviews were held with study participants. A semi-structured interview was the method adopted for this study.

Pilot study

To test the appropriateness of the interview guide, I conducted a pilot interview as a preliminary exercise to refine the methods I to be adopted (Grove et al., 2014). The purpose of a pilot interview was to test the clarity of the questions in the interview guide, my interview style, communication and use of the audio recording device (Creswell, 2013, Polit and Beck, 2013). This provided an opportunity to practice the timing of interviews and questioning techniques as well as developing my interview skills.

Given the study’s focus on describing nurses’ views of the use of hand massage, it was considered that this was the most appropriate method whereby the researcher engaged with the participants, encouraging the sharing of rich descriptions of their experiences (Morse et al., 2008). This approach provided a clear structure – by asking all participants the same questions - but there was no defined ordering of the questions. Participants were encouraged to talk about their experiences through open-ended questions, and the ordering of further questions was determined by their responses, thereby retained flexibility by enabling and encouraging a diversity of responses (Silverman, 2013). Being present and demonstrating active listening to participants also enabled the flow of prompts and clarification of meaning (Holstein and Gubrium, 2016). The core of responsive interviewing (which is not exclusive to semi-structured
interviews) involves three factors: formulating and asking the main questions, having probes ready to stimulate, and then having follow up questions to explore and test ideas together. There is an opportunity to change words and order but not the meaning of the questions. The list of topics used in the interviews is presented in Appendix 7. An interview guide was used to ensure consistency across all interview and study settings (Appendix 7). Interviews were audio recorded with permission and lasted approximately 30 - 45 minutes. Anonymity was maintained by removing from the written transcripts any reference to the participant’s name and work location. Interview numbers were issued in their stead.

The important element of trust between researcher and participant was highlighted in the section on ethical principles. During the interviews, it was essential that awareness was maintained of a participant’s actual and potential discomfort and vulnerability in responding to some questions. For example, during the first interview, the participant spoke emotionally about an aspect of practice. However positive this exchange felt, as an insider researcher the necessity to maintain a level of emotional distance was recognised so as not to thwart the authentic view of the participant (Holloway and Wheeler, 2013). While not possible to bracket the emotional response, distance was achieved by giving the occasional knowing glance but maintaining a warm detachment (Duncombe and Jessop, 2002). That said, the experience opened the rest of the interview, and it turned out to be quite a unique experience. This experience also served the researcher and enabled her to maintain a heart-trusting connection during the other interviews.

Consistent with the opinions of Kvale and Brinkmann (2009) ethical issues of mixing roles of research interviewer and colleague/ confidant were always maintained in constant reflective awareness (Kvale and Brinkmann, 2009). Awareness of ethics surrounding roles was kept to the forefront. The process of establishing rapport was an essential element in the encounters and involved trust and respect for the participant (Holloway and Galvin, 2016). A relaxed, responsive conversational approach was adopted with active listening in which I responded to the interviewee with prompts that repeated the question to show that I was actively listening (Rubin and Rubin, 2011). Establishing a comfortable place to hold the interview was also prioritised, to making the interview as convenient and as pleasant as possible for the participant.
3.6 Data Analysis

Having described the process for data collection this section now moves on to outline how the data collected was analysed.

3.6.1 Approaches to data analysis

Data analysis is labour intensive, demands creativity, conceptual sensitivity and commitment (Polit and Beck, 2013). This approach to data analysis is consistent with a qualitative descriptive study within the interpretive constructivist worldview of the researcher (Sandelowski and Leeman, 2012). As soon as data collection began, the researcher became aware of similarities in the literature and possible new findings. Morse and Field (1996) advise against attempts to match data with concepts in the literature, so it was necessary for the researcher to separate thoughts regarding the literature from the data so that recognition of new information would not become contaminated at an early stage.

The description in qualitative descriptive studies presents facts from the data untouched by researchers interpretation (Sandelowski, 2010). The researcher acknowledges the human tendency for subjective interpretation and thus the invaluable use of reflection through art and poetry, described in more detail later. The ongoing process of inner reflectivity, embracing subjectivity, checking ‘what I know’ and ‘how I know it’ maintained the data analysis as a descriptive encounter (Jootun et al., 2009). This qualitative study is inductive in nature, and hence the data analysis process is also inductive and true to the voice of the participants. Inductive reasoning uses the data from the findings of the study to generate ideas and themes (Thorne, 2014).

In order to enable data analysis, the interviews were transcribed verbatim. Data collection and data analysis tend to be concurrent processes (Thorne, 2014), and the interaction of these processes is described in detail in the following sections. Data were thematically analysed using the updated framework developed by Newell and Burnard (2006) (Appendix 8). Content analysis and thematic analysis is often used interchangeably and there no shortage of discussion about their similarities and differences (Sandelowski and Leeman, 2012). Both approaches are used in nursing research. They share the same aim of analytically exploring narrative materials from interviews by breaking the text into relatively small units of content (Vaismoradi et al., 2013) Both approaches are largely based on the “factist” perspective. A factist perspective assumes data to be more or less accurate and truthful reflections of the reality out there.
By using content analysis, it is possible to analyse data qualitatively and at the same time quantify the data by counting the codes (Grbich, 2012). Conversely, the thematic analysis provides a purely qualitative, account of data broken into themes. Themes are not dependent on quantifiable measures, but rather on whether it captures something important in relation to the overall research question (Braun and Clarke, 2006). Thematic analysis, as employed in this study, is widely used in qualitative research and is a particularly useful tool for giving structure to data analysis (Newell and Burnard, 2010, Braun and Clarke, 2006). Newell and Burnard (2006) identify six phases of analysis to guide the researcher. These include post interview memo taking; reading transcripts and making notes of general themes; subsequent re-reading of transcripts; reducing the codes using higher order codes; revisiting the data with the higher order codes/themes and finally, collating the organised data for reporting.

One of the benefits of using Newell and Burnard (2006) approach is that although structured, it allows flexibility and freedom to construct key themes of interest and interpretation by the researcher by letting the data lead the identification of themes. The Newell and Burnard thematic framework allowed for the minimal organisation of the data with a rich and detailed description of key themes, and was, therefore, the most suitable framework to guide this study (Appendix 8). A theme captures something that is important in the data and demonstrates patterns or meanings within the data set (Newell and Burnard, 2010).

The identification of themes is foundational to all kinds of qualitative research and analysis (Sandelowski and Leeman, 2012). In this study, thematic statements from the data were used to name some of the themes and sub themes. Such statements summarised the key ideas presented in the said theme. These introductory statements were prepared in a way that made them intelligible to any reader working in health care. Moreover, such statements may help readers to follow the line of ideas the researcher hopes to communicate (Sandelowski and Leeman, 2012). In addition, visual displays of the presentation of findings in the form of diagrams were used to guide the reader.

**NVivo as Data management tool**

To aid the process of data analysis, the researcher used NVivo10 software (QSR International Pty, Doncaster, Victoria) as a data management tool. NVivo is compatible with Newell and Burnard, and evidence of its use is widely available in the nursing literature (Taggart et al.,
2010, Cronin et al., 2015). Key points made by the participants were identified and assigned a code within NVivo.

Similar codes were gathered into themes and subthemes. Each participant was given a number and the NVivo programme identified each response associated with that number. This number made it easy to trace back to the original transcripts, particularly in the later stages when data was reduced and collapsed into themes and subthemes. An advantage of NVivo is a single (password secured) location for storage of data. This provides easy access to material and the ability to hold large amounts of data with consistent coding schemes (Bergin, 2011). Disadvantages were the time and effort to become proficient in using the programme, but this was partly offset by the availability of expert support. NVivo was used for data management, not analysis, so a more in-depth look at its merits or otherwise was not required. Transcripts were transferred to NVivo software for data management. Each of the Newell and Burnard (2006) phases as applied in this study is described in more detail below.

3.6.2 Applying the Newell and Burnard approach

The Newell and Burnard approach to data analysis involves six stages. Each of these as applied in this study is now described.

**Taking memos after each interview**

Each meeting with a study participant was like a snapshot in time that needs more than one way to capture them fully. Each interaction created meaning, some of which could be digitally recorded. However, the unspoken essence of each encounter, impressions and feelings, were also considered important and merited recording. On occasion, important data was shared when the recording was off, in that instance a post interview memo ensured that nothing was lost. More generally, post interview memos were used to support the recall and to locate interviews in the broader context of human interaction. I allowed myself time after each interview to reflect on the encounter and take notes. I did not take notes during the interviews as I felt this would distract both the participant and myself (Charmaz and Belgrave, 2012, Doody and Noonan, 2013).

**Reading transcripts and making notes of general themes**

In reality, professional help for transcription was required due to factors related to time and the researcher's skills. Great care was taken to ensure that participant confidentiality was
maintained. This was achieved by the use of a number/code system. Seven of the interviews were transcribed professionally; the remaining four were transcribed by the researcher. Transcription is time-consuming, and it is considered that the most effective approach would be a combination of deep immersion through self-transcription allied with detailed examinations of the remaining professional transcribed interviews (Bernard et al., 2016). In taking this approach, the process of deep engagement with the data became embedded and was subsequently carried over into the analysis of the transcriptions.

Having created the transcripts, the second stage in the analysis framework involved the initial reading of the participant transcripts. First, the transcripts were read with an open mind to get an overall impression of the interviews without being too influenced by my preconceptions. Thoughts and reactions to the text were always maintained in constant reflective awareness (Kvale and Brinkmann, 2009). The transcripts then re-read until a state of immersion in the data was achieved. At this stage, also I referred to my reflective diary entries to supplement examination of my initial transcript impressions to add further depth of understanding to the analysis process. My depth of understanding changed and developed throughout this process.

Repeating reading through the transcripts:

In the third stage, Newell and Burnard (2006) refer to categorising data where summaries are written in the margins and then the text is reduced into categories or codes. This was facilitated by the NVIVO data management using the initial coding exercise. Coding the data in NVivo involves the creation of nodes. The node is a collection of references about a specific theme (Bazeley, 2013). Once interviews were imported into NVivo, free nodes emerged organically from reading the transcripts and initial codes/themes were identified (see Appendix 9).

Reducing the codes under higher order code:

The next stage of the process involved the collection of categories or codes and reducing them under higher order codes. In this way, a smaller set of codes were developed. This reduction was achieved by NVivo ability to locate all the passages that matched the criteria set in a query. Locating ensured that any issue described in the findings was not the perception of just one participant, but rather confirmed that a number of participants held the same experience or opinion. In addition, this confirmation guaranteed dependability in different contexts.

---

3The words codes and themes are used interchangeably between NVivo and the Newell and Burnard framework.
**Returning to the data with the higher order codes/themes:**

Having identified a set of higher order codes, I then returned and revisited the data. Constant reflection and self-analysis were required to stay on track. Over time, all the text other than that which was irrelevant was allocated a code (Morse and Field, 1996). The references associated with each code / theme varied. The codes were refined, and a framework was created to organise the emerging findings. These findings could be readily categorised into factors that preceded the use of hand massage; factors relating to its delivery, and factors relating to observation of the outcomes or impacts of hand massage.

The result meant that all interview material related to specific codes / themes were recorded in a manageable and easily accessible way, with NVivo acting as the tool for data management that enables the researcher to more efficiently undertake the analysis of the data. This enabled the creation of an audit trail, which illustrated the structured approach to the management of data. The process of initial and refinement of codes is illustrated in the screen shots (See Appendix 9).

**Collating the organised data for reporting as the final stage:**

The final stage in the Newell and Burnard framework involved the collation of organised data in preparation for reporting. The method described here offered a method of generating categories under which similar themes or categories were collated.

As will be seen in the next chapter, the findings are presented in the exact voice of the participants. There was no speculation or theorising about the results (Newell and Burnard, 2006).

**3.6.3 Trustworthiness and rigour**

The significance of trustworthiness and rigour cannot be overstated (Rolfe, 2006). There is an acceptance that as a qualitatively researcher one will never find direct unobstructed views of experience (Daiello, 2014). Thus, there is an accompanying obligation to make visible the description and construction of participants’ views. A number of key factors can help to reinforce a study and can convince the reader of the trustworthiness and rigour of the research. These are especially important in affirming the merits of qualitative research approaches (Silverman, 2013).
Qualitative inquiry is subjective, interpretive and time and context bound. ‘Truth’ is relative and ‘facts’ depend upon individual perceptions (Nowell et al., 2017). Trustworthiness refers to the robustness of the methodology of a study (Holloway and Wheeler, 2013). The trustworthiness of this study was based on the framework used for establishing the rigour in qualitative studies, which include transferability, dependability, credibility and confirmability (Newell and Burnard, 2006, Ryan-Nicholls and Will, 2009). These concepts are discussed in the following sections:

**Transferability**

Transferability according to Creswell and Poth (2017) is the ability to apply a study’s findings to other settings and populations. This is also known as the generalisability of the findings (Polit and Beck, 2013). In qualitative research, there are multiple realities, which may not be applicable to other situations (Morse and Field, 1996). However, transferability is strengthened when findings are meaningful and recognisable to others not involved in the study. Houghton et al. (2013) suggest that the responsibility of transferability lies with the researcher who wants to transfer findings to another setting as opposed to the original researcher. The expectation of determining whether the findings are transferable lies with potential users (Sandelowski and Barroso, 2006).

In this study, the researcher engaged with participants in the construction of rich, detailed data that was described in the social context of the participants, in a particular setting at a particular time (Houghton et al., 2013). The findings of this study may fit into other contexts. So, while this study was not designed to be generalised, a small purposive sample was used to elicit meaningful data in a way that could make it recognisable to others, though as suggested above, this is the responsibility of the researcher who assesses the research. However, a description of the broader literature, the study locations, and clear inclusion criteria is informative to readers and other researchers who may wish to transfer findings to another setting.

**Dependability**

Dependability is the equivalent of reliability in quantitative research (Lincoln and Guba, 1985). Dependability is understood as the stability of data over time and over conditions (Colorafi and Evans, 2016). It is used as a measure by reviewers who audit the research process (Ryan-
Nicholls and Will, 2009). Dependability is achieved when the researcher rigorously follows a number of strategies in the course of the research through which dependability can be fostered (Rolfe, 2006). The study strategies used to ensure dependability included a visible schedule to guide semi-structured interviews alongside post interview memos, a reflective journal (Appendix 10), audio recording and transcribed interviews. A transparent approach to data management was developed, aided by software and a related analytical framework drawing on the 2006 Newell and Burnard framework.

The steps already outlined within this framework kept the researcher in tune with the rigour required. All these were integral to the conduct of inquiry. The audit trail is for readers of a study to track how the researcher arrived at the findings (Sandelowski and Barroso, 2006).

**Credibility**

Credibility refers to the believability of the study to the reader (Creswell, 2013). Credibility is enhanced when researchers are self-aware and describe and interpret their experience as researchers (Lincoln and Guba, 1985). Credibility is established when the researcher accepts the subjectivity within the research process. Personal issues pertaining to background and influences are made explicit. Credibility in this study was enhanced by using a clear interview guide and ensuring the tapes were transcribed verbatim. The use of an interview guide ensured that all participants addressed the same research questions, thereby allowing credible conclusions to be drawn from the study cohort. A sample of the interview transcripts was checked with the study supervisors. Following data collection, the rigour of the Newell and Burnard (2006) data analysis framework helped the researcher to identify, analyse, organise the research materials. This enhanced the capacity to directly present the voices of the participants, one of the key determinants of credibility. It is the richness of direct quoting that enables participants to recognise their experience in the accounts (Ryan-Nicholls and Will, 2009). Given the transparency of the researcher’s thought processes in understanding the raw data, reflexivity assisted towards an unbiased viewing of the raw material without being clouded by personal judgement. This is discussed further in the next section.

**Confirmability**

Finally, in the pursuit of trustworthiness and rigour, confirmability refers to the means by which the results or findings in a study can be confirmed and trusted by others (Thomas and Magilvy, 2011). This study used a thematic analysis of data and the Newell and Burnard (2006) analysis
framework to create a transparent analytical framework with a view to enhancing confirmability. A decision trail also helps readers to decide on the methodological merits of the study. Koch (2006) commends researchers to engage reflexivity in establishing confirmability and suggests that it is the responsibility of readers to decide if they can follow and believe what has occurred throughout the study process. It is acknowledged by Denzin and Lincoln (2008) that findings are not facts as such but are created by the interaction of the participant, researcher and the data.

Galletta (2013) also warn against undermining the intuitive, tacit knowledge inherent in qualitative research in nursing and suggest that qualitative research at its best is unrestrictive and fluid in its approach. Nonetheless, to assist authenticity, decisions undertaken in this study were justified to elicit rich, meaningful messages grounded in the data through the interpretive constructivist lens of the researcher.

The importance of rigour in the qualitative study cannot be over emphasised. Morse et al. (2008) confirmed that rigour is critical to qualitative studies in the sense that it prevents methodological errors. Throughout this study, the researcher was explicit regarding methodology, data collection and data analysis. My reflective processes are described in the next section.

3.6.4 Reflexivity

Reflexivity is an important aspect of qualitative research. It is associated with rigour and credibility (Rolfe, 2006). It is a process involving critical self-reflection and encourages a self-conscious approach to research. It involves different types of awareness: being aware in the moment of interaction between researcher and participant; being aware of what is influencing the researcher's internal and external responses, and simultaneously being aware of the researcher's relationship to the research topic (Dowling, 2006). The principals underpinning reflexivity integrate well with the constructivist- interpretive paradigm which underpins this study as they help to ensure identification and management of pre-existing biases and preconceptions that may cloud the process of description and interpretation.

When interviewing participants, the importance of getting beyond professional discourse to how things work in practice was seen as particularly important. Participants sometimes began by describing what should or could be done in an abstract way and were gently guided back by asking about their actual individual experience and perception. Utilising an initial preamble to
settle the participants into conversation formed an important part of the mindful research process and allowed expansion and illumination of challenging situations. Distraction from the main focus of a question sometimes occurred but was part of the normal course of any conversation. On such occasions, the conversation was gently and respectfully redirected by asking the respondent to describe what they did the last time they gave a hand massage or the last time they were indirectly involved in a patient receiving a hand massage. In this way, I could investigate what frontline staff actually did as opposed to what they thought they should do.

I was also alert to instances of stresses of consciousness and cognitive dissonance where participants expressed the tension between their values and beliefs and the reality of their work practice. I asked participants specifics about when they did or did not give hand massage to patients, and their feelings and experiences connected with giving a touch. An example of the perceived discomfort initiated from this line of question was revealed in the data. These aspects of discovery were respectfully brought to a close with the implicit conclusion that in-depth answers were not forthcoming.

The depth of connection that hand massage precipitates can be frightening and likewise does not do anything for a sense of well-being of some participants. Self-knowledge was exhibited in the realisation among participants that giving hand massage was not possible for all. They recognise the failings and frailties they bring to the care setting and which will contribute to the experience of those in their care. The findings indicated participants to be reflective about their practice during the interview process, but some participants could be perceived as shying away from reflection in actual practice. Participants described their efforts to provide compassionate care through hand massage. Yet, at the same time, they spoke of trying to maintain emotional ‘space’ using the language of professionalism, boundaries or survival, i.e. what they felt they needed to do in order to continue working effectively in a particular setting (Whitby, 2008).

In this study, a reflective journal through art and journaling was used to record the researcher’s personal feelings to examine potential bias and to ask questions about what was being heard. This blending of writing with creative imagination and expression was inspired by the ‘Critical Creativity framework’ developed by (McCormack and Titchen, 2006, Titchen and McCormack, 2010). Their principles for action display the interplay of art, poetry and critical dialogue. This enabled the use of critical creativity in which the interplay of cognitive reflection
and critique was expressed through creative imagination and arts. Creative approaches in health research are increasingly contributing to a capacity to deepen and extend a researcher's reflexivity (McCaffrey and Edwards, 2015). One way of increasing self-awareness was to note the content and the process of any interactions and also personal reactions in the various research settings (Atkins, 2004).

The researcher initially explored her experiences by meeting the gate keepers (directors of nursing) and delivering the hand massage workshops at the study sites. The researcher’s anxieties and vulnerabilities were given voice through poetry and art. Poetry in such a setting is thought to increase the researchers capacity for compassion, empathy, problem-solving and conflict resolution (McCormack et al., 2013). Haiku poetry is an art central to Japanese culture. Haiku poetry has a long association with Zen Buddhism. Haiku is one of the shortest forms of poetry within the expressive writing paradigm. (Stephenson and Rosen, 2015).

A sample of the researcher’s artwork and Haiku poetry is displayed below.

![Figure 3-1: An example of haiku](image-url)
In this study, I was both the researcher and a member of the same profession as the participants of the study. Being an insider gave me certain advantages. It helped to facilitate trust and confidence in the research-participant relationship and allowed me to establish rapport during the workshops and in the data collection process. I understood their world and the participants knew this.

Parallel to this, I was attuned to the contradiction that I could never truly capture participants’ reality. The language of practice was shared. However, there was always the risk that I may ascribe meaning to certain words or phrases with which the participants may differ.

For example, during the interviews and workshops, I used the term ‘distress reaction’, rather than ‘challenging behaviour’. This preferred term, I gained from reading the literature. I felt this to be a more appropriate and positive language to help care teams understand the possible causes of such communication in patients with dementia.

I know my primary aim is a description of the analysis, but the inferring meaning is always present in any interaction between two humans. Reflexivity is critical for ensuring the validity of judgements made by the researcher. Reasoning and communication are frequently tacit and happen outside our awareness and occur in context. Outside the context, that reasoning can lose its meaning, eroded by time and memory, both for the researcher and ultimately for the consumer of the final research output. Throughout this research it was essential to take opportunities for thoughtful analysis of the research experience, being equally present to myself and the research process. Reflexivity is expanded upon in Appendix 10.

3.7 Chapter summary

This chapter outlines the research methodology for this qualitative descriptive study. Research aims and objectives were detailed. An overview of quantitative and qualitative approaches was provided and the justification for choosing a qualitative descriptive approach was offered. Access to the research sites and population was discussed. Ethical considerations to safeguard the rights and wellbeing of the study participants were explored. Details regarding the data management, collection and analysis were presented. Finally, a brief description of rigor in research was given including an overview of how this was achieved in this study. The purpose of this study is to explore dimensions of the use of hand massage by nurses working in a long-term older person setting.
In the next chapter, the findings arising from the application of this methodology will be presented.
Chapter 4 Findings

4.1 Introduction

This chapter presents the findings from this qualitative descriptive research describing nurses’ experiences of hand massage as an intervention to support patients with dementia. The findings present a detailed description of participants’ narratives.

Three integrated themes are explored in the data analysis. These three themes are identified as ‘Opening Doors’; ‘Being With’ and ‘Challenges’, describing the various stages and experiences of introducing and using hand massage (Figure 4.1).

The first theme entitled Opening Doors, details how hand massage is seen as an opening, introductory act of care. Within this theme, two sub themes are identified: beginning and choosing moments. The second theme, Being With, captures the nurses actual experiences of using hand massage. This theme views the personal, environmental and therapeutic value of hand massage for patients with dementia in residential settings, and is presented under three related sub themes: self-awareness, presence, and benefits. The third theme, Challenges, illustrates participants’ experience of day to day realities of providing hand massage in residential settings. The influences that affect hand massage in alleviating anxiety are described. Three sub themes contributing to challenges are detailed namely, Surrounding, time and support and encouragement.
Throughout the chapter, findings are illustrated using quotations from participants. Participants are referred to throughout the data as participant 1 to 11.

4.2 Opening doors

Hand massage is described by participants as offering opportunities to enter into a caring relationship, touching a patient’s hands in ways that comfort and soothe. As one participant commented hand massages ‘opens doors’ (Participant 1). Participants describe a personal journey from being unaware of touch and the use of their hands in their daily work towards a point of increased awareness of the potential of touch as a therapeutic tool to ease anxiety. Participants related how patients respond when hand massage is introduced into care practices. Hand massage is described as helping to create an environment where patients can begin to relax, interact and participate in social contact. It happens following a period of adjustment from living at home to living in a residential setting, as patients become familiar with and appear to sense an atmosphere of ease which encourages relaxation.

Hand massage is described as a means of introduction. Participants stress the value of hand massage in getting to know a new patient and as an important component of individualised care:

*I find hand massage great for getting to know the person in their first few weeks (Participant 7).*

Hand massage also opens the door to help patient relax as illustrated:

*... in the early stage, it wasn’t something they [patients] were used to... after a while they knew when the activities girl was coming, they enjoyed it... they are not actually very conscious that you are actually doing the massage, that they get more talkative and they interact (Participant 2).*

Furthermore, hand massage is described as an opportunity for nurses to connect with patients. One participant comments that the act of hand massage makes connecting with patients easier and more meaningful. Engaging in hand massage implies a skin to skin contact, getting close to a patient, usually sitting close to one another:

*I’d say that hand massage is an instinctive, sensory, skin to skin connection... Yeah, it’s nice to see the positive effect. It makes me feel good (Participant 10).*

Opening Doors has two related sub themes Beginnings and choosing moments. These are discussed below.
4.2.1 Beginnings

Beginnings identifies a starting point for engaging and connecting with patients. For some participants, hand massage is an everyday part of practice:

*I suppose we are doing it without realising. Holding hands, rubbing in cream and the use of soothing, comforting touch created moments of connection and helped in relationship building (Participant 1).*

Another participant draws on life experience, describing her beginnings with hand massage, speaking about time spent with her grandmother:

*When my grandmother had Alzheimer’s for 14 years, she loved me putting cream on her hands (Participant 9).*

For other participants, hand massage began as an intentional aspect of caring. One participant elaborated, by recounting her experience with a distressed patient and how to touch, through hand massage, as an intervention was used to soothe and comfort:

*In the beginning, there may be a focus on doing the hand massage, concentrating on my own movements, then after a few moments, I stopped thinking... the movement takes over, and the breathing slows down...her eyes [patients] were closed... (Participant 4).*

Two participants discussed an introduction to hand massage as part of an activities programme
I suppose because when we were on the activities course, they told us hand massage was one of the things that people enjoyed and the one to one contact (Participant 6).

The process of initiating hand massage opened up opportunities for caring connections:

**Once she [patient] can tune into someone, then it [hand massage] works, (Participant1).**

Hand massage is spoken by participants as enabling a few moments of early connection between nurse and patient, and as central to developing trust:

**I suppose it [hand massage] helped her trust me. I suppose they have a fear of the unknown. I suppose it’s a kind of a trust thing (Participant 10).**

Patient’s initial experiences were considered, and participants describe their endeavour to start from where the person is and creating a homely atmosphere where patients could experience ease through hand massage:

**We use all their own creams for the hand massage...all the smells of home (Participant 4).**

Throughout the data; there is recognition that making a transition and settling into a residential setting can be difficult. Some participants felt that touch increased familiarity and helped ease and comfort for patients within their new environment.

While participants acknowledge that they may not know a lot about the person, one participant describes using hand massage as a way of helping to connect with

**.patients to think more positively about where they are....It's [hand massage] going to make their life a little bit better...can help them figure out that its (living in a residential setting) not so bad you know (Participant 1).**

Participants spoke about having empathy and compassion for persons with dementia and the stress associated with entering a long-term care setting. It appears the transition from home to residential care may be distressing:

**These people [patients with dementia] were at home...all of a sudden, they are in here in [nursing home] ... with us...it’s so sad for them (Participant 3).**

The data illustrates examples of participants getting to know patients through hand massage. In one instance, a participant felt that hand massage helped a patient to feel safer. The patient’s reality was the starting point for this interaction. A participant describes a step by step process
in calming a patient while taking the hand of a distressed patient. Participants were conscious of exploring ways in which they get to know more about patients’ past life history, previous occupation, interests and family members and how patients respond to situations or stimuli.

*All you have to do is tell him your name and who you are and what’s happening. His anxiety is led by overtiredness. ...So, when he gets overtired, and he’s in that awful stage [early dementia] (Participant 8).*

Gaining meaningful consent and understanding from a patient living with dementia is a minute by minute checking activity. One participant described how she gained consent from a patient before engaging in hand massage. Findings also indicated that there was an assumed consent. This assumption was more implicit than explicit in the data. Nevertheless, one participant described how she gained consent by observing the patient’s reaction to touch.

*Well you watch, you watch the smile on their face or if they are reluctant (Participant 4).*

There is a continued awareness among participants that some patients with dementia have little concept of time. They live in the moment and sometimes that moment can be an anxious time. Hand massage was identified as helping to make that moment less fearful:

*It’s their life and what’s happening to them...He appears trapped in the moment; like he’s had a big fright...massage helped him (Participant 9).*

Hand massage also enabled other avenues of communication. For some participants, it was a natural response to massage and talk at the same time:

*I’m doing the hand massage ...I would just chat away and talk about her prayer books and her prayers and everything...Well, she just couldn’t stop talking...It's [hand massage] amazing (Participant 3).*

Thus, the data suggests that the act of giving hand massage begins with sitting closely with a patient which opens a space for interaction with participants and engaging in a non-task activity. It is described as a shared experience rather than a task to be completed. Participants considered hand massage as a non-intrusive intervention but did not take this for granted. Several participants spoke about the importance of regarding every engagement as a beginning and individual subjective encounter between nurse and patient. They identified hand massage as fostering positive feelings that aim to help a sense of calmness when a person is becoming increasingly agitated. The following quote describes an interpersonal exchange where the patient showed an active engagement and initiated the massage component of the encounter.
It is noteworthy that the patient had difficulty making meaningful connections without the communication support of the participant:

> She [patient] was pacing and pacing. I held her hand and walked with her...after a while, we sat on her bed ...She stroked my hand...I massaged her hands (Participant 4).

These moments of engaging and connecting are facilitated by hand massage.

4.2.2 Choosing moments

Choosing moments as sub theme illustrates moments of engagement between participant and patient through hand massage. All participants described opportunities to choose hand massage as a way of alleviating distress and as a calming influence.

Organisational factors: Participants reported familiarity with planned hand massage-related activities which are integrated within a Sonas activities programme. Participants involved in such activities described the hand massage activity as an enjoyable contact between patients and staff. Group activities also are described as facilitating social interaction and engagement.

Whereas another identified that there were little opportunities when working in 29 bedded unit ‘where the only care you are getting is task orientated’ (Participant 10)

The difficulty of sustaining hand massage in the larger units is clear from the following excerpt.

> I just go to the dementia unit... I’ve just stopped doing it [hand massage] in the long stay units ...too many patients (Participant 3).

Another participant spoke about introducing hand massage into her work place but found that while

> Some of them [staff] were very interested [in hand massage] ... they just wouldn’t know where to put it in the day...it is about changing their [staff] train of thought (Participant 1).

However, other participants believed staff have a choice whether or not to include hand massage in their patient care.

---

4 Hand massage has protected time within the Sonas programme.
It really only takes a few minutes. I’ve told them it may save time if a patient is anxious...they [staff] have to have their jobs done...then do hand massage. (Participant 10).

Choosing moments and creating an atmosphere conducive to relaxation was not always possible. However, some participants described awareness that the very act of touching undoubtedly had a calming effect in a noisy ward and gave an environmental message of calm and ease.

Actually, it’s very calming all round if it’s in the completely right setting. But we don’t always have the right setting. But I think you just do respond to [patients] becoming more relaxed and comfortable in their environment like this is effectively their home so when you are massaging their hands like, and you can see that they are calmer (Participant 7).

Knowing a patient’s past is identified as helping participants engage with the patient as a person. Repeatedly, participants perceived patients to be either anxious or withdrawn; interpreting that some of their needs could be met through connection using the gentle touch of hand massage. According to the one participant, small steps were regarded as best so as not to appear to intrude on a patient’s personal space.

Participants describe that identifying patient distress is important. One participant elaborated and described an expertise in recognising subtle changes in a patient well-being and commented:

Yes. And sometimes they [patients with dementia] can exhibit different behaviour in different ways they can manifest itself in different ways. Sometimes you have to check like the cause of the anxiety.

So sometimes it may be due to pain or discomfort or they might not always have the verbal skills to communicate the problems they are having, I do find hand massage actually really helps (Participant 7).

However, the importance of awareness for practitioners in preparing and checking in with self before beginning to provide a hand massage is noted:

You have to give your whole self... It might be five minutes doing hand massage. It might be twenty minutes to get the best out of it ... but you have to be there with that person... Wholly... (Participant 1).

This participant adds that her team members understood her commitment to focus on personal interaction rather than focus entirely on task orientated work practices. Another observed:
You see the opportunity if you can just do it at that time. You pick up on things and movements, body language. (Participant 1).

Participants trusted their experiences of the value of hand massage as a relaxant and potential alleviator of the patient’s discomfort or pain. There appeared to be a consensus that any training in hand massage complemented an already present innate skill:

*It is just a matter of doing it [hand massage] and learn as you go along... It’s sort of instinctive, isn’t it? (Participant 8).

There was a caveat in this consensus. Some participants felt that this type of touch was more innate in some workers and they felt that some staff should not give hand massage because it seemed like a task that one had to do or which ‘ticked a box’,

*...rub, rub rub, also adding I don’t think you can teach this ... the feelings (Participant 1).

Others, who had a long exposure of integrating hand massage into practice, were mindful of what they perceived as the wrong way to engage a patient in hand massage. One participant emphasised the need to watch, to listen, to be aware of self and the effect one has on the patient experiencing anxiety in dementia.

*If a patient with dementia and they are anxious it’s the people that are around them that can exacerbate the anxiety... or close them off altogether (Participant 4).

The same participant was concerned about the possible inappropriate use of hand massage. She was concerned about the monitoring of therapeutic boundaries and being conscious that to be physically touched or to physically touch is a matter of sensitivity:

*I also think that sometimes if it’s not properly managed boundaries could be crossed. Both ways. Like, a client perhaps crosses your boundaries but that’s to be expected, maybe. But staff can also cross their boundaries (Participant 4).

Regarding nurse led beginnings and the management of boundaries, the danger that members of staff might favour some patients over others and give hand massage to their ‘favourites’ was also raised:

*They get favourites, people [patients] who they become close with and others [patients] they can’t be so close to (Participant 4).

Further boundary elements that influenced the initiation of moments of touch arose for two participants. The sexual and intimate aspect of touch and were seen as a potential cause for
concern. These participants were concerned about using hand massage and feared that their patients would equate hand massage with more intimate personal touch.

One of the concerned participant described a male patient living with dementia who...

...used to walk around a lot, trying to get out the door. I was trying to settle him by massaging his hands...each time he’d say. “Come on down to the room”..., so I had to stop massaging his hands, but I’d still sit down and chat with him (Participant 9).

There was a general agreement among participants that awareness of the complexity of dementia and the use of touch requires supportive mentoring because of its potential effects on patients and staff:

I was immediately aware that there ... you are in a hetero environment whether you like it or not or whether somebody [patient] is 95 it’s still there you know... (Participant 4).

These instances underscored the need for training and raising awareness about hand massage as an intervention. Participants were aware of the effects of this type of touch on the patient, themselves and other staff members.

As well as nurses using hand massage to ‘opening doors’, there were occasions when patients initiated or chose the moment the intervention. In one case, a seemingly withdrawn patient saw a nurse giving hand massage to another patient, and he said

He saw the comfort it gave, and he wanted it too... he said do mine! (Participant 8).

All participants described believing hand massage was a core value to get ‘in tune’ with the patient’s needs so they could know what patients needed. One participant illustrated a special moment of communication and connection:

....and now she will sit beside me, and she has no communication skills really but now she will tap my leg or my hand, and I know that means she’d like her hands to be massaged or rubbed or whatever (Participant 7).

In this example, the patient’s ability to make a choice was respected by responding to her desire for touch. The participant was showing her ability to enable the patient to make a decision and honour the expression of the silent communication.
4.3 Being with

*Being with* illustrates participants descriptions of ways of engaging with patients living with dementia and this data is explored into the second main theme. Three sub-themes were identified, all of which explore participants’ relational experience (Figure 3). The first, *self-awareness* presents participants’ perceptions of how they connected with patients through hand massage. *Presence*, as a second sub theme, relates to intentionally focused attention that allowed participants to be fully present with a patient, particularly when using hand massage as a tool to alleviate stress. *Benefits* as a third sub theme explores participants’ perceptions of the power of touch on patients, referring both to the influence it had on individuals and on the overall impact it had on the atmosphere of the residential care setting.

![Figure 4-3: ‘Being with’ sub themes](image)

4.3.1 Self-awareness

The findings indicated that most participants were motivated to develop meaningful relationships with patients, and they were aware of the potential of hand massage to facilitate connection. Some participants directly connected their feelings to a perception of creating
benefits for patients, as doing something of a personal nature for the patient and as something for the person living with dementia:

*It makes me feel good that you are doing extra for your patient. More holistic approach (Participant 10).*

And another participant added

*It makes me feel that I’ve done something for that person (Participant 9).*

Another participant described how hand massage provided an opportunity to develop a relational connection:

*I feel like I’m getting to know them as a person. I enjoy learning about them (Participant 6).*

Particular situations repeatedly described by participants indicates becoming more aware and realised moments of presence and tuning in during the few minutes of hand massage

*once you get in tune, it [hand massage] works (Participant 4).*

The findings also illustrate another element within hand massage related to a heightened consciousness of power issues. Within the seemingly straight forward interaction of two people holding hands, participants recognised moments of presence and tuning in, in which the recipient (the patient) could be seen as less powerful. In response, some participants raised the importance of working in partnership with a patient living with dementia.

*Some people you will sit beside them, and you’ll see how they react with that closeness and then maybe hold their hand and see how they react with that. Maybe suggest then you’d have your bit of massage going. You know, you have to go with the person. And see how they react to you... You’ll never get deep you know. Unless you have that connection... or the ability to connect with someone like that [patient with dementia] (Participant 1).*

A balance of power was achieved through negotiation and a shared decision-making process between the patient and participant.

The participant realised it was important for the well-being of the patient to, ‘just be with’, navigating moment by moment to the patient’s needs. Connecting to the patient in this way appeared to give her a sense of fostering relationship which was empowering for her. Offering hand massage was empowering for her and enhanced her sense of being able to give and to be of benefit in a meaningful way. Some participants said they also felt better about themselves.
as a result of engaging in hand massage, with one suggesting that ‘hand massage is calming all around’. Another commented that the act of hand massage reconnected her with a form of caring she had lost from ‘years of running and flying around working’. She further elaborated:

I feel better about myself for being more caring...more aware of the patient’s predicaments (Participant 3).

Also, hand massage was described as more about touching as a way of being with patients with dementia and, at the same time, feeling psychologically safe themselves:

And you do relax...Your mind does start to wander and think about things in a softer, gentler kind of way...you feel safe (Participant 4).

However, another participant expressed a degree of apprehension arising from experience in practice. She expressed a fear of hand massage. Her words indicate an association of the potential of this type of touch to connect at a depth that caused her emotional discomfort.

But it’s also very frightening for us to, to go there. You connect on a deeper level (Participant 4).

Conversely another participant felt that this type of touch facilitated this bond and afforded a degree of emotional protection for both parties. The concerns expressed by participants demonstrated the depth of connection that can develop and the potential to deepen one’s connection to self and others.

The use of hand massage may protect the staff and protect the patient from getting agitated (Participant 10).

Participants were also cognisant of their limitations and the limitations of giving a hand massage. One participant knew that she couldn’t fix everything, but she was able to accept that it was sufficient to allow a patient to sense an atmosphere of ease through hand massage:

Just to be...you don’t have to take on everything...or fix everything...just allow them [patients] to get the stuff off their chest (Participant 1).

A similar assessment of the potential mutual benefits was made by another participant:

And do you know actually it’s so therapeutic not only for the patient but for the person doing it (Participant 7).

However, others felt some discomfort when asked if giving hand massage also helped them and didn’t associate the practice of providing hand massage with the potential to enhance their own sense of personal well-being.
No hand massage doesn’t make me feel better about myself…I don’t think of it[hand massage] that way (Participant 9).

Equally, important self-knowledge was exhibited in the realisation among participants that giving hand massage was not possible for all. One participant, while recognising the benefits and encouraging her team members to engage in hand massage knew that she was not best suited to it herself:

I couldn’t do it…all this touchy feely stuff…it's completely different nursing where everything is calmed down (Participant 8).

4.3.2 Presence

The sub theme of self-awareness is further extended as participants identified how hand massage enhances their capacity to be more engaged with and be present for patients living with dementia. Hand massage provided opportunities for participants to be present in a relational way. Participants described their use of touch to offer comfort, and their discovery of a potential relationship that transcended the moment of touch and influenced their perception of care. This participant reconnected with a way of caring that she felt had been absent:

Sometimes I feel I lose that ability to be compassionate, and then I get sad about that myself (Participant 1).

The findings revealed that all participants had observed the different effects of hand massage: touch in calming a patient; touch in showing compassion to a patient, and touch giving pleasurable sensation, were all experienced by being present to patients living with dementia during the few moments of massage. Nurses moving from patient to patient and assisting with activities of daily living are often not afforded the opportunity to provide this type of intentional, focused attention. One participant expressed how relating to a patient is about truly engaging for the few moments that she was present with a patient.

‘doing [hand massage] to’ a patient with moments of ‘being with’ a person. You are there so fleetingly, and then you’re on to the next person. So, while you’re there, you’re there. Paying you attention while I’m there with you [patient] (Participant 8).

For one participant, the heightened awareness of ‘being with’ a disengaged patient who had only limited capacity to express his/her needs was described:

A lot of the older people are kind of withdrawn when they come into hospital...they won’t be asking you for anything, and they are the ones that I tend
to zone in on. Come here, and I’ll give your hands a little bit of moisturiser, they’d get dry in here, you know that kind of thing. But I find if you can get it at the right moment, you can get all the information you want with rubbing cream on the hands (Participant 1).

Drawing attention to experiences of being with a patient in an anxiety state gave insight into the world of practice. One participant explained how she doesn’t feel seen by patients even while caring for them.

This invisibility can lead to potential frustration and/or emotional withdrawal. It also highlights’ how potentially distressing it is to be around patients in distress:

Yes, they[patients] are so anxious and so caught up in their own anxiety that even the person that’s trying to help them out they [patients]can’t see them[staff]as helping them out (Participant 8).

In this case, she didn’t use hand massage to deal with an anxious patient but encouraged others to do so. For participant 4, engaging in hand massage was described above as personally frightening because of its potential to connect in an out of the ordinary way, but paradoxically hand massage is also described as enabling this participant in the negation of any emotional distancing. The caring touch intervention in the quote below describes a compelling tool to challenge any negative emotions arising from an anxious situation:

Yeah because it helps me [participant], you see the effect is often so successful then you have to do it [hand massage] because people are in such a state if you don’t do it (Participant 4).

The above participant gave a precautionary reason and showed a level of pragmatism for offering hand massage, stressing that if she did not spend time doing hand massage, a more difficult situation may have arisen, which would be time-consuming and distressing for both patient and nurse. Some participants felt that patients with dementia need people around them who can relate emotionally; being emotionally present was ethically important for this participant:

And you have a lot of people [staff] who don’t like sharing their emotions; they don’t like... being seen as emotional or... any way soft or gentle or do you know... you’re [ staff] skirting across the top of the water you know, you never get to dive in underneath if you haven’t that connection. (Participant 1).

The findings portray that self-awareness in practice takes various forms. It is a complex process which may have a major influence in practice and on self. Another participant shared a dilemma about touch. The participant incorporated hand massage into her practice and had
engaged deeply with patients living with dementia. She described as ‘heartbreaking’ her sense of her limitations and the need to maintain professional boundaries:

\[
\text{Once you’ve made contact but people want to do it, they want to be with you the whole time, and they want to hold you the whole time. You know.}
\]

\[
\text{And it’s hard when you talk about it, I feel it’s heartbreaking because often you can’t go there, or there’s such an honest need expressed that is I think within our system so badly needed cos it’s such an anti-human system you know (Participant 4).}
\]

It became apparent that for some participants, physical touch through hand massage produced some risk of getting too close to the patient and thereby losing the protection of professional distance. However, the findings reveal a consensus that the activity of hand massage allows therapeutic engagement. The opposite is also suggested - if one doesn’t engage in hand massage as a therapeutic intervention to alleviate anxiety, a valuable tool in the management of the distress reaction may be lost.

4.3.3 Benefits

Findings suggest an awareness of hand massage as an intervention for distress. Overall, subtle benefits involved meaning, self-awareness, and the sense of a calmer atmosphere overall when hand massage was practised. These less tangible, less obvious benefits of hand massage were not as such ‘seen’ but very much experienced by participants.

A quote, conveying many of participants’ views and experiences of the value of touch is noted:

\[
\text{Touch is powerful...powerful stuff (Participant 1).}
\]

Participants described touch through hand massage as meaningful if they were able to see positive effects in patients:

\[
\text{She [patient] settled in the chair and fell asleep (Participant 4).}
\]

Participants elaborated, drawing on incidents of distressed behaviour which, in their views, responded effectively to hand massage. One participant perceived the unit atmosphere gradually changed as she was massaging a distressed patient’s hand and continuously checked the response of the patient to the hand massage:
So, I just sat with him and I asked him if I could massage his hands and this man was picking up chairs and throwing them out windows and everything else... I massaged his hands, and he definitely became calmer... And then when he fell asleep, like the benefits were huge... now he didn’t sleep for very long... This man obviously wanted some comfort, holding his hand, massaging his hand, the warmth of my hand in his (Participant 7).

There was a vivid portrayal of the reality of dementia care in a situation where a patient refused medication. One participant viewed hand massage as a gentler approach to alleviate anxiety and explained how it could lead to satisfactory outcomes:

*If someone is spitting out and refusing their medication how hard do you go to give medication ... as opposed to interact with them and try to alleviate their stress in that way. .... with touch massage (Participant 9).*

It also appears that the perceived benefits of the introduction of hand massage are not confined to the patient with dementia, but that families also benefited and appreciated seeing their loved ones engaging in hand massage. One participant describes how family members reported a sense of calm during their visit. While there was no explicit association with the calm atmosphere and a possible therapeutic effect of hand massage, there seems to be an acknowledgement of sensing a positive difference.

*The relatives love it [hand massage] actually. They love to see the little bits and pieces going on....But they like to see them doing activities. I don’t know if they actually see the therapeutic value like as in[hand massage] ... the odd time they might think it’s so lovely and calm in here today (Participant 7).*

Inducing an atmosphere of calm is described as valuable at all times, but there is little doubt that within end of life scenarios calm is especially important, for the patient and their family. One participant described the emergence of a feeling of hope as she realised that using touch through hand massage made her feel useful and present. This participant expanded and described a purposeful use of comforting touch which had particular significance for patients who were dying.

*This is something that every nurse could use in... say the palliative care setting (Participant 2).*

Hand massage was not seen to be effective in all circumstances. In some circumstances, hand massage may be offered, and in some cases, participants recognised that might not be appropriate for all people living with dementia. As one participant explained
It’s very relaxing, very soothing for you [patient] would you try it, would you be open to it? ... It’s something you have to continue with in small stages. So, I suppose you have to be realistic as well and it’s not something that’s a five-minute fix. For some people, you have to abandon it (Participant 5).

Some participants expanded on the effectiveness of hand massage as a therapeutic intervention. One participant expressed some uncertainty:

*I personally am sceptical about getting relief from a hand massage or is it just the physical contact that gives relief to dementia patients* (Participant 8).

The experience of closeness through touch with a patient was identified and the sense of not knowing how it worked but realising her pleasure at assessing a positive reaction from the patient. As one participant commented

*You know I don’t mind how they view it [hand massage], but it works...their [patients] faces light up* (Participant 3).

Benefits of hand massage as an intervention have been described while the challenges to the use of hand massage remain. The next section describes aspects of nursing and residential care practice that challenges the implementation of hand massage for participants.

### 4.4 Challenges

Challenges are the third theme emerged from the findings describing participants’ experience of the day to day reality of practice in residential settings. Influences that affected their use of hand massage with patients living with dementia in residential settings are interrelated. These included *surroundings; time and support / encouragement.*
4.4.1 Surroundings

Individual nurses describe a critical role implementing hand massage as a therapeutic intervention for people living with dementia. Forces that enables or inhibits the use of hand massage are a crucial factor. Participants in this study have identified some challenges associated with the broader work surroundings.

The influence of surrounding is fundamental to translating the rhetoric of person centred care into a reality. Participants associated a person centred care environment with the implementation of hand massage. One participant noted

*They [management] need to incorporate person centred care into the day as opposed to just into the philosophy that’s on the wall (Participant 9).*

Similarly, another commented in a similar vein:

*‘We have person centred care plans ... not much else’, (Participant 11).*

The language of person-centred care was part of one participant’s experience in the UK. As the participant noted

*Person centred care was talked about in the UK before Ireland ... not just about the nursing and the medical model. It’s also about looking at the psychological*
Several participants outlined that person centred values are fundamental to care approaches in Irish residential care settings:

_They [staff] want to work in a person centred way, but it isn’t always supported from either direction. Why would they bother?_ (Participant 7).

Ultimately though, the capacity to utilise hand massage as a therapeutic or anxiety reducing intervention has to be situated alongside and as part of prevailing regimes of patient care.

Participants in this study identified varying approaches to care across multidisciplinary teams. Managing anxiety medication seemed to be a key strategy in alleviating anxious behaviours experienced by patients with dementia.

One participant described how nurse managers recommend medication as part of a management plan for patients presenting with responsive behaviours and who may ‘upset other patients’:

_The manager said, get the doctor in and get him [agitated patient], get his medication reviewed... well, they did..._ (Participant 3).

Another participant offered a different perspective and acknowledged the support and encouragement in the use of other interventions:

_That’s one good thing about the unit ...Medication is very, very limited. That would be partly to do with Dr. ......He has prescribed music for dementia_ (Participant 8).

While several participants expressed the view that a combination of both pharmacological and complementary approaches are most effective in reducing and managing anxiety for patients, continued tensions exist between medication as the first choice of action and the potential of therapeutic interventions like hand massage for an anxious patient. One participant shared her observations and assessments of the effect of antipsychotic medication on patients living with dementia:

_Well, I suppose it is medication to be honest if I was to be really honest about it. A lot of it is medication...I suppose with experience, and with training and knowledge and information I’m not one for wanting medication to be the first port of call because people are more unstable on their feet and then they are a higher_
risk of falling, of course, medication is only one factor for that...Some of it resolves with medication as well, of course, you know (Participant 5).

The complexity of care was elaborated on by another participant who spoke about the limitations of medication:

*He was given Molipaxin and Respradol, but that only made him worse. Medication will often make dementia worse. Because they are trying to deal with what’s going on. They are trying to fight against the tablet as well as anxiety* (Participant 8).

Another participant recounted reading a review of antipsychotic medication for people with dementia and had conversations with attending doctors about practice.

She said that there is an emerging consensus concerning the level of use and risk of antipsychotic drugs for people with dementia:

*Yes, you would feel so guilty. I remember at the last place I worked I remember having a conversation with a couple of different G.P.s asking at this stage of their life [the patients] are all these medications actually necessary. A lot of them wouldn’t be, but there is this train of thought that they have to have all of them [medication] .... ... I’ve been told my opinions are very idealistic* (Participant 9).

Participants recognised the challenges in developing best practice interventions and reported on the need for guidance, clarity and further education. Most participants felt there was a need to change practice.

*Just if this is ever going to be introduced properly in our place, a lot of work would have to be done with people [management, co-workers] on their own skills first* (Participant 1).

This question of educational background and or individuality in approach was raised on a number of occasions by participants:

*Well, I suppose the nurse’s role, would be to promote it [hand massage] if they haven’t the time to do it... there are all kinds of personalities...* 

*And some people love this. And some people are just more into the tasks. I suppose you have to take that as it comes* (Participant 2).

Another participant described the importance for staff in learning how to balance daily tasks so that opportunities to give hand massage arise:
But as you know yourself trying to educate staff that that’s [hand massage to alleviate anxiety] is as much importance as attending towards the activities of daily living. It’s getting balance between the two (Participant 8).

Alongside managing care activities, administrative requirements were perceived as increasing the demands on staff:

‘The amount of paperwork is increasing every day’ (Participant 11).

One participant commented on the priority given to aspects of physical care and the demands of infection control and safety:

It’s all about safety. Infection control. Wearing gloves for everything (Participant 1).

Safety is a factor which was identified by participants as imposing limits on abilities to interact naturally with patients. The apparently simple task of taking off gloves to give a hand massage during morning rounds in itself introduced additional complexity:

Understanding the importance of skin to skin contact when attempting to connect to patients with dementia is vital (Participant 10).

One participant wanted to use hand massage more regularly but felt that there was little room for manoeuvre when using hand massage within the Sonas programme.

I have to stick to the programme [activities] ... and there is so much written work (Participant 8).

One participant emphasised the impact of staffing levels which created additional challenges in managing daily tasks and routines:

I know they HCAs[health care assistants] are run -off their feet... It [hand massage] would be done a lot more if we had more staff. Staffing level is one nurse and two HCAs to 20 patients. [Four HCAs] in the morning (Participant 10).

Another participant described a constant balancing of different demands:

I’m doing hand massage, but someone is calling for the toilet…or falling on the floor (Participant 1).

Another participant speaks about team work:

We’re all on the sort of level in there. It’s not a nurse led environment… it’s a carer led environment. More or less they [HCAs] tell me what to do (Participant 8).
This participant elaborated:

*Hand massage is part of our practice but not in a structured way. (Participant 5)*.

A Participant added that massaging hands is a fundamental aspect of care and described an occasion whereby a

*...carer sat with a patient held and massaged her hands; spoke softly with her until the anxiety passed (Participant 4).*

4.4.2 Time

Findings suggest that participants constantly strive to find time and support for hand massage as a therapeutic intervention in the midst of daily routine care practices, which were all seen as having priority. Time is identified as a significant factor influencing participants’ capacity to initiate and continue to use hand massage as an anxiety reducing intervention. Challenges of finding the ideal time and place to give hand massage within the reality of daily nursing practice and accompanying work pressures was a recurring theme in the findings:

*Making time is a challenge... the whole relationship to routine based practice... We are very restricted to time... they [nurses and carers] would have to have jobs done (Participant 6).*

Another participant spoke about the challenge of fitting in with established routines:

*The morning is routine and planned... Maybe we need to change our way of thinking, why do we need to do the same thing the same time every day? (Participant 10).*

Nevertheless, one participant emphasised that opportunities to give hand massage can and do exist with careful time management:

*In the morning when you are getting patients ready, you can take five extra minutes when you are sitting down assisting with a feed. I think there are loads of ways hand massage can be brought in without it being disruptive to the time management in the day and delegate (Participant 9).*

Another participant described how she took the opportunity to perform hand massage when there was time

*‘I’ve time today. I’ll do it [hand massage] today’ (Participant 11).*
While another participant commented that it is not the lack of time that is the problem but the relationship with and use of that time:

\[
\text{Time is always a factor. But to make time for what? [the patient] Time is there. When God made time, he made a lot of it. I wouldn’t say time is a factor (Participant 8).}
\]

Similarly, a participant highlighted her approach to managing time issues;

\[
\text{I feel strongly about it. [Hand massage] I manage my time you know, I’m very open to anything that will help [the patient] (Participant 5).}
\]

Participants were also aware of the potential negative consequences if there was no time to give hand massage, particularly as hand massage is known in the literature that it helps reduce agitation and anxiety for people living with dementia.

\[
\text{If we don’t take the time to engage in hand massage, there may be further consequences (Participant 7).}
\]

Another participant offered advice for future care, suggesting that time-driven daily practices are slowly changing in her practice world.

\[
\text{We need to just realise ... and it is slowly, slowly happening... stop with the time constraints. Stop with have x, y and z done before ten o’clock in the morning (Participant 1).}
\]

Several participants suggested that working in a designated dementia unit provided more time and impetus to include hand massage as an intervention for people experiencing anxiety. Being with a patient in dementia-designated settings was described as easier than other settings.

One participant commented that:

\[
\text{The day isn’t about tablets and getting everybody up and dressed and fed. The day is about letting the people do what it is what they want to do. And the carers that are there to spend time and interact with them as opposed to the washing and dressing and the usual routine that can happen in nursing homes sometimes (Participant 9).}
\]

Overall though, findings strongly indicated that most participants were constantly aware of the need to find time to ensure that patients’ experience of care was positive. However, finding time in a world of routine seems to be a recurrent challenge within their world of care provision. However, beyond the concern of finding suitable times to begin and engage in hand massages
practices: the interrelated aspects of finding support and encouragement from management and staff presented a further set of challenges and are now described.

4.4.3 Support and encouragement

Participants in this study expressed their perceptions on the role and value of hand massage; this cannot be separated from the perceptions and dispositions of others who share their work environment. Frequent references are reported on the existence of different attitudes amongst team members and management:

*Some nurses think it’s a waste of time. I have said that it may be time-saving but overall the attitude needs to change (Participant 11).*

Several participants drew attention to many challenges in integrating hand massage practices into daily practice. These challenges, not only relate to participants management of time but may also be influenced by differing levels of support and recognition across the organisation. The influences of support from management and colleagues are described as critical to using hand massage.

In some settings, a broad sense of endorsement on the use of hand massage as an expression of person centred care was reported:

*Management encourage hand massage...they talk about person centred care all the time (Participant 7).*

One participant, a nurse manager, spoke at length about having the freedom and scope to use hand massage as a therapeutic intervention in practice. This approach was, grounded in her belief in complementary practices which led to motivating her team and staff to consider the use hand massage:

*I’m very open to alternative practices...even if I wasn’t a ward manager...*  
*If something [hand massage] is of benefit...I will use it ... There is a big emphasis on motivation ... being creative and doing things with residents (Participant 2).*

This participant challenge was when she was on duty this philosophy of care was evident but when this participant was absent for more than a few days, practices such as hand massage slipped out of use:
Constant motivation is needed...when Im not there, it[hand massage] doesn’t work....Nursing has really changed. It’s now about looking at the psychological and emotional and all that (Participant 5).

Another participant reported her experience of a different management perspective. The participant expressed a commitment to using hand massage and a willingness to support colleagues in learning how to use hand massage as a process to help alleviate anxiety for people living with dementia in residential settings.

This participant experienced a lack of active encouragement from management. This was expressed through these words:

After the conference, I told them [management] success stories about motivating staff to implement change...I was willing to train staff in my unit in hand massage and other interventions ...no protected time was offered, so I didn’t bother (Participant 7).

This type of response was not isolated:

After my last course in dementia, I suggested to management about giving some training, but they never got back to me (Participant 9).

This view is expanded by participant 9 expressing frustration with senior management

I think management higher up need to be on board with person centred care, really on board and understand that structure and routine don’t have to be that rigid (Participant 9).

The same participant experienced a sense of disengagement with hand massage as an approach in a demanding and busy practice. This was strongly suggested by one nurse manager’s words: ‘we have no time for that craic here’ (Participant 9).

However, alongside negative attitudes, there were also many positive occasions whereby there was encouragement and affirmation from management. The importance of collegial support from colleagues was identified as important in using hand massage as meaningful and consistent practice. Some participants described a sense of frustration. Despite a recognition of the potential benefits of using hand massage for people living with dementia, the reality was described differently. As one participant commented:

You can encourage hand massage, but if they [staff] don’t believe in hand massage and are not going to be happy doing it anyway, so it’s not going to help the person [with dementia] (Participant 2).
Many participants experienced a sense of scepticism from colleagues about the value of hand massage:

_Sadly, I think there is huge scepticism about therapeutic activities...we are like in a blurred area of still being focused on routines and rituals (Participant 7)._

Allied to this a growing sense of frustration was described. Colleagues appear to minimise the value of hand massage for a distressed patient and declined to use hand massage when the participant was off duty, thereby breaking the cycle of incorporating hand massage into daily care practices:

_I know it’s going to happen again and again and again...it’s not through any badness from the people [staff]...They just don’t do things the way I want them [staff] to do it [laugh] (Participant 1)._

This constant motivation required for the sustainability of hand massage is a running theme throughout. Half of the participants interviewed described a wish to feel valued by their colleagues and the organisation in which they worked. Without authority in decision making and respect in practice, participants did not feel ownership of the practice of hand massage.

It also emerged that the perception of being undervalued as a nursing professional was compounded by negativity arising from the absence of collegial support. One participant illustrated this point vividly:

_I think there is a big sort of thing at the moment like as we say, nationally that nurses feel hugely undervalued, and that’s like if we have nothing else if we don’t value each other (Participant 7)._

Data generated from the interviews showed a tension between desired ways of being with patients while at the same time this may lead to some routine daily tasks being incomplete.

_‘Cos if you have somebody knocking it [criticising hand massage] and saying oh my God, what is she doing there [hand massage] and all we have to do here...type of things you know... (Participant 2)._

This comment raises a significant point about the importance of a positive frame of mind when approaching hand massage as a caring practice. Participants emphasised that hand massage needs to be valued as fundamental to care rather than an optional luxury of the use of time:

_I suppose you need your coworkers to understand about hand massage and to focus more on person centred care rather than task orientated (Participant 5)._
Another suggests that this positive frame of mind could be generated if hand massage was included as an intervention in patients’ care plans:

*If it were part of the patient's care plan hand massage, it would be a more regular occurrence (Participant 11).*

However, any approaches to considering the use of hand massage may benefit from agreement and collaboration across teams. There appears to be a tendency to view hand massage as an individual practice by individual nurses rather than a collective practice in promoting patient well-being for those living with dementia. Participants suggested that the initiation of hand massage is dependent on when individual staff are on duty on any particular day.

As a participant said:

*‘It depends on the team on any particular day’ (Participant 10).*

Such an individualised approach by nurses may lead to a lack of continuity and lack of acceptance of hand massage as a therapeutic intervention in alleviating anxiety for people living with dementia in residential settings. Overall this is a continuing challenge for participants and patients.

Another participant offered advice for future care, suggesting that time-driven daily practices are slowly changing in her practice world.

*We need to just realise ... and it is slowly, slowly happening... stop with the time constraints. Stop with have x, y and z done before ten o’clock in the morning (Participant 1).*

### 4.5 Summary

The purpose of this chapter was to present the findings from interviews with nurses about their experiences on the role and value of hand massage in reducing anxiety amongst patients living with dementia in a residential setting. Firstly, participants described their involvement in the use of hand massage when introducing the practice into their care practice. This description of *‘Opening Doors’* outlines the beginnings or the process of introducing massage as a therapeutic option. It also described how appropriate times and settings for hand massage could be chosen, both by the nurse and by the patient but also determined by organisational factors.
The chapter continues by describing participant’s actual experiences of using hand massage captured in the theme *Being With*. Within this theme, the importance of self-awareness within care processes is identified.

It further captured participants’ sense of enhanced presence that results from engaging in the practice of hand massage, as well as their assessment of the power of its therapeutic value. Finally, the chapter takes a step back from the immediacy of hand massage practice issues to describe and reflect upon some of the environmental, time and support **Challenges** that exist for nurses caring for patients living with dementia in residential care settings. These are discussed in the next chapter.
Chapter 5 Discussion

Introduction

The chapter explores the experiences of eleven participants regarding their use of hand massage in residential settings and discusses the study findings in relation to current research and literature. The chapter is organised around the three themes described in the findings chapter: *Opening Doors, Being With* and *Challenges*. The structure of the discussion is in keeping with the qualitative descriptive research methodology used throughout this study (Sandelowski 2000). The overarching goal is to provide a practical discussion following the description of common themes and to summarise and reveal and detail the rich descriptions within these common themes as described by participants in their semi structured interviews (Willis et al., 2016, Sandelowski, 2010). Meaning in qualitative description is described at the level of the visible and obvious (Graneheim and Lundman, 2004). In this case meaning relates to nurses’ experience of hand massage, identifying factors which facilitate, challenge and inform the use of hand massage as a therapeutic intervention within residential settings in Ireland.

The findings chapter provided in-depth examples of the how, when, and where’ of hand massage from the perspectives of eleven participants. The theme ‘*Opening Doors*’ reflects on the process of introducing hand massage as a therapeutic option and considers how appropriate moments and settings for hand massage might be chosen, both by the nurse and by the patient and how these choices are affected by organisational factors. The second theme, *Being with*, explores participants’ actual experiences of using hand massage. The importance of self-awareness is identified by participants within care processes, in particular, awareness of one’s presence in each encounter. The benefit of hand massage and the nature of interaction with patients but also with other colleagues in the care environment. Finally, the third theme, *Challenges*, steps back from the immediacy of hand massage and discusses the interrelated factors that complicate participants’ use of hand massage as a tool to alleviate anxiety. These challenges include the environment, time management and support for the use of hand massage as a tool to alleviate anxiety for patients living with dementia within the various settings.

5.1 Opening Doors

Opening doors refer to the stage before nurses might engage in hand massage as a means of reducing anxiety or indeed as a means of preventing it or reducing its likelihood. Drawing on
relevant literature this section critically reflects on some interrelated issues that arose in the findings chapter. These included nurses’ **choosing moments** to use hand massage and the factors that may influence such a choice. Another interrelated issue concerned the **creating the right conditions** for massage to be used, as well as the importance of **fostering a sense of comfort and safety**. Finally the section discusses some of the ethical questions involved in **gaining consent and managing boundaries** in the complicated world of patients living with dementia and who frequently experience diminished capacity for communicating (De Vries, 2013).

### 5.1.1 Choosing moments

The literature introduced earlier in this thesis suggests that it is the **‘in tuneness’** of nurses, the immediacy and spontaneity of their giving attention that is the important component of quality care (Scerri et al., 2015, Edvardsson et al., 2010). However, as this study’s finding illustrates, individual attitude and disposition significantly determine capacity and willingness to believe in and exercise personal power, control and responsibility. The reverse is also true of course: the perception of being undervalued as a nursing professional brings with it the potential to generate a negative frame of mind when appraising the use hand massage as a caring practice. While a supportive environment may assist in this decision making, as has been suggested elsewhere, ultimately it is down to the individual practitioner to choose or not to choose to use hand massage to manage distress reactions (McCormack et al., 2010). However, participants in this study emphasised that if hand massage is to become a viable choice, it needs to be valued as fundamental to care rather than an optional extra when time permits (Kitson et al., 2013), thus creating the conditions to impact on broader staff disposition. However, using hand massage as a tool to alleviate anxiety was not part of the day to day expectations of participants or other workers. For the participants who viewed hand massage as a spontaneous, easy to use tool to alleviate anxiety, other inner processes were at work that led them to choose to employ it. These include a commitment to person centred care, a predisposition to value the therapeutic value of touch and a willingness to critically reflect on their practice and how their approaches and caring styles may be linked to the actions of persons with dementia (Sumner and Fisher Jr, 2008, Sumner, 2010).

Inevitably, the settings in which staff work, influence their choices. This study and others suggest that flatter structures with less formal modes of communication appear to be more conducive to empowerment (Corbally, 2004, Passalacqua and Harwood, 2012, Kapur, 2014).
A strictly hierarchical structure is less conducive to the exercise of individual agency and choice that those that accept a degree of staff autonomy (Sorensen et al., 2008, Farrington and Townsend, 2014). Moreover, smaller organisations with designated dementia units are shown in this study to be more empowering due to the increased potential for all nurses to retain some control over practice and have closer relationships with other healthcare staff (Dröes et al., 2016).

Engaging in hand massage in a non-task mode or a ‘non-busy’ frame of mind can alter the stress response and achieve functionally adaptive behaviour. Participants indicate how choosing sensitive moments to engage in hand massage helps patients work through the resulting emotions and distress associated with changes in their living circumstances. (Edvardsson et al., 2005), As suggested by the same authors, nurses who have warmth in their hands and voices are perceived by patients as having an awareness of the use of their hands as a tool to alleviate distress (David Edvardsson et al., 2003b). Engaging in hand massage redirects attention from environmental stimuli to a soothing tactile stimulus (Remington, 2002). For patients living with dementia, the concept of time may be nebulous. Depending on their relationship with reality, past and future may be foggy (Irish and Piguet, 2013). It is suggested that patients with dementia live in the moment (Dewing, 2003, Dewing, 2006), and that moment can be of any time or place. Patients with cognitive impairment may not have the cognitive reserve to filter unpleasant moments and may be effectively tethered to the present moment (Irish and Piguet, 2013). Making these moments as pleasant as possible is the focus of person centred caring. Every encounter for a patient living with dementia may be a first. The importance of first moments and first encounters has been shown to lay a solid foundation for the development of a trusting relationship and the use of hand massage assists in creating positive encounters and supporting a sense of self for the patient experiencing cognitive impairment (Remington, 2002, Caddell and Clare, 2011, Dröes et al., 2016). Participants described their commitment to finding out what mattered to the patient and using this information in shaping the way care was given and when it was given (Fjær and Vabo, 2013). The findings in this study are similar to those reported by Westin and Danielson (2007) in their hermeneutic study with nursing home residents in Sweden. These residents’ experiences were expressed as ‘being somebody’ and belonging somewhere’ or ‘being nobody’ and not being seen as a person. The Westin and Danielson study identified that the first encounters for patients within the care context were seen to be important to residents particularly in building
relationships. In the above study, positive first encounters seemed to set the tone of what was to come and validate same as representing good caring practice.

5.1.2 Creating the right conditions

Participants in this study suggest that the potential for hand massage to be used to alleviate anxiety requires the creation of appropriate conditions, not least an awareness of the calming effect of massage on the patient and his/her surroundings and its ability to enhance the overall care environment. It is reported in the broader literature and supported by this study that hand massage can help to create an environment where patients can begin to relax, interact and participate in social contact (Kolcaba et al., 2006a). It is accepted that patients respond enthusiastically to encounters that create feelings of security and comfort (Kolcaba et al., 2006a). Similar aspects of environmental influence in nursing care have been described by Edvardsson (2005) who found the specific atmosphere of care setting (hospice, geriatric ward and at an acute ward) to be of importance for the experience of personal satisfaction. At three different care settings, Edvardsson (2005) identified the importance of how the environmental atmosphere influenced staff, patients and relatives experiencing a welcoming environment. In line with other research (Brune, 2011, Siegel et al., 2012, Tuvesson et al., 2011) this study found that the less routinised or institutionalised a setting is, the more a hand massage component was integrated by participants into daily care as a first aid intervention. (Hansen et al., 2006a). This suggests that an enriched environment allows participants an enhanced awareness of their actions and use hand massage in their caring as a more deliberate act (Verbeek et al., 2009, Rahman and Rahman, 2014, Thomas, 1996).

It is noticeable that for participants in this study who worked within designated dementia units felt there was more time available to use massage to prevent and to manage distress behaviours, not least due to higher staff to resident ratio and more flexible schedules. As a result, participants were able to adapt their daily tasks to a pace and sequence that suited the patients’ mood and needs on any particular day (Kitwood, 1997, Egede-Nissen et al., 2013), thereby echoing other research on the potential for the task and person-centred relationships to mutually co-exist (Westerhof et al., 2013). The similar potential was not reported by participants working in non-dementia specific units, with a mix of patients.

Creating the right conditions is also aided by open sharing of uncertainty and dialogue about the attitudes and behaviour of other staff. Participants in this study report feelings of
powerlessness and frustration as a result of not knowing how to handle situations where they perceived care practices to be poor or where they felt forced to defend the value of hand massage (Whitby, 2008).

While the benefits were enough to make it worthwhile for them, the use of hand massage remained a hard sell for others and inevitably involves a degree of personal risk taking. As has been suggested elsewhere, risk may derive from negative responses within the nursing and broader care team as a result of making decisions that may be in conflict with ritual, routine, cultural practices or personal philosophies of other workers (Dewar, 2011). or which may signal competing loyalties, to the patient, to themselves. These echo the conclusions of Jakobsen and Sørlie (2016), who found that caregivers sometimes felt they had to go against the work and management cultures to deliver what they perceive to be good quality care.

5.1.3 Fostering a sense of comfort and safety

Alongside the creation of appropriate conditions, fostering a sense of comfort and safety was seen by participants as a prerequisite for the use of hand massage. Inevitably, moving into residential care can cause distress for the patient. It marks a further shifting balance from autonomy to dependence on strangers (Gilleard and Higgs, 2016). The patient needs to develop emotional bonds with their new place of residence to enhance psychological and emotional well-being (Van Oel and Boer-Lootens, 2015). Participants in this study found that hand massage helped patients feel safe particularly during the first few weeks of the settling in period and offered a starting point for engaging and connecting with patients. Providing hand massage using the patient’s creams, for example, opened up a window of opportunity to introduce familiar smells into the patients care routine.

Participants reported gaining meaningful knowledge about the patient while engaged in massage, enabling unobtrusive observation and interpretation of patients’ behaviours. Hand massage was shown in the findings to increase familiarity and bonding between participant and patient which can be considered as a pre-requisite to creating an environment where patients feel comfortable, safe and welcoming. Similar to the research by David Edvardsson et al. (2003b) and Kolcaba et al. (2006a) the findings showed participants employed hand massage to enhance relationships which in turn enabled compassionate care-giving.

The use of hand massage as described by participants in this study forms part of emotionally orientated care approach, which in turn can contribute to building a sense of safety and security.
for those living with dementia. Elsewhere, research studies involving randomised controlled trials in the Netherlands by (Van Der Kooij et al., 2013, Finnema et al., 2005) concluded that care encounters for patients are favourable if they receive integrated, emotion oriented care at the same time as they receive routinised care. Positive effects from integrated emotion-oriented care were found in patients with a mild to moderately diagnosed dementia on two adaptive tasks: maintaining an emotional balance (less anxiety) and preserving a positive self-image (Finnema et al., 2005). The findings from this study point to participants’ increased capacity to identify patient distress and support the maintenance of emotional balance. Participants elaborated and described an expertise in recognising subtle changes in a patient well-being and the value of gentle interaction as a way of checking for underlying pain or discomfort, emphasising the practical multi purpose use of hand massage (McFeeters et al., 2016). Interestingly, the more recent study confirmed that working in a more empathic and experience/emotion-orientated way was no more time consuming than usual, routinised care (Van Der Kooij et al., 2013), albeit that it does raise additional challenges around consent and boundaries.

5.1.4 Gaining consent and managing boundaries

Gaining consent for the use of hand massage is an important ethical consideration (Rees et al., 2013). For the patient with dementia, distress behaviours ranging from agitation to apathy may be the only means of communicating a change in condition or illness, unmet needs, or person–environment incompatibility (Cohen-Mansfield et al., 2015). The findings in this study highlight the tendency of participants to acknowledge abilities and diversity of patients with dementia in the way they honoured patients’ unique expressions of consent or otherwise. A strong underlying relationship were believed by participants to facilitate communication. That said, the findings indicate that in some cases there may have been a presumed or informal consent from some participants because of the position of the ‘nurse’. How consent is sought appeared so automatic for participants that some had difficulty articulating the action. Consistent with the literature, participants described using some strategies to gain consent for the use of hand massage with patients. These ranged from a minute by minute checking activity, processes of shared decision making, the conscious building of rapport; talking to establish capacity and gauging expressive abilities in advance of hand massage. Other strategies included participants focusing on their intuitive feelings and experiences as well as
observations (Hellström et al., 2007). Building knowledge of the patient over time also helped participants get in tune with the patient's likes and dislikes (Hubbard et al., 2002).

Patients living with dementia develop unique ways of utilising nonverbal behaviours to express their personality and needs (Hubbard et al., 2002). The data shows the seemingly complex task of understanding a patient's needs can be simplified by using hand massage to connect. One could almost say that there are no words to explain the encounter as the meaning may be incomprehensible to the analytical brain. This is consistent with the perspectives of a variety of researchers (Caddell and Clare, 2011, Hubbard et al., 2002, Phinney et al., 2007a, Sabat, 2005, Kelly, 2007). When a patient’s ability to communicate is compromised by dementia (Pathway-Dementia, 2006, Andrews, 2011, World Health Organization, 2013), the responsibility to help the patient communicate lies with the nurse (Hall, 2011). This places additional demands on nurses and creates the risk that nurses might attribute incorrect meanings to the patient’s cues, such that he or she becomes a creation of the nurse’s perception of needs. Similar to the conclusions of Page and Hope (2013) for some participants the findings did reflect a lack of confidence, understanding and uncertainty about managing distress behaviours for patients living with dementia. For other participants there was evidence of a quiet confidence around the assessment and management of distress behaviours.

The findings highlight awareness around ethical dimensions particularly therapeutic boundaries within hand massage activities (Badawi, 2016). One participant in this study described situations where care staff choose to give hand massage to their ‘favourites’ only. Such an anecdote, if true, may represent a potential for abuse of power and reflect a reality where caring for anxious, distressed patients in an unsupported environment may produce undesirable outcomes, such as staff members avoiding the anxious or apathetic patient (Whitby, 2008). Conversely the anecdote may suggest that the care workers had developed a rapport with particular patients and felt best equipped to use hand massage in caring for these particular patients (Murphy et al., 2015).

Working in the absence of specific guidelines, participants in this study demonstrated their awareness of the complexities of working in partnership with patients while remaining sensitive to moral/ethical concerns, seeing massage as a way of supporting a face to face and potentially equalising connection. Little is known about what makes communication a good and meaningful experience from the perspective of people with dementia (Vasse et al., 2010). This need to continually involve people living with dementia in research is becoming more
This has also been illustrated by Murphy et al. (2015) and structured into a guide consisting of four main areas; gaining Consent, maximizing Responses, Telling the story, and Ending on a high (CORTE). This CORTE guideline of grouped strategies could be used to maximize the meaningful involvement of persons with dementia in research and everyday living. While these guidelines may not provide all the answers for nurses, in a world of multiple viewpoints and values they could at least support the efforts of the nurse (Hughes and Common, 2015, Strech et al., 2013). Hand massage was voiced continually by participants as an enhancing factor in opening relevant doors to communication.

These interrelated issues of gaining of consent and choosing moments for hand massage in the right conditions to foster a sense of nurturing and enable communication have been discussed as a prerequisite and antecedent to being with patients in the experience of giving hand massage.

5.2 Being with

Moving onto the actual practices and processes of using hand massage, the findings raise some key questions for discussion, namely, interpersonal relationships; enhanced self-awareness, the revitalisation of intuitive knowledge and moments involving families in aspects of caring are voiced as significant issues.

5.2.1 Interpersonal relationships

Several authors have highlighted the importance of interpersonal relationships between patient and staff in the delivery of person-centred care (Brooker and Latham, 2015, Kitwood, 1997, Coyle et al., 2011, Heliker and Nguyen, 2010). Heliker and Nguyen (2010) suggest that respectful presence and bearing witness to others’ stories create mutually positive relationships. In this study, participants’ ways of providing such care were sometimes influenced by their personal life history, in particular, if they had themselves had experience of a vulnerable relative being in care. They described the delicate process of interpretation; interpreting the patient’s situations through the patient’s eyes facial expressions body movements, body tension and the overall physical expression. Hand massage enhanced communication capacity. Hand massage enabled participants to slow down, facilitating intuitive, expressive processes to move the care experience to one that inspired participants. This is witnessed in the findings where participants reported hand massage session evolving into patients reminiscing on their own life
stories. It is suggested that during delicate interpretation of patient’s needs, Life Story work helps nurses to make the link between a patient’s past and present, giving them a greater awareness of the person’s preferences for care (McKeown et al., 2010, Thompson, 2011). Lack of appreciation of a patient’s history may lead to difficult encounters (Kolanowski et al., 2010). Story telling enables the voice of the person with dementia to be heard, verbally and non-verbally (McKeown et al., 2015). The patient’s reality becomes the starting point for these interactions. Each encounter with a patient living with dementia requires a sensitive, aware presence. Relational interactions are identified in the literature as crucial toward helping patients with dementia feel “in touch with the world,” through meaningful encounters (Dewing, 2010, Mitchell and Agnelli, 2015, Hunter et al., 2013). In this study participants discovered that engaging in hand massage is shown to stimulate a response for patients to request this type of touch and meaningful encounter on an ongoing basis and also to engage in the giving of hand massage. Being able to empower patients towards this interactive ability implies a connection and trust that can occur during interactions in the care environment and demonstrates how massage can provide a welcome respite for participant and patient from distress behaviour. This social interaction is active, dynamic and adaptive and contributes to the maintenance of personhood and identity (Kitwood and Bredin, 1992).

The person centred approach to dementia has generated research literature around identity (Caddell and Clare, 2010). It is evident from this study that hand massage provides a type of psychological nourishment and maintenance of identity and personhood. Hand massage gives the opportunity to relate at a deeper level, reach beyond the type of communication barriers particularly typically encountered in caring for patients with dementia. The patients living with dementia are in turn described by participants as responding to being touched, reaching out in a way. It is in this reaching out that the benefits of hand massage can be fully appreciated, reiterating the learning that patients living with dementia in a residential setting need physical touch to feel connected (Field, 2014b, Nicholls et al., 2013). Moreover, when a distress/response reaction by the patient is addressed early, it is less likely to accelerate into a full distress response (Fitzsimmons et al., 2014). Participants describe being proactive and avoiding escalating behaviours and confrontations by engaging in a few moments of hand massage. Similar strategies were illuminated in the study by Edberg and Edfors (2008) in the management of frontal Lobe dementia.
5.2.2 Enhancing self-awareness

As well as a perceived enhancement of the sense of comfort for patients, a similar outcome was also reported for participants themselves. Several described how giving hand massage benefitted their sense of self-worth and ‘usefulness’ and how the gentle flowing movement of massage induced in the participant a relaxed and meditative state of mind, opening a path to a deeper awareness of self, of the patient and the nature of the connection between the two. In this way, the massage became a creative encounter with tangible and observable consequences for giver and receiver, participant and patient, in generating ‘moments’ of engagement and mutual recognition. This allowed the participant the awareness to understand her practice in a different and expanded way (Goldschmidt and Van Meines, 2011). There were no fixed meanings and ways of labelling their experience, but they began to allow occasions where direct experience was increasingly held without judgment. The act of giving hand massage was described as stilling both the mind and the moment. By opening into these dimensions with another human, participants helped to create environments in which their confidence in their caring ability was enhanced and meaningful connections were made with patients, echoing other research in this area (McCarthy and Bockweg, 2013, Gordon, 2011).

The findings in this study complement research findings that suggest that nurses reinforced the notion of being nurturing simply by sitting with the patient or holding hands (Christine Edwards, 1998, Goldschmidt and Van Meines, 2011). Participants detailed the relationship quality of their being with regarding self-awareness and presence. Throughout the study participants describe self-awareness as critical to the process of connecting with patients through hand massage. Self-awareness presents participants’ perceptions of how they connected with patients through hand massage. Consistent with the perspective of Tuohy et al. (2015), presence can be viewed as an extension of self-awareness where the participant seeks to connect both emotionally and physically. Together they relate to intentionally focused attention that allowed participants to be fully present with a patient, particularly when using hand massage as a tool to alleviate stress, thus enhancing the development of therapeutic trusting relationship echoing the literature which highlights the value of the interpersonal components of caring that make up the nurse/patient relationship (Arnold and Boggs, 2015, Gleeson and Timmins, 2004, Sumner and Fisher Jr, 2008, Karlsson et al., 2004). Conversely as acknowledged in the grounded theory study by Edvardsson et al. (2012) when staff were present but not really engaging with the patient when carrying out care, situations could turn
positively or negatively depending on the person. This confirms the multi-faceted nature of interaction.

Self-awareness also focuses on participants understanding of their strengths and weaknesses (Paukert et al., 2013), bringing the discussion to the question of emotional intelligence and emotional labour. Emotional intelligence is the capacity to relate to ourselves and others and cope with daily demands (Carragher and Gormley, 2017). Fostering relationship for participants in this study highlighted the significance of being with patients with dementia while at the same time ensuring that they felt psychologically safe, regarding their own emotions, as well as their engagement with the broader care team and the environment.

The feeling of psychological safety relates in no small part to the culture of the individual residential settings and accepted ways of communicating that culture (Brown and McCormack, 2011, Lynch et al., 2017). Being able to say how you are feeling also depends on whether or not people can recognise these feelings within self (Freshwater and Stickley, 2004). Recognition of feelings related to an experience requires that a person undertakes a level of reflection, raising the potential for a related change in the self (Freshwater, 2002, Freshwater, 2007). The findings from this study showed that some participants reflected on their practice while the interview process was ongoing. While reflection increases capacity for critical and innovative thinking, the challenge of being able to stay with personal subjective insecurity and to have the inner flexibility to consider altering deeply held ways of being is not insignificant (Bolton, 2010). One participant shared self-knowledge of her limitations in engaging in hand massage. She knew that she as a practitioner didn’t attune to the ‘touchy feely stuff’, but preferred instead to get stuck into the faster pace or nursing. This participant further clarified that she enabled and encouraged the care assistants working in her team to engage in hand massage. This way of working through others raises the possibility of caring at a distance and signals the importance of focusing attention on all of the contexts in which care is delivered, and not just on the quality of individual relationships (Allen, 2004, Allen, 2007).

The findings also raise questions about the level of caring and empathy that is acceptable when staff find it hard to engage emotionally. Losing the ability to be compassionate was a concern expressed by one participant. To be able to develop support systems for nurses in dementia care, it is important to shed light on their vulnerable situation and especially on factors that strain the capacity for compassion (Edberg et al., 2008). The totality of the circumstances and other work-related factors increase emotional stress and burnout for nurses and may provoke a
parallel need for detachment. Despite these attempts to stay professionally distanced, most participants described experiences with patients that had a lasting and moving impression; emotionally rich language was used by some participants. This balance between attachment and detachment has been referred to in the literature. Although being professional through detachment has been part of the nursing culture, emotional honesty in interactions with patients is considered by some to be healthier, as it spares the emotional labour involved in suppressing emotions (Lopez 2006). Engagement in being reflectively mindful of self and the ability to be compassionate to oneself is essential for positive work practices (Heffernan et al., 2010). A combination of emotional support and increased control, at least over the caring situation, could be one plausible way to reduce the experience of strain in dementia care and to mediate the engaged/disengaged dichotomy. Without such support, there is a risk that nurses will lose their sensitivity to the patients’ situation as a strategy to maintain their well-being (Edberg et al., 2008, Whitby, 2008).

Participants show an awareness of the risk attached to engaging emotionally, or of engaging in hand massage in the absence of time in which to be totally present (Dewar and Kennedy, 2016). Recognising emotion and the potential influence this might have on the way care is given and received was evident in some stories from all participants. Compassion fatigue has been described as a natural consequence of caring. This may be connected to the disassociation observed by participants in other workers. Dewar and Nolan (2013) argue that there is a need to develop the capacity to connect emotionally as part of the caring relationship and challenges theory that relates to the containment of emotions (Dewar, 2011). Enhancing well-being by awareness of interpersonal interactions and their fundamental contribution to relationship building is at the heart of the person-centred approach to dementia care (Downes, 2013, Kitwood, 1997). Being in a relationship is a core element in person centred caring (Dewing, 2002, Dewar and Nolan, 2013). Participants described their efforts to provide compassionate care through hand massage. At the same time, they spoke of trying to maintain emotional ‘space’ using the language of professionalism, boundaries or survival, i.e. what they felt they needed to do to continue working effectively in a particular setting (Whitby, 2008).

These responses revealed a rationality that the personal self is intertwined with the professional self whether or not the participant is conscious of it (Sumner and Fisher Jr, 2008). There is an important relationship between the well-being of staff and the well-being of patients (Maben et al., 2012). Staff need to feel nurtured and emotionally sustained themselves to be able to
emotionally nourish those cared for (Sumner, 2010). There is some evidence in the literature that person-centred care leads to more emotionally exhausted staff (Willemse et al., 2015). This is not necessarily a negative dimension as focusing on the patient rather than the task gives more work satisfaction (Peeters et al., 2013).

5.2.3 Revitalising intuitive knowledge

The findings from this study affirm that the experience of providing hand massage for participants revitalises intuitive knowing and traditional nursing skill that has been there since nursing began (Field, 2014b). The Cochrane review by Hansen et al. (2006b) indicated that historically and traditionally massage was looked on as a ‘common sense’ interaction to soothe anxiety in dementia and although reliable evidence was limited the review supported the use of massage to alleviate anxiety. The study findings certainly concur with the ‘common sense’ theory in that participants experienced hand massage as generating a fulfilling encounter which in turn alleviated potential distress responses. Within the findings, self-descriptions of participant’s interpersonal behaviours suggest an awareness and need to practice in these ‘common sense’ ways. Participants spoke about understanding the patient living with the experience of dementia and the other aspects of their lives impacting on the patient as an individual. This meant that participants were careful to avoid being predictive about care needs and reaffirm the role of intuition in clinical decision making (Pearson, 2013). Participants voiced a growing intolerance of doing the same thing the same way every day.

One issue may be that the place of massage as part of a ‘tacit knowledge’ of care within the history of nursing has been lost. To reintroduce something which has been ‘lost’ in the professionalisation and institutionalisation of care may be a fundamental issue as discussed in the Cochran review by Hansen et al. (2006b).

Little is known about the way in which nursing home staff members select and implement interventions to alleviate distress behaviours. This study suggests that awareness of the benefits of hand massage seemed to help staff to trust their intuition to spot opportunities to adapt their care-giving practice so that it met the needs of patients. The attitudes that long-term care workers hold about dementia, the work stress they experience and the satisfaction they derive from working with these patients all influence the point and nature of the interaction. This heightened awareness was described succinctly by one participant in this study, referring to hand massage as connecting her to a form of caring in which she flourished. This participant
was more conscious of her behaviour and used this to change the way in which she interacted with patients. The changes that occurred in the participant's practice arose out of a deeper fundamental shift in understanding. Not making assumptions about care and finding out what is important to the individual was partly facilitated through her practice in hand massage. In line with other research, the participant experience suggested that she became aware and open to new perspectives. Other participants felt deeply about the vulnerability of patients with dementia and used their own beliefs and values to influence care-giving (Nordam et al., 2005, Schmidt et al., 2012, Melvin, 2015, Rose et al., 2010).

Many contributors to nursing journals now talk about a ‘slow nursing’ philosophy (Gallagher, 2012, Sellman, 2007) inviting practitioners to reconsider the possibility of slowing down their caring practices and to recognise that work matched with more acute awareness of patient needs may increase efficiency and effectiveness. This acute awareness recognises a need to explore the nature of being with patients. This study has presented evidence of learning new ways of caring for those living with dementia, including the importance of revitalising intuitive knowledge and engaging with families.

5.2.4 Moments involving families

Finally, regarding the choosing moments sub theme, there is growing awareness that an all-inclusive responsive relationship with family is the way forward (Ryan et al., 2008, McKeown et al., 2015, Prichard and Newcomb, 2015). While hand massage therapy is primarily focused on the outcome for the immediate beneficiary i.e. the patient, the act of hand massage was observed by participants in this study as having a greater effect, extending to the families of patients and the quality of the broader care environment. New possibilities of including other significant people in the care of patients with dementia were briefly touched on in the findings. Collaborating with patients and families was something staff routinely did when working with them to plan their care, but this was less apparent concerning involvement in interventions like hand massage. It can be assumed that family members feel secure in the knowledge that their relative is both well looked after and having a good time, their stressors (like guilt) are relieved. It has been found however those relatives have low expectations about what is possible in residential care (Campbell 2014). However, when family think the nursing home is above average regarding a person-centred approach, they experience a higher sense of satisfaction and involvement than the family members who are less positive about the person-centeredness of the nursing home (Heijkants, 2016).
The unrelenting pressures on contemporary health care systems suggest that, in future, the nurse’s role will also involve supporting family members in the development and operationalisation of caring competencies (Allen, 2007). However, the findings of this study indicate that there is an under utilisation of potential care partners such as family and volunteers. Translating this idealistic inclusion into practice was seen to be problematic, due to the nature of organisational structures and processes i.e. restricted visiting hours and excluding family from being involved in the patient’s physical care needs.

5.3 Challenges

The final section of this discussion chapter explores some of the perceived challenges encountered in the use of hand massage to relieve anxiety. Throughout the findings the main challenges identified are time; competing solutions to dealing with distress; influence, leadership and the role of education; the presence or absence of a supporting infrastructure and enabling innovation in care practice.

5.3.1 Time

Time and the relationship participants have with time prove to be highly significant factors when considering the role of hand massage and choosing moments. Giving undivided attention to patients and being centred in the moment of giving hand massage was achieved by participants on occasion. However, it does appear that due to a lack of time, such moments may be too few to be able to fully claim the use of hand massage as a central tool in the alleviation of anxiety within the reality of practice. The philosophy and rhetoric of health care systems to enable person-centred-care is often at odds with the pressure to optimise the use of resources and encourage time-efficient care interventions (Sjögren et al., 2013). A typical perspective reported in this study suggest that efforts to integrate hand massage in ordinary everyday care practices often fall victim to competing demands on time, leading on occasions to feelings of professional incompleteness (Fairchild, 2010). Ritual time allotted for activities and that may be taken for granted by staff may not always happen when patients or relatives could realistically participate. Instead, the activities become institutionalised in what Kitwood and Bredin (1992) describes as ‘outpacing’. This suggests that organisations, individual staff members and ultimately the patients could benefit from a re-conceptualisation of what smart productive time management in residential aged care facilities involves (White et al., 2014).
The struggle with time was amplified by increased demands to complete documentation, participate in audits, safety checks, etc. in keeping with quality related regulation regimes (Hayter, 2013). The availability of time to enable regular use of hand massage is further compromised by reduced staffing levels which in turn contribute to overuse of pharmacological interventions. Participants noted that it is often on evenings and weekends that medications are first ordered for the distress behaviours, because there may not be sufficient staff at these times to do the needed one-on-one interactions. Thus, the link emerges between staffing levels and the capacity to incorporate hand massage more fully into the care environment. Participants shared how they felt when talking to other workers and shared perceptions of what was happening in these interactions. While in some cases there was an acknowledgement of the potential value of hand massage, others were more entrenched in their opinion that it was little more than an optional extra, of no real value compared to medication in managing anxiety.

The use of medication to manage behaviours is a significant part of nursing culture in residential care (Janzen et al., 2013) and is highlighted in this study. As might be expected, the tension between pharmacology and complimentary intervention was palpable from all participants, with many participants perceive that distress behaviours can be managed effectively with interventions like hand massage or at least a carefully assessed combination of pharmacological and non-pharmacological (hand massage) approach. While the research evidence base indicating benefits from hand massage is small, there is research and practice evidence to support the use of hand massage for the alleviation of anxiety in dementia (Hansen et al., 2006a, Kolcaba, 2003, Kolcaba et al., 2006a). However, this and other studies suggest that it is resisted and resistance to change has been identified as one reason why task-oriented care remains so pervasive (Murphy et al., 2006; McCormack et al., 2010; O’Dwyer, 2012).

Whitaker et al. (2015) compared the outcome of two approaches to distress responsive behaviours, one focusing on causality and using predominantly complementary interventions, the other relying predominantly on psychotropic medication.

5.3.2 Influence, leadership and the role of education

The freedom and support of a generative management style are frequently commented on in the literature (Disch, 2009, Whitby, 2007) and emerges as a key challenge in efforts to broaden the use of hand massage to address distress in people living with dementia. Participants in this study described various circles of influence and leadership potential in their workplace. Some participants in managerial roles facilitated creative practices including hand massage. Other
participants expressed a feeling of achievement and assertiveness in their use of hand massage. Others still reported that using hand massage in a dementia-designated setting was easier than using hand massage as a tool to alleviate anxiety in generic settings.

These findings point to different experiences of communication, accountability and leadership. Such differences can create potential for conflict where relationships are stressful, and where there is typically poor communication and collaboration resulting in a lack of teamwork (Potter et al., 2010). Mutual performance monitoring came across as one such stress zone. Participants gave the impression of perceptions that spending time engaging in hand massage was not considered good team performance unless all the real work was completed. Participants also highlighted a degree of mistrust and misunderstanding as a result. Understanding and trust are core components of teamwork. However, if the organisation trusts and supports staff, this motivates them to do their job, resulting in more involved and committed personnel (Peeters et al., 2013). The potential to create such a positive work environment was evidenced in the findings as described by the participant nurse managers. As leaders of their teams, they appear to have co-created a person-centred environment. As a result of communication within the team and sharing successful strategies, there is an increased likelihood that hand massage would subsequently be used by other staff members. By contrast, non-management/leader participants did not always feel able to challenge the system. Participants were uncertain or despondent about the consequences of a challenge.

There is little doubt that education, broadly defined, plays a key role in fostering leadership, facilitating empowerment and in generating a more supportive environment. The findings in this study suggest that while some participants were willing to play a role in educating their colleagues about the implementation of person centred practices, they feel that they are underutilised as a resource and not encouraged to do so. This affects their motivation and constant striving to implement empowering practices (Mitchell, 2013). Research shows that education and training in dementia care is vital for person centred care practices (Surr et al., 2016, Karlin et al., 2016). Anxiety/agitation is interpreted differently based on the educational background of staff, and how they were trained to evaluate the situation and recognise an unmet need (Janzen et al., 2013). This study highlights that communication with others about why particular care practices were happening or had been prioritised was important. Most participants felt there was a need for education and clear guidance if there is to be a wider
acceptance of the value and legitimacy of hand massage as a recognised tool to alleviate anxiety.

While maintaining a role for intuitive practice, some formalised visibility and a standardisation of approach and method are needed, as was recommended by authors of the Cochrane review (Hansen et al., 2006a) as was the development of protocols by (Moyle et al., 2013b). Equally, as highlighted early in the literature review, the experience of empowerment is dependent on individual experience and critical perception of their world of work (McCormack et al., 2007). Believing that one has the capacity and ability to be empowered featured prominently in the findings. Being empowered through education appeared to lead to more curiosity about what was happening in practice (Laschinger et al., 2012). Participants were becoming more deliberate and assertive about their use of hand massage, captured in assertive statements like: ‘You know, I don’t mind how they [staff] view it [hand massage] ...it works’. Confidence in one’s competence and decision making seemed vital for empowerment amongst the participants in this study. Indeed, some participants felt that the actual practice of hand massage was an empowering communication tool. Links between self-esteem and a sense of meaning impacting one’s self-determination have been illustrated in the literature (Olthuis et al., 2007).

Another component of empowerment namely, respect, emerged consistently as a significant challenge. Being able to exchange ideas in an open and non-threatening manner was seen as important. Participants appreciated when managers demonstrated respect by showing interest in their promotion of person centred practices. On the other hand, participants’ confidence were diminished when managers dismissed the value of hand massage. If participants feel they are not trusted by managers or their professionalism is called into question, they can become demotivated. It is suggested that if they feel their professional goals are in conflict with those of the organisation, this can move them in the direction of self-interest or disengagement. As reflected upon in the literature, practice development invites one to engage in inquiries into one’s flourishing at work. (McCormack and Titchen, 2014), in turn, enabling a person-centred philosophy to permeate residential settings. A recent action research study undertaken in Ireland in a privately operated nursing home sheds light on the possibilities of practice development to further the sustainability of hand massage in residential care. The Person-Centred Situational Leadership Framework (PCSL) was used to develop person-centred care and person centred cultures. This framework was shown to be effective in its capacity to support the process of continuous learning within the care environment (Lynch et al., 2017).
More autonomy to organise own work, to self-manage and to set and agree objectives joint
with colleagues and management is seen as motivating and empowering (Le Grand, 2009). These strategies will assist in meeting the challenges and standards set out in the Dementia Strategy (Department of Health, 2014).

Caring for patients with dementia can be challenging, and staff can experience high levels of strain (Dewing, 2010, Testad et al., 2010). As part of this, effective communication between all parties involved in caring is seen as a key part of effective support (McCabe C, 2006, Majerovitz et al., 2009). Also, building confidence has been found to be a feature of empowerment in previous nursing studies (Corbally, 2004, Manojlovich, 2007, Cawley and McNamara, 2011). However, if management and nurse directors don’t buy into the benefits of hand massage as a therapeutic intervention training and protocols will inevitably be undermined. It is argued that training nurse leaders in therapies such as hand massage is feasible in the work place and can lead to a reduction in their stress which potentially leads to an increase in their value in hand massage (Tang et al., 2010).

5.3.3 Enabling innovation in practice

Hand massage has been described as a psychological, social, behavioural and creative intervention to support and enhance patients’ expression of feelings, their sense of self and their ability to connect and communicate with other people. The findings detail so much potential innovative practice, mostly in the conceptual phase, ready to be tapped but not ready to blossom, a participant experiencing hand massage as a gentle encouragement during dining, another participant amazed at the potential of hand massage to connect with a withdrawn patient. The very act of using hand massage to alleviate anxiety is evidence of creative management in care, to interact spontaneously and expressively, to create the possibility of meaning out of the tiniest expression or touch. Hand massage is an intervention that has a mostly positive effect, is easy to use, flexible, adaptable into practice more so than interventions that require planning, equipment and expertise.

Careful leaders can motivate and empower team members to make changes and innovate within their circle of influence. A variety of authors concurs that creativity and motivation are intrinsically linked with partaking therapeutically with patients (Freshwater, 2002, Wilson and Carryer, 2008, Lynch et al., 2017). Touching hands, connecting in the instant of the encounter and listening with the heart are approaches to practice that foster understanding and effective
nursing care. However, many participants in this study acknowledged that they felt bound to structure and routine minimising the potential for the spontaneous and self-directed use of hand massage. Such challenging aspects of health care have been identified by Crawford et al. (2014) who suggest that health care practitioners are products of their environments.

**Conclusion**

This chapter has presented a discussion of findings of this study. It has explored the meanings deriving from the use of hand massage for participants themselves - their perceptions of its importance to patients, to families and the broader work environment. It has also analysed the factors that both inhibit and enable the wider use of hand massage, including key factors such as disposition, the work culture/environment, education and regulatory regimes.

Some key insights emerged regarding how participants perceived the characteristics of hand massage. In the first instance, there appears to be a tendency to view hand massage as an individual practice by individual nurses rather than a collective practice in promoting patient well-being for those living with dementia.

Secondly, the findings suggest that there was a need for training and some standardisation of protocols for hand massage that required training into specific techniques. However parallel to this what emerged was recognition of the power of ‘simple touch’, the ‘common sense’ touch we engage in every day of our lives and which was part of traditional nursing. Here, questions of disposition, sensitivity and self-awareness are key.

Thirdly, holding a vulnerable patient’s hand with a heightened degree of sensitivity, seeing the patient with dementia relaxed and smiling, produces a similar relaxing impact on those people who are near. The intention to be present in the instant, the versatility and availability of hand massage, the level of engagement are decided upon on the moment and according to the need of patients. This is shown to be the beauty of hand massage, in producing a positive cascading effect which may enrich the care settings.

Finally, what becomes evident from these findings is that using hand massage as a tool to alleviate anxiety was not supported by the existing organisational cultures. The discussion of this acknowledges the complexity of what intentional physical touch comprises in practice. Even so, a relatively short and simple hand massage proved to be immensely important within
a residential care context. In the next chapter, final reflections and conclusions are drawn from this study.
Chapter 6 Conclusion

Introduction

As set out in the first chapter, this research proceeded from a core aim and five related objectives. The main aim of the research was to illuminate nurses’ experience of the use of hand massage in Irish residential care settings and thus contribute to the body of knowledge and evidence that will inform future nursing practice and lead to positive, beneficial outcomes for both patients and staff. The first of the five related objectives was to describe nurses’ experiences of giving hand massage to patients living with dementia in residential settings. The second was to identify the factors that facilitate the use of hand massage, while the third objective was to explore the challenges that nurse experience when using hand massage as a therapeutic intervention. These first three objectives have been met in the findings and discussion chapters, where the rich descriptions of the individual experiences were shared by study participants. These findings and discussion illustrate the individual nature and complexities of hand massage as a process in alleviating anxiety for people living with dementia. As illustrated in the discussion chapter many of the findings are in keeping with relevant national and international research. The final two objectives share the identification of recommendations and knowledge guidance relating to the use of hand massage in residential care settings. In concluding the thesis, this chapter addresses these objectives by reviewing its contributions to the existing body of knowledge and offering recommendations for future research, education and practice. Finally, some of the study limitations are identified as are some personal insights of the researcher journey.

6.1 Contribution to knowledge: Answering the research question

This research asked the question ‘What are nurses’ experiences of using hand massage to alleviate anxiety for patients living with dementia in residential settings’? In short, the findings generated from this study demonstrated that incorporating selected therapies, such as hand massage, into a plan of care provides multiple opportunities for nurses to demonstrate caring and to create calm present moments in which patients and the entire residential care environment can flourish. The literature review in chapter 2 shows that hand massage is a complex, multifaceted intervention (Craig et al., 2013). However, an identified weakness in the literature is the lack of empirical evidence about the efficacy or otherwise of hand massage (Hansen et al., 2006b, Harris and Richards, 2010), particularly in the case
of older patients with dementia in long-term care environments. This study addresses a gap in the research and demonstrates that nurses do report positive perceptions about the benefits of hand massage as part of a broader, reconfigured care regime.

Being one of the few studies that focus on nurse’s experience of hand massage in residential settings, this study adds understanding and identification of characteristics that contribute towards the effectiveness of hand massage in caring for patients with dementia. It shows that integrating hand massage in a caring act helps to create a connectedness with patients and give nurses an opportunity to become more caring caregivers, particularly in residential settings where touch is confined to existing procedures and tasks the reality of institutional settings touch is confined to procedures and tasks, reinforcing the conclusions of Pedrazza et al. (2015). This study illustrates that in today’s healthcare world with a shortage of nursing staff (McGilton et al., 2012) and associated pressure on time, providing hand massage may give nurses moments of awareness and presence in touch. Little time is required to incorporate this technique as even a 5-minute massage may create a moment of connectedness in the patient–nurse relationship. However, utilising a complementary treatment, such as hand massage, requires a supportive environment, structure, and time for nurses to maintain their inner balance, which in turn, requires organisational support and economic and political commitment.

This study has also added to the body of research knowledge by identifying key factors that enable or inhibit the use of hand massage. The enabling factors include time and willingness to displace routinised working; adequacy and attitude of the workforce; the emotional intensity of patient needs; the value placed on the use of hand massage within settings. Factors which inhibit the use of hand massage take in the stress level of the staff; work and peer influence; shared meaning of hand massage between patient and nurse and, finally, past experience of touch and hand massage for patient and nurse. As well as highlighting the benefits of hand massage in the relief of anxiety, participants in this study were clear in their articulation of the supports needed from care setting management to support their endeavours to become effective reflective practitioners in the context of dementia care. Participants were also aware of what needs to change in their practice to enable person centred practices to occur for patients and staff alike. This study has highlighted the importance of self-awareness and communication as essential, prerequisite skills for nurses.
The findings suggest that the philosophy of care, determined by the care settings’ management system and the dominant caregivers’ work ethics significantly influences the quality of care. Care givers ability to reflect ultimately also affects their care delivery. However, although not a focus of this study, participants hint that self-reflection amongst staff working in care settings is poorly developed. This reinforces the systems oriented conclusions of earlier research (Duffin, 2012, Stacpoole et al., 2015) and emphasises that hand massage needs a system level as opposed to an individual practitioner level response.

Finally, this study adds to a growing body of knowledge regarding gerontological nursing care. Creating healthy work environments is a major concern for the nursing profession. However, less conducive work environments, can have severe repercussions for staff, patients, and families (Tillott et al., 2013, Hanson Michele, 2014). While there is an institutional obligation to cultivate healthy work environments, it is equally up to each practitioner to explore their particular area of practice and reflect on where they may enhance aspects of practice that they are enthusiastic about, in the process supporting their own personal empowerment. In such an environment, the potential of hand massage as valuable intervention may be realised.

6.2 Implications for Practice, Education and Future Research

Having reflected on the contribution of the study to existing knowledge, this section now provides some recommendations to enhance nursing practice, for education and training and to guide further research.

6.2.1 Enhancing practice

Hand massage as a practice seeks to engage the patient’s primary, positive connection with touch and has been shown to have the potential to enable patients to experience moments in which they feel a secure sense of connectedness with the nurse, providing moments of calm and security. The sustainability of hand massage as a ‘common sense’ intervention to alleviate distress/response behaviours requires a paradigm shift in thinking for administrators so that their focus becomes centred on communication and on considering their power and circle of influence. When ‘person- centred’ is espoused as a key principle of an organisation all those within it, and those who access its services can experience person centred ways of being. Moreover, engaging in hand massage can become a fruitful mode
through which to view and re-frame the communication and participation of patients in
dementia care.

6.2.2 Enhancing education and training

The findings from this study are consistent in identifying the crucial role of education and
training in promulgating a deeper appreciation of the role of hand massage. Thus, the
development of education and training programs to enhance understanding and capacity are
essential to promote understanding amongst staff of the potential for a more holistic model
of dementia care as opposed to more narrow, medical model of dementia management,
echoing the type of ‘slow nursing’ philosophy (Gallagher, 2012, Sellman, 2007) that invites
practitioners to consider slowing down their caring practices and to better attune awareness
of patient needs, in the process, increasing efficiency. Any such programmes must, however,
be applied across teams to ensure equity of understanding about dementia, facilitate
dissemination of knowledge and sharing of learning. Spaces are needed that provide
psychological safety for staff to articulate, debate and challenge ingrained assumptions about
the nature and nurture of dementia (Brown and McCormack, 2011). These programmes
should cultivate a spirit of inquiry about the versatility of hand massage as part of a tool box
for distressed behaviours and should educate conscientious staff about the significance of
personhood, rehabilitation and recovery for the patient experiencing anxiety in dementia.
The design, as well as the delivery of programmes, should seek to ignite the reflective,
curious mind and inculcate a sense of the potential for creative, individualised interventions,
in the process allowing tacit skills and knowledge to be recognised, articulated and made
explicit.

The way in which people learn and access information has changed. Online learning
programmes have become increasingly popular in recent years. Recognising this, an
educational DVD on hand massage was co-created by Tuohy et al. (2015) and was made
easily accessible via the web. This type of learning medium offers a flexible and accessible
way of individualising learning for health care workers and families of patients living with
dementia. Of course such approaches don’t replace but can supplement direct carer to patient
contact. Hand massage is best learned at the bedside where it is easily incorporated in a care
routine. This involves a demonstration by an instructor and then a return demonstration by
the caregiver (Moyle et al., 2013b).
Data generated from this study demonstrates that incorporating selected therapies, such as hand massage, into a plan of care provides multiple opportunities for nurses to demonstrate caring and to create calm present moments in which patients and the entire residential care environment can flourish.

6.2.3 Enhancing research

While this study has produced interesting findings, it is clear that further research on the use of hand massage is needed to strengthen arguments for its inclusion as part of a dementia care toolkit. In particular, greater attention needs to be focused on the importance and complexity of maintenance of self for patients living with dementia in nursing homes. How patients living with dementia are viewed by the nurses as well as the care organisation should be revisited, taking account of the complexity of relationships in residential care and the aspirations of the person centred care literature. Based on the findings of this study and supporting previous literature, some recommendations for further research are suggested.

Firstly, it is recognised that obtaining data from patients with dementia would have allowed further comparison of experiences of the value of hand massage and may have altered the overall conceptualisation of emotional responses during and after receiving hand massage. While this was not the focus of the study, it represents an important, albeit ethically complicated, area for further research consideration.

Secondly, the inclusion of perspectives from other care staff and families would offer a broader viewpoint. Reliance on the perspectives of one group only could be seen as a less than comprehensive inquiry approach. Thus further research could be undertaken to incorporate the perspectives and experiences of the breadth of health care staff as well as family members.

Finally, this research has repeatedly highlighted the significance of staff disposition, about dementia in general and the use of hand massage more specifically. It is considered that more detailed research into the first of these, disposition about dementia and those living with it, would be important to gain an insight into pre-existing attitudes. These, in turn, might enable or inhibit the potential for the use of a broader range of strategies to enhance the quality of life of those living with the condition.
6.3 Limitations

While this study contributes to current knowledge by exploring the experiences of nurses regarding their use of hand massage to alleviate anxiety, the findings are limited by the sample size. Although the small sample size is acceptable for a qualitative descriptive study, the views and perceptions of those interviewed cannot claim to be representative of all nursing staff. Arising from this is the issue of generalisability. The findings express the views of a small number of participants, recruited from five nursing homes. This may reduce the generalisability of the findings. However, nurses that work in this field may recognise the description of the context, of the participant circumstances and the particular findings. Thus transferability is possible by linking these findings to their own work experience.

The findings in this study are grounded in the nurses’ perspectives. As with any qualitative research, there are always possible alternative explanations for what nurses perceive as factors that may contribute to the challenges with the use of hand massage. There is a risk that the nurses’ interactions may have multiple meanings and that they cannot be fully relied upon as objective truths. However, the findings point to subjective descriptions of experience, rather than to statistically verified knowledge and absolute truths.

6.4 Final conclusion

In considering the broader context of the rich descriptions by participants within this study, there is an implicit thread of the potential and realities for individualised person centred nursing and the role of hand massage within it. The findings showed an opening of awareness, embodied moments of presence and an extended ability to act creatively in caring and reflection. Hand massage benefits patients and, for the nurse, it opens doors to an expanded view of one’s own caring ability that will benefit the patient. As such, it enhances the quality of care and contributes to a more person centred work environment. Moments of giving hand massage provided patients and nurses with a mutual sense of well-being in an otherwise stressful environment. Hand massage encouraged the skin-to-skin touch for the sole purpose of comfort and easing the anxieties that manifest in many different forms. Hand massage promoted an attitude of thoughtful, sensitive contemplation in caring, an integration of head, heart and hand. This study adds new insights into the value and potential of hand massage in connecting with and relieving anxiety for people with dementia, reinforcing arguments for incorporating hand massage as an intervention into caring practices.
Reference List


Alsawy, S., Mansell, W., Mcevoy, P. & Tai, S. 2017. What is good communication for people living with dementia? A mixed-methods systematic review. *International Psychogeriatrics*, 1-16.

An Bord Altranais 2007. Guidance to nurses and midwives regarding ethical conduct of nursing and midwifery research.


Authority, H. I. Q., 2015, Annual Overview on the Regulation of Designated Centres for Older People-2014 HIQA. Dublin^.


Barry, R. 2008. 'Does Hand Massage Help to Reduce Anxiety in Hospitalised Older Adults?’. NUI, 2008 at Department of Nursing Studies, UCC.


Cahill, S. & Diaz-Ponce, A. M. 2011. 'I hate having nobody here. I'd like to know where they all are': Can qualitative research detect differences in quality of life among nursing home residents with different levels of cognitive impairment? Aging & Mental Health, 15, 562-572.


Cahill, S., O'Shea, E. & Pierce, M., Creating excellence in dementia care: A research review for Ireland's national dementia strategy. Dementia Services Information and Development Centre.


Clinton, G. 2010. *Aspects of registered psychiatric nurses' talk about their clinical judgement and decision-making*. Dublin City University.


Duffin, C. 2012. How namaste principles improve residents’ lives: Christian Duffin describes how older people in a home in Kent are benefiting from an American programme that uses sensory techniques to comfort and soothe them. Nursing older people, 24, 14-17.


Galletta, A. 2013. *Mastering the semi-structured interview and beyond: From research design to analysis and publication*, NYU Press.


Hall, S. 2011. *Palliative care for older people: better practices*, World Health Organization,


Hanson Michele. 2014. We have fifteen people. Thats 1000 years of history. *The Guardian*, 12/04/2014.


Health Information and Quality Authority, 2016, National Standards for Residential Care Settings for Older People in Ireland.


Heijkants, C. 2016. *The influences of person-centered dementia care; on the satisfaction, involvement and strain of formal and informal caregivers*.


Higgs, J., Horsfall, D. & Grace, S. 2009. *Writing qualitative research on practice*, Sense Publishers Atlanta^ eGA GA.


Majerovitz, S. D., Mollott, R. J. & Rudder, C. 2009. We're on the same side: Improving communication between nursing home and family. Health communication, 24, 12-20.

Marianna, M. 2011. What are the major ethical issues in conducting research? Is there a conflict between the research ethics and the nature of nursing? *Health Science Journal*.


Mckeown, J., Ryan, T., Ingleton, C. & Clarke, A. 2015. ‘You have to be mindful of whose story it is’: The challenges of undertaking life story work with people with dementia and their family carers. *Dementia,* 14, 238-256.


Mitchell, G. 2013. Selecting the best theory to implement planned change: Improving the workplace requires staff to be involved and innovations to be maintained. Gary Mitchell discusses the theories that can help achieve this. *Nursing Management*, 20, 32-37.


Nicholls, D., Chang, E., Johnson, A. & Edenborough, M. 2013. Touch, the essence of caring for people with end-stage dementia: a mental health perspective in Namaste Care. *Aging & mental health*, 17, 571-578.


Nursing and Midwifery Board of Ireland 2014. Code of Professional Conduct and Ethics for Registered Nurses and Midwives,. Blackrock, Co Dublin: Nursing and Midwifery Board of Ireland,. 


Phelan, A. & Mccormack, B., 2010, Exploring nursing expertise in residential care for older people in Ireland. Nursing Homes Ireland,


Ryan-Nicholls, K. & Will, C. 2009. Rigour in qualitative research: mechanisms for control: Qualitative researchers have been criticised for a perceived failure to demonstrate methodological rigour. Kimberley D Ryan-Nicholls and Constance I Will offer cautionary recommendations related to the mechanisms for control of methodological rigour in qualitative inquiry. *Nurse researcher*, 16, 70-85.


Sandelowski, M. 2000b. *Devices and Desires Gender, Technologies and Americanian Nursing*.


Seidman, I. 2013. *Interviewing as qualitative research: A guide for researchers in education and the social sciences*, Teachers college press.


Thompson, R. 2011. USING LIFE STORY WORK TO ENHANCE CARE. *Nursing Older People*, 23, 16-21.


Van Oel, C. & Boer-Lootens, D. Hallways in the eyes of patients with moderate dementia. ENHR 2015 Conference ‘Housing and Cities in a time of change: are we focusing on People?’ Lisbon, Portugal, 29 June-1 July 2015, 2015. ENHR.


Whitby, P. 2008. Why is good quality residential care so very difficult to achieve? Paul Whitby explores the powerful forces at work in any institution, arguing that until these are addressed even the best training and skills development will not improve the quality of residential care for people with dementia. *The Journal Of Dementia Care For All Who Work With People With Dementia, 16*, 30.


Wolcott, H. F. 2002. Writing up qualitative research... better. *Qualitative Health Research, 12*, 91-103.


Appendices

Appendix 1: Access to Research Site

Appendix 2: Communication from Nursing Homes Ireland and Research Officer

Appendix 3: Participant Information Sheet

Appendix 4: Written Consent and Reply Slip

Appendix 5: Poster to Participate

Appendix 6: Participant Invitation Letter

Appendix 7: Interview Schedule

Appendix 8: Newell and Burnard Framework

Appendix 9: NVivo Coding Process

Appendix 10: Reflexivity

Appendix 11: Ethics Scan
Appendix 1: Access to Research Site

Research Study Exploring nurses’ experience of the use of hand massage to alleviate anxiety in individuals with dementia in residential settings.

RE: Application to facilitate a research study in your organisation for research purposes.

Dear

My name is Ann Larkin and I am a research master’s student with the University of Limerick. I am writing to you to ask if you would agree to allow me access to staff to facilitate a research study in your organisation.

The Department of Nursing and Midwifery at the University of Limerick offered a Master by Research Fees Studentship in 2013. This afforded the opportunity to conduct a research project exploring nurses’ experience of the use of hand massage to alleviate anxiety in individuals with dementia. While it is acknowledged that hand massage is provided as a therapeutic nursing intervention in some/many residential care settings, not all nurses will be familiar with providing hand massage. Therefore, I will offer hand massage workshops using materials and a DVD created by UL and St. Camillus’ Hospital. This research project will be part of a proposed bigger study considering the applicability of hand massage as a treatment for dementia in an Irish context.

I would be grateful if you would consider my request.

Thank you for your time and I look forward to hearing from you.

Yours Sincerely,

xxxxxx
c/o Department of Nursing and Midwifery, University of Limerick.

Tel: xxxxxx email: xxxxxx@ul.ie
Appendix 2: Communication from Nursing Homes Ireland and Research Officer

xxxxxx <xxxxx@nhi.ie>
Wed 6/11/2014 5:40 PM
Inbox
To:
UL Student: ANN.LARKIN;
You replied on 6/16/2014 10:27 AM.
Hi Ann
Sorry for the delay in replying. I spoke with Gaynor, our Practice Development Facilitator and forwarded her your mailing.
Gaynor has advised in respect of ethics; each individual nursing home would have its own ethical practices in place.
While NHI could advise Member nursing homes in such respect, it is a matter for each individual nursing home – in keeping with the national standards – to implement and adhere to ethical practice.
I hope this of assistance
Regards
Michael

Michael McGlynn
NHI Communications & Research Officer
Nursing Homes Ireland,

Tel: (01) xxxxx / 087 xxxxx

Appendix 3: Participant Information Sheet
Participant Information Sheet

Title of Study: Exploring Nurses experience of the use of hand massage to alleviate anxiety in individuals with dementia in residential settings.

Aims of Study: To explore nurses’ experiences of using hand massage as a therapeutic intervention to support individuals with dementia in residential settings.

What will you have to do?

If you volunteer to take part in this study, you would be required to participate in a one-to-one interview with the researcher. This interview would last approximately 30 to 45 minutes. The time will take place at a time and venue of your choice. This interview will be audio-recorded to assist the researcher in the data analysis stage. “You will be not identified by name in this research project.”

- “Any information given in the course of interviews may be used in the study, but your privacy will be respected in all other matters.”

What are the benefits for you?

There may not be a personal benefit to you (but it is said that giving a massage can be just as pleasurable and beneficial as receiving one). If you choose to participate, however by highlighting your perceptions in this area, you will be contributing to the current body of knowledge and understanding of this topic area and thereby enhancing future services to people with dementia and their families.

What are the risks to you?
While there are no anticipated risks to participants, it is acknowledged that all qualitative research has the potential to raise emotive responses in people, especially when participants are drawing on past experiences. Your confidentiality and anonymity are safeguarded at all times.

**What are the alternatives?**

Participation in this research study is voluntary. If you decide to participate you can still withdraw from the study at any time or stage of the research if you so wish without penalty or disadvantage occurring.

**Who is taking part?**

The study involves registered nurses.

**What happens to the data?**

If you volunteer to participate in this research study, your confidentiality and anonymity will be protected at all times. Your name will not be linked to your responses either in the research transcripts, conference proceedings, research reports or in any publications. Pseudonyms will be used at all times and in the presentation of findings. On completion of the study, the researcher will forward a summary of the research findings to each participant. All data gathered during the interview will be stored securely by the researcher. Only the researchers named below will have access to the data. The findings from the study will be presented in the researcher’s master’s thesis, which will be held in the UL library. All data will be destroyed after a seven-year timeframe.

**Name and contact details of the researchers**

Ann Larkin,
Research Masters Student,
Department of Nursing and Midwifery, UL,
Email: xxxxxx@studentmail.ul.ie  Mob.087xxxxxx.

Margaret Graham,
Lecturer / Research Supervisor
Department of Nursing and Midwifery,
Email: Dympna.Tuohy@ul.ie

Dympna Tuohy
Lecturer/Research Supervisor,
Department of Nursing and Midwifery, UL,
Email: Dympna.Tuohy@ul.ie
Appendix 4: Written consent and reply slip

Informed Consent Form

Title of Study: Exploring nurses’ experiences of the use of hand massage to alleviate anxiety in individuals with dementia in residential settings

You are invited to take part in a research study to explore nurse’s experience of using hand massage as a therapeutic activity to support individuals with dementia in residential settings. If you agree to take part, you would be required to take part in a one-to-one interview, lasting approximately 45 minutes.

Before you consent to participate in the study please note the following points:

- Your participation is voluntary and you may withdraw from the research at any time for any reason
- Your confidentiality and anonymity are assured by the researcher. Your name or any information that might identify you will not be linked to your responses either in the research transcripts, research report or in any publications.
- On completion of the study, you will receive a summary of the findings.

By signing below, you are agreeing that you have read and understand the Participant Information Sheet and that you agree to take part in this research study.

__________________________________________  ____________
Participant’s signature            Date

UL,
Email: Margaret.Graham@ul.ie

Appendix 4: Written consent and reply slip
Printed name of person obtaining consent

Signature of person obtaining consent
(Lead investigator)
Appendix 5: Poster

Poster

Would you like to participate in a research study?
The aim of the study is to explore nurse’s experience of using hand massage to alleviate anxiety in individuals living with dementia in a residential setting.
If you are a registered nurse I would be delighted to hear from you.
Participation is entirely voluntary. Confidentiality and anonymity are guaranteed.
If you are interested please contact me and I will provide you with further information on the study. I look forward to hearing from you. Many thanks,

Ann Larkin 087 xxxxxx or
email = xxxxx@studentmail.ul.ie

Ethical approval for this study has been granted from the Research Ethics Committee, Mid-Western Regional Hospital, Dooradoyle, Limerick
Appendix 6: Research Participant Invitation Letter

Research Study: Exploring nurses’ experience of the use of hand massage to alleviate anxiety in individuals with dementia in residential settings.

Dear

My name is Ann Larkin and I am a research Master’s student with the University of Limerick. I am writing to you to ask if you would agree to become involved in a study I am about to conduct. I aim to explore nurses’ experiences of using hand massage as a therapeutic activity to support individuals with dementia in residential settings.

While it is acknowledged that hand massage is provided as a therapeutic nursing intervention in some/many residential care settings, not all nurses will be familiar with providing hand massage. Therefore, I will offer to facilitate workshops on the use of hand massage and will subsequently invite nurses to be interviewed about their practice and experience of using hand massage. I would be grateful if you would consider becoming involved by agreeing to participate in the study. Your participation will involve an interview conducted by myself. The interview will be audio-recorded and will take approximately 45 minutes. Participation in the project is voluntary and confidential; your anonymity will be protected and maintained at all times. If you decide to respond it is important that you are aware that you can withdraw from the study at any time, if you so wish.

If you are willing to take part in the study please return the enclosed reply slip, which indicates your consent to participate, you can use the stamped addressed envelope enclosed or email the reply slip to me at the email address above. Following receipt of the reply slip I will contact you in relation to any questions that you may have.

I would be grateful if you would consider my request and return the reply slip so we can have a broader discussion of what is involved. Should you wish to participate in the study you will not be expected to make any commitments that will put any pressure on your daily life. I will work around your availability. Thank you for your time and I look forward to hearing from you.

Yours Sincerely,

Ann Larkin
c/o Department of Nursing and Midwifery, University of Limerick.

Tel: 087 xxxxxx Email: xxxxx@ul.ie
Reply Slip

**Research Study:** Exploring nurses’ experiences of the use of hand massage to alleviate anxiety in individuals with dementia in residential settings

I am interested in your research study and I would like to find out more about what is involved. My contact details are (*please give details of whatever means of communication is most suitable and preferable to you*).

Name:

________________________________________________________________________

Preferred means of contact:

________________________________________________________________________

My preferred times of contact are:

________________________________________________________________________

All correspondence can be sent to this address:

________________________________________________________________________

________________________________________________________________________

Please return this form to Ann Larkin via email or post using the stamped addressed envelope provided:

Email: xxxxx@studentmail.ul.ie 087 xxxxxx

Post: Ann Larkin, Cappalaheen, Kilkishen, Co Clare
Appendix 7: Interview Schedule

Research Study: Exploring nurses’ experience of the use of hand massage to alleviate anxiety in individuals with dementia in residential settings.

Interview Guide

The researcher will thank the participant for taking part in the study and reassure about confidentiality and the right to end the interview at any time.

The researcher using semi-structured interviews has a series of topics in mind around which she will frame questions. There is no particular order to the questions. It will be led by the participant’s responses. This encourages the interview to flow more freely while allowing some structure (Newell and Burnard 2006).

The following questions are a guide.

Tell me about your experience of using hand massage.
How did you choose to work with a patient and consider providing a hand massage?
What happened?
And what would encourage you to continue and or stop using hand massage?
Did you notice any benefit?
Tell me about the challenges
What would hinder the use of hand massage?

Supplementary probes

What supports would help you in considering the use of hand massage
When do you find it useful, when would you consider using hand massage
Have you learned anything from your own experiences and feelings of using hand massage?

Concluding

Reaffirm confidentiality
Is there anything else that you would like to add?
Thank you
Appendix 8: Newell and Burnard Framework

Data analysis

The data collected was subject to thematic content analysis using (Newell and Burnard’s 2006) framework.

Key points:

Transcription involves writing out recordings of an interview. Categories can be predefined or emerge from the data. This approach involves six stages:

1. Taking memos after each interview
2. Reading transcripts and making notes of general themes
3. Repeating reading and generating open coding headings to describe all aspects of the data
4. Reducing the codes under higher order codes
5. Returning to the data with the higher order codes
6. Collating the organised data for reporting
# Appendix 9: NVivo Coding Process

## First level codes

<table>
<thead>
<tr>
<th>Name</th>
<th>Sources</th>
<th>References</th>
<th>Created On</th>
<th>Created By</th>
<th>Modified On</th>
<th>Modified By</th>
</tr>
</thead>
<tbody>
<tr>
<td>anxiety</td>
<td>2</td>
<td>3</td>
<td>07/03/2015 13:05</td>
<td>AL</td>
<td>12/03/2015 12:31</td>
<td>AL</td>
</tr>
<tr>
<td>distressed behaviours</td>
<td>1</td>
<td>1</td>
<td>24/03/2015 10:36</td>
<td>AL</td>
<td>16/01/2016 20:23</td>
<td>AL</td>
</tr>
<tr>
<td>gender issues</td>
<td>4</td>
<td>7</td>
<td>25/02/2015 14:14</td>
<td>AL</td>
<td>24/03/2015 15:19</td>
<td>AL</td>
</tr>
<tr>
<td>hand massage</td>
<td>9</td>
<td>57</td>
<td>24/02/2015 21:38</td>
<td>AL</td>
<td>24/03/2015 15:19</td>
<td>AL</td>
</tr>
<tr>
<td>connection</td>
<td>7</td>
<td>15</td>
<td>27/02/2015 15:33</td>
<td>AL</td>
<td>20/03/2015 15:39</td>
<td>AL</td>
</tr>
<tr>
<td>language</td>
<td>1</td>
<td>3</td>
<td>24/02/2015 21:57</td>
<td>AL</td>
<td>25/02/2015 15:11</td>
<td>AL</td>
</tr>
<tr>
<td>intimacy</td>
<td>3</td>
<td>11</td>
<td>25/02/2015 14:10</td>
<td>AL</td>
<td>27/02/2015 21:34</td>
<td>AL</td>
</tr>
<tr>
<td>massage from outside</td>
<td>3</td>
<td>14</td>
<td>27/02/2015 16:11</td>
<td>AL</td>
<td>12/03/2015 12:26</td>
<td>AL</td>
</tr>
<tr>
<td>medication</td>
<td>1</td>
<td>2</td>
<td>12/03/2015 12:32</td>
<td>AL</td>
<td>19/03/2015 19:28</td>
<td>AL</td>
</tr>
<tr>
<td>opportunities</td>
<td>6</td>
<td>9</td>
<td>27/02/2015 15:22</td>
<td>AL</td>
<td>16/01/2016 20:23</td>
<td>AL</td>
</tr>
<tr>
<td>Stake holders</td>
<td>9</td>
<td>36</td>
<td>25/02/2015 15:50</td>
<td>AL</td>
<td>12/03/2015 12:43</td>
<td>AL</td>
</tr>
<tr>
<td>the nurse</td>
<td>8</td>
<td>30</td>
<td>24/02/2015 20:54</td>
<td>AL</td>
<td>24/03/2015 15:19</td>
<td>AL</td>
</tr>
<tr>
<td>motivation</td>
<td>2</td>
<td>4</td>
<td>18/03/2015 18:30</td>
<td>AL</td>
<td>19/03/2015 19:30</td>
<td>AL</td>
</tr>
<tr>
<td>personal benefits of hand massage</td>
<td>2</td>
<td>4</td>
<td>18/03/2015 18:22</td>
<td>AL</td>
<td>19/03/2015 19:20</td>
<td>AL</td>
</tr>
<tr>
<td>the patient</td>
<td>8</td>
<td>33</td>
<td>24/02/2015 21:15</td>
<td>AL</td>
<td>12/03/2015 12:30</td>
<td>AL</td>
</tr>
<tr>
<td>patient benefit</td>
<td>1</td>
<td>1</td>
<td>19/03/2015 19:22</td>
<td>AL</td>
<td>19/03/2015 19:22</td>
<td>AL</td>
</tr>
<tr>
<td>task orientation</td>
<td>4</td>
<td>6</td>
<td>27/02/2015 15:27</td>
<td>AL</td>
<td>24/03/2015 15:19</td>
<td>AL</td>
</tr>
<tr>
<td>the way in</td>
<td>1</td>
<td>3</td>
<td>25/02/2015 15:43</td>
<td>AL</td>
<td>27/02/2015 15:11</td>
<td>AL</td>
</tr>
<tr>
<td>training</td>
<td>9</td>
<td>31</td>
<td>24/02/2015 10:40</td>
<td>AL</td>
<td>24/03/2015 15:19</td>
<td>AL</td>
</tr>
<tr>
<td>work experience</td>
<td>7</td>
<td>15</td>
<td>24/02/2015 10:41</td>
<td>AL</td>
<td>12/03/2015 11:52</td>
<td>AL</td>
</tr>
<tr>
<td>work role</td>
<td>5</td>
<td>9</td>
<td>24/02/2015 10:47</td>
<td>AL</td>
<td>12/03/2015 10:05</td>
<td>AL</td>
</tr>
<tr>
<td>Name</td>
<td>Sources</td>
<td>References</td>
<td>Created On</td>
<td>Created By</td>
<td>Modified On</td>
<td>Modified By</td>
</tr>
<tr>
<td>-------------------------------------------</td>
<td>---------</td>
<td>------------</td>
<td>------------</td>
<td>------------</td>
<td>-------------</td>
<td>-------------</td>
</tr>
<tr>
<td>Antecedent behaviour</td>
<td>0</td>
<td>0</td>
<td>24/03/2015</td>
<td>AL</td>
<td>24/03/2015</td>
<td>AL</td>
</tr>
<tr>
<td>language (2)</td>
<td>1</td>
<td>3</td>
<td>24/03/2015</td>
<td>AL</td>
<td>27/03/2015</td>
<td>AL</td>
</tr>
<tr>
<td>medication - alternatives</td>
<td>5</td>
<td>10</td>
<td>24/03/2015</td>
<td>AL</td>
<td>27/03/2015</td>
<td>AL</td>
</tr>
<tr>
<td>motivation</td>
<td>3</td>
<td>11</td>
<td>24/03/2015</td>
<td>AL</td>
<td>27/03/2015</td>
<td>AL</td>
</tr>
<tr>
<td>task orientation</td>
<td>1</td>
<td>2</td>
<td>24/03/2015</td>
<td>AL</td>
<td>27/03/2015</td>
<td>AL</td>
</tr>
<tr>
<td>time issues</td>
<td>6</td>
<td>17</td>
<td>24/02/2015</td>
<td>AL</td>
<td>27/03/2015</td>
<td>AL</td>
</tr>
<tr>
<td>training (2)</td>
<td>10</td>
<td>37</td>
<td>24/03/2015</td>
<td>AL</td>
<td>27/03/2015</td>
<td>AL</td>
</tr>
<tr>
<td>work environment</td>
<td>3</td>
<td>6</td>
<td>24/03/2015</td>
<td>AL</td>
<td>27/03/2015</td>
<td>AL</td>
</tr>
<tr>
<td>work experience (2)</td>
<td>8</td>
<td>16</td>
<td>24/03/2015</td>
<td>AL</td>
<td>27/03/2015</td>
<td>AL</td>
</tr>
<tr>
<td>work role</td>
<td>6</td>
<td>11</td>
<td>24/03/2015</td>
<td>AL</td>
<td>27/03/2015</td>
<td>AL</td>
</tr>
<tr>
<td>change thinking</td>
<td>7</td>
<td>12</td>
<td>26/03/2015</td>
<td>AL</td>
<td>26/03/2015</td>
<td>AL</td>
</tr>
<tr>
<td>behaviour (practice)</td>
<td>2</td>
<td>3</td>
<td>24/03/2015</td>
<td>AL</td>
<td>26/03/2015</td>
<td>AL</td>
</tr>
<tr>
<td>anxiety reduction situations</td>
<td>1</td>
<td>2</td>
<td>24/03/2015</td>
<td>AL</td>
<td>26/03/2015</td>
<td>AL</td>
</tr>
<tr>
<td>Entry points (2)</td>
<td>4</td>
<td>7</td>
<td>24/03/2015</td>
<td>AL</td>
<td>26/03/2015</td>
<td>AL</td>
</tr>
<tr>
<td>gender issues (2)</td>
<td>6</td>
<td>11</td>
<td>24/03/2015</td>
<td>AL</td>
<td>26/03/2015</td>
<td>AL</td>
</tr>
<tr>
<td>integration hand massage into practice</td>
<td>8</td>
<td>20</td>
<td>26/03/2015</td>
<td>AL</td>
<td>26/03/2015</td>
<td>AL</td>
</tr>
<tr>
<td>massage from outside (2)</td>
<td>3</td>
<td>14</td>
<td>24/03/2015</td>
<td>AL</td>
<td>24/03/2015</td>
<td>AL</td>
</tr>
<tr>
<td>opportunities (2)</td>
<td>6</td>
<td>16</td>
<td>24/03/2015</td>
<td>AL</td>
<td>26/03/2015</td>
<td>AL</td>
</tr>
<tr>
<td>Consequence &amp; outcomes</td>
<td>3</td>
<td>3</td>
<td>24/03/2015</td>
<td>AL</td>
<td>22/01/2016</td>
<td>AL</td>
</tr>
<tr>
<td>anxiety</td>
<td>2</td>
<td>4</td>
<td>24/03/2015</td>
<td>AL</td>
<td>26/03/2015</td>
<td>AL</td>
</tr>
<tr>
<td>Theme</td>
<td>Value</td>
<td>Value2</td>
<td>Date</td>
<td>Time</td>
<td>Date2</td>
<td>Time2</td>
</tr>
<tr>
<td>--------------------------------------------</td>
<td>-------</td>
<td>--------</td>
<td>---------</td>
<td>--------</td>
<td>--------</td>
<td>-------</td>
</tr>
<tr>
<td>anxiety reduction</td>
<td>3</td>
<td>3</td>
<td>24/03/2015</td>
<td>15:49</td>
<td>26/03/2015</td>
<td>14:26</td>
</tr>
<tr>
<td>connection (2)</td>
<td>10</td>
<td>24</td>
<td>24/03/2015</td>
<td>15:56</td>
<td>22/01/2016</td>
<td>18:54</td>
</tr>
<tr>
<td>intimacy (2)</td>
<td>3</td>
<td>12</td>
<td>24/03/2015</td>
<td>15:58</td>
<td>22/01/2016</td>
<td>18:54</td>
</tr>
<tr>
<td>patient benefit</td>
<td>3</td>
<td>4</td>
<td>24/03/2015</td>
<td>16:12</td>
<td>26/03/2015</td>
<td>15:19</td>
</tr>
<tr>
<td>personal benefits of hand massage</td>
<td>8</td>
<td>15</td>
<td>24/03/2015</td>
<td>16:12</td>
<td>26/03/2015</td>
<td>15:43</td>
</tr>
<tr>
<td>hand massage</td>
<td>10</td>
<td>32</td>
<td>24/03/2015</td>
<td>15:57</td>
<td>16/01/2016</td>
<td>20:23</td>
</tr>
<tr>
<td>the nurse</td>
<td>3</td>
<td>11</td>
<td>24/03/2015</td>
<td>16:11</td>
<td>16/01/2016</td>
<td>20:05</td>
</tr>
<tr>
<td>the patient</td>
<td>8</td>
<td>33</td>
<td>24/03/2015</td>
<td>16:11</td>
<td>12/03/2015</td>
<td>12:30</td>
</tr>
</tbody>
</table>
### Third level codes

<table>
<thead>
<tr>
<th>Name</th>
<th>Sources</th>
<th>References</th>
<th>Created On</th>
<th>Created By</th>
<th>Modified On</th>
<th>Modified By</th>
</tr>
</thead>
<tbody>
<tr>
<td>Challenges</td>
<td>6</td>
<td>7</td>
<td>16/01/2016 17:51</td>
<td>AL</td>
<td>31/01/2016 16:23</td>
<td>AL</td>
</tr>
<tr>
<td>Being with challenges</td>
<td>8</td>
<td>17</td>
<td>16/01/2016 17:53</td>
<td>AL</td>
<td>01/02/2016 12:06</td>
<td>AL</td>
</tr>
<tr>
<td>Ethos of care</td>
<td>5</td>
<td>5</td>
<td>16/01/2016 17:58</td>
<td>AL</td>
<td>12/03/2016 11:57</td>
<td>AL</td>
</tr>
<tr>
<td>Support</td>
<td>2</td>
<td>3</td>
<td>16/01/2016 17:58</td>
<td>AL</td>
<td>31/01/2016 16:20</td>
<td>AL</td>
</tr>
<tr>
<td>Time</td>
<td>2</td>
<td>4</td>
<td>16/01/2016 17:58</td>
<td>AL</td>
<td>31/01/2016 16:23</td>
<td>AL</td>
</tr>
<tr>
<td>Opening doors</td>
<td>10</td>
<td>47</td>
<td>16/01/2016 17:51</td>
<td>AL</td>
<td>01/02/2016 12:40</td>
<td>AL</td>
</tr>
<tr>
<td>Beginnings</td>
<td>7</td>
<td>8</td>
<td>16/01/2016 17:53</td>
<td>AL</td>
<td>01/02/2016 12:04</td>
<td>AL</td>
</tr>
<tr>
<td>Checking</td>
<td>9</td>
<td>18</td>
<td>16/01/2016 17:53</td>
<td>AL</td>
<td>01/02/2016 12:40</td>
<td>AL</td>
</tr>
<tr>
<td>Choosing moments</td>
<td>7</td>
<td>11</td>
<td>16/01/2016 17:53</td>
<td>AL</td>
<td>22/01/2016 18:45</td>
<td>AL</td>
</tr>
<tr>
<td>Being with</td>
<td>6</td>
<td>19</td>
<td>16/01/2016 17:51</td>
<td>AL</td>
<td>31/03/2016 17:11</td>
<td>AL</td>
</tr>
<tr>
<td>Empowerment</td>
<td>3</td>
<td>6</td>
<td>16/01/2016 17:56</td>
<td>AL</td>
<td>20/02/2016 17:11</td>
<td>AL</td>
</tr>
<tr>
<td>Knowing self</td>
<td>4</td>
<td>11</td>
<td>16/01/2016 17:55</td>
<td>AL</td>
<td>31/01/2016 16:45</td>
<td>AL</td>
</tr>
</tbody>
</table>
Excerpts from data

Reference 1 - 0.31% Coverage

suppose a lot of times it’s ... it’s a relax, a release of them and us kind of anxiety.

Reference 2 - 0.89% Coverage

P01: Yeah. We have a very good team and some of us have strengths in one area others in another area and so on and so forth and we tend to use each other with the strengths we have you know. And we all kind of understand when things are going on.

Reference 3 - 0.42% Coverage

The MTAs are very task orientated and very driven to have a certain amount of work done in a certain amount of time.

Reference 4 - 0.53% Coverage

P07: And do you know actually, it’s so therapeutic not only for the patient but for the person doing it. And in any case/

Reference 1 - 2.14% Coverage

Come here and I’ll give your hands a little bit of moisturiser, they’d get dry in here, you know that kind of thing. And you’ll sit down with them and you’ll rub the bit of cream on and the talk starts. They start talking about, it could be anything. It could be th Researcher: And would they have been trained in practices like hand massage or would they be/

P04: /They would, in general they would have quite an interest in hand massage and in activities, they would have that. And am...

Reference 2 - 1.02% Coverage

P04: Yes, there is. Yeah, we even have it in our mission statement as you/
their children, it could be themselves, it could be you – they’d be asking you about your life

**P06:** AT the beginning, yeah. At the beginning they would have resisted. Definitely a lot of the older ones’ resist. Some of the younger and newer staff see the benefits.

Reference 3 - 1.03% Coverage

**Researcher:** So how does the mission statement marry with what/

**P06:** /See they are so short staffed that’s the problem
Appendix 10: Reflexivity

The researcher in the field of qualitative work is urged to open to the difficulties of the task of understanding other people's perceptions (Burnard 1991). Speziale et al. (2011) implies that research encourages an in depth attention to the care of human beings and grounds its practice in awareness the holistic belief that nurses care for mind, body and spirit. This holistic way also implies the artful use of self and strives toward achieving a sense of balance within oneself and the world, often achieved through reflective practice (McEvoy and Duffy 2008). A researcher doing field work exploring nurses’ experience through this method embodies this holistic ethos. Price (2002) suggests that research nurses using interview methods draws on their existing skills gained through their practice. As a practitioner and novice researcher I am drawn to reflection in action and reflection on action (Schön, 1987) as a model to guide my thoughts. My reflections in action is the instinctive self-inquiry that has always been part of my being. My reflections on action was greatly assisted by my art work.

I was aware of the acknowledged danger for potentially ‘leading the witness’ during the qualitative interviewing, finding only what I set out consciously to look for to confirm my thesis. I was conscious that I wanted the natural voices of the participants to come through. Therefore, not only did I have to ensure that the questions developed were not leading, I had to ensure that I actively monitored and was mindful of my own dialogue and interviewing technique. I reflected continually on how my values and perceptions impact upon the research setting and affect the data collection and analysis.

Ethical dilemmas that may rise from data collection (interview) are difficult to predict but I needed to be aware of sensitive issues and potential conflicts of interest. One of the opportunities and challenges of qualitative research is for the researcher to be an integral part of the study, researching among co-workers rather than on them (Wolcott, 2002). Wolcott advises descriptive accounts to be personalised by writing in the first person. Because there is teaching workshops involved in the project, there was another layer of complexity in the interview process as the participants will be aware of my obvious positive bias towards the use of this intervention in practice. I managed this by being as transparent as possible and self-disclosing about my thoughts, feelings and assumptions. Reflexivity for me means interpreting my own interpretations (Etherington 2004) and continually asking self “Am I getting this right”. Knowing well, that there is no such thing as ‘right’ just my perception of the word right.
When I was writing up my findings, I continually asked myself about the descriptive choices I was making. The participants described their practice and I was using the categorical method, taking what was relevant. I believe I extracted enough of text to allow the reader to understand the topic under exploration.

I needed to consider the extent to which a reader must take on trust what I have included. Even though I try to control my assumptions, I am a nurse working in this type of setting. My own lens gets foggy sometimes. Comparing the nurse’s role in the designated and generic settings was interesting. I found myself being judgemental and reductionist. I was making big statements about the dominance of one type of knowing over another. I suppose that this subjectivity/objectivity requires constant inner dialogue.

Also, when participants said “Well, you know what I mean,” and I thought I did. On exploration though, it became obvious that often I assumed what they meant as I’m an insider researcher. So, my goal is to visualise myself as an outsider researcher. Being an outsider researcher means that one can take a new look through the lenses of our participants’ eyes, and it may also help to theorise.

I am committed to descriptive research but there is a constant awareness of a psychologically informed approach which concedes the impossibility of ever presenting the ‘pure’ truth of a situation. The participants and I interplay with conscious thought processes. Parallel to this is the unconscious process which may bear little resemblance to the spoken words exchanged between participant and self. There is an unpredictability to subjectivity but I embrace the data we construct together.

Both the workshops and the data collection as approaches seek to generate knowledge that will allow judgements to be made about the impact of hand massage as an intervention. I am also very conscious of the privilege a researcher has to encounter the delivery of something that wishes to be uttered, which is coming forth from the existential space between the researcher and participant (Yoshida, 2002). Yoshida’s work on Martin Buber is illuminating. I like to think, when Buber (1939/1962) was writing about educators being a channel through which the force is working as implied by Gordon (2011), that a researcher can fit into the same category, with constant reflexivity required to avoid clinging to the assumptions with which one entered the study (Thorne et al., 2004).
Participants in the private sector are the leaders of a team of health care assistants. This role appeared to bring forth a different set of experiences as regards the use of hand massage intervention. These participants voiced empowered work practices. I felt there was more possibility for the use of hand massage as a tool to soothe an individual in distress.

Then again am I blinded to the ‘elephant in the room’? Maybe that is because I work in the public sector and am unconscious in this setting? Then again am I really blinded? My darkest thoughts come forth at times. I asked nurses to view their practice of hand massage through a lens of illusion. From some of their faces I read a tension of me creating yet another expectation of practice. Reality bites!!!

My reflexivity through art and poetry is represented below. There is a messy back and forth process of inner turmoil, escapism, darkness and light intertwined with a committed self-witness to my thought processes. I construct and reconstruct a personal version of the critical creativity framework in an embodied way then ‘ME’ comes to the foreground.

<table>
<thead>
<tr>
<th>Possibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reconstructing me,</td>
</tr>
<tr>
<td>to be free,</td>
</tr>
<tr>
<td>to be,</td>
</tr>
<tr>
<td>to see,</td>
</tr>
<tr>
<td>the ordinary.</td>
</tr>
<tr>
<td>Falling</td>
</tr>
<tr>
<td>---------</td>
</tr>
<tr>
<td>My Journey to ME</td>
</tr>
<tr>
<td>The more writing...less touching</td>
</tr>
<tr>
<td>Time to face reality</td>
</tr>
</tbody>
</table>
Calmer waters
Sailing into calm
Sense of repeating mistakes
No resolve …but calm
Appendix 11: Ethics Approval

16th October, 2014.

Ms. Margaret Graham,
Lecturer,
"nursing and Health Science,
University of Limerick,
Castleirny,
Limerick

Re: Protocol Title
Exploring nurses’ experience of using hand massage to alleviate anxiety for individuals with dementia in residential settings.

Dear Ms. Graham,

I am in receipt of your study as above submitted for review by our Research Ethics Committee. I have reviewed the contents of same.

I wish to advise that I have given your study Chairperson ethical approval.

You should note that your study cannot commence until you also receive AON approval which will issue from the Quality and Patient Safety Department shortly. You are obliged to inform us as soon as your study is completed or if it terminates early for any reason.

I wish you every success with your study.

Yours sincerely,

Pat Dillon,
Consultant Anaesthetist,
Chairperson, Research Ethics Committee.