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Dementia-Friendly Hospital—The Perspective of Professional Dementia Experts

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Received: 28 March 2024 | **Revised:** 5 August 2024 | **Accepted:** 15 August 2024

Funding: This work was supported by the internal grant program (project IFF 2020-30) of the Faculty of Health at Witten/Herdecke University, Germany and the DZNE/Witten.

Keywords: acute care | cognitive impairment | healthcare professionals | qualitative research

ABSTRACT

Aim: To investigate the professional dementia experts' understanding of a dementia-friendly hospital to identify its characteristics.

Design: We used a qualitative design embedded in a case study. A total of 16 semi-structured expert interviews were conducted with 17 professional dementia experts. Using inductive content analysis, the interviews were analysed in a participatory manner involving a group of researchers and dementia experts.

Results: We identified six characteristics of dementia-friendly hospitals: *Proud to be dementia-friendly—That's what we want; Seeing the human being—Taking care of everyone; Having everyone on board—It's a collective task; Being professional—It takes more than being nice and kind; Rethinking the 'running' system—We have to change, not them;* and *Being part of the community—Thinking beyond the hospital.*

Conclusion: The concept of a dementia-friendly hospital seems complex and requires a rethinking of the traditional hospital. For a conceptualisation, the involvement of people with dementia and their relatives is important to gain a comprehensive understanding.

Implications for the Profession and Patient Care: A dementia-friendly hospital is characterised by professional care that comprises a safe, familiar and supportive environment, is prepared but also flexible, has everyone on board, and sees the human being. To become dementia-friendly, individual interventions such as training courses can be a starting point. However, an overall concept is required that also includes components that contribute to successful implementation and a welcoming culture of people with dementia.

Impact: Our findings on the perspective of professional dementia experts contribute to the conceptualisation of dementia-friendly hospitals.

Reporting Method: We reported our study according to the COREQ checklist.

Abbreviations: DEMfriendlyHospital Study, Characteristics of dementia-friendly hospital study; DFH(s), dementia-friendly hospital(s).

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Patient and Public Contribution: The investigation of the perspective of professional dementia experts is one part of a larger study. In this overall DEMfriendlyHospital study, we interviewed professional dementia experts, people with dementia and their relatives and also involved them in a participatory manner in various stages of the research process.

1 | Introduction

Hospitals are often characterised by functional organisational structures that are fragmented into independently controlled departments (Amato et al. 2022; Fiorio, Gorli, and Verzillo 2018) and oriented to acute health conditions (Digby, Lee, and Williams 2017; Parke and Hunter 2014; Scerri, Innes, and Scerri 2020). Additionally, hospitals face increasing workloads, inadequate staffing, budget constraints, reduction in length of patient stay, rapid pace and inflexibility (Carayon and Gurses 2008; Digby, Lee, and Williams 2017; Harvey et al. 2020). Owing to the increasing number of older patients and chronic diseases, this system does not meet the needs of some patients, such as people with dementia (Digby, Lee, and Williams 2017; Fiorio, Gorli, and Verzillo 2018).

In Germany, two in five older patients in hospitals have cognitive impairment, and one in five have dementia (Bickel et al. 2018). The main reasons for hospital admission for people with dementia are infections, cardiovascular diseases, gastrointestinal diseases, falls, injuries, fractures and poisoning (Stiefler et al. 2023). Only a few hospitals have special units for people with dementia, so most of them are treated for their acute disease in departments that do not specialise in dementia (Bickel et al. 2018; Zieschang et al. 2019). This poses various challenges for people with dementia, their relatives and healthcare professionals (Beardon et al. 2018; Reilly and Houghton 2019; Scerri, Innes, and Scerri 2020). Accordingly, hospitalisations are often associated with adverse outcomes, such as functional decline, delirium, longer length of stay or death (Fogg et al. 2018), and lead to negative experiences (Gwernan-Jones et al. 2020; Reilly and Houghton 2019).

A transformation in the hospital care of people with dementia is needed, and dementia-friendly hospitals (DFHs) have been proposed as one solution (BMFSFJ and BMG 2021; Gwernan-Jones et al. 2020; Manietta et al. 2022). According to the World Health Organisation (WHO), dementia-friendly initiatives '[...] will enable people with dementia to participate in the community and maximise their autonomy through improved social participation, and will improve the quality of life for people with dementia, their carers and the broader community' (WHO 2023).

Various dementia-friendly interventions have been developed to improve the hospital care of people with dementia and to create a more DFH, such as educational programmes (Allegri et al. 2021; Galvin et al. 2010; Gehr et al. 2021; Hobday, Gaugler, and Mittelman 2017; Palmer et al. 2014), environmental designs (Brooke and Semlyen 2019; Eastham and Cox 2017; Kirch and Marquardt 2021; Parke et al. 2017), special care units (Zieschang et al. 2019) and communication tools (Parke et al. 2019). Furthermore, there is an understanding of a DFH as an overall concept. In an integrative review, six DFH characteristics were identified: *continuity*, *person-centredness*, *consideration of phenomena within dementia*, *environment*, *valuing relatives*, and *knowledge and expertise* (Manietta et al. 2022). Similar characteristics were identified in a concept analysis by Munsterman et al. (2024) with a broader view of the concept of dementia-friendliness in the context of hospitalisation, considering both interventions and overall concepts. Based on these results, Munsterman et al. (2024) developed the following initial definition for the concept of dementia-friendliness in the context of hospitalisation:

> the delivery of person-centered care by interprofessional clinicians with dementia-specific knowledge in an environment modified to meet the needs of persons living with dementia. Family caregivers are integrated into the hospital experience. Nurses value their own expertise in providing skilled care for the unique needs of this population, supported by administrators and in environments that enable them to do so.
>
> (10)

According to this definition, people with dementia, relatives and healthcare professionals are the main actors in a DFH and are therefore important in the development of a DFH concept, as each of them has a different perspective on the topic due to their perceptions, experiences and expertise. To date, some studies have investigated their perspectives on dementia-friendly environments (Brooke and Semlyen 2019; Eastham and Cox 2017; Kristiansen, Olsen, and Beck 2023), but only a few studies have investigated their perspectives on the overall concept of a DFH (Manietta et al. 2023; Toubol et al. 2020). A workshop with hospital nurses specialising in dementia contextualised the characteristics of a DFH and indicated that research is needed to present the perspective of dementia experts from various healthcare professions and fields working in hospitals (Manietta et al. 2023). Accordingly, this perspective is particularly important, as they have dementia-specific expertise and familiarity with hospital structures and processes and the resulting challenges for the care of people with dementia. Therefore, we investigated the professional dementia experts' understanding of a DFH to identify its characteristics as one part of our DEMfriendlyHospital study (2020–2024). This part of our study was guided by the following research question:

What are the characteristics of a DFH based on the professional dementia experts' understanding of DFHs?

2 | Methods

2.1 | Design

A qualitative case study with a multiple case holistic design (Creswell 2013; Yin 2018) was chosen for the overall DEMfriendlyHospital study (2020–2024). A case study is an

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Summary

- A dementia-friendly hospital is characterised by the professional care of people with dementia that considers dementia alongside the acute condition by providing a safe, familiar and supportive environment, is prepared but also flexible and has everyone on board, including people with dementia, their relatives and the entire multi-perspective healthcare team.
- For professional dementia experts, one important dementia-friendly hospital characteristic is that the human being is seen. This applies to people with dementia and their relatives as well as to healthcare professionals, and requires a person-centred approach that also takes their well-being into account.
- A dementia-friendly hospital requires an overall concept that includes components that contribute to successful implementation, such as available resources, learning opportunities and leadership commitment, as well as a welcoming culture for people with dementia in addition to components of professional care.

in-depth, multifaceted empirical enquiry of a complex phenomenon in its real-life context (Creswell 2013; Yin 2018). We conducted a qualitative case study to gain an in-depth understanding by examining multiple perspectives (professional dementia experts, people with dementia and their relatives). We defined the cases through the multiple perspectives bounded by the experience of hospitalisation of people with dementia. First, within-case analyses are conducted for each case, that is, each perspective is analysed as an independent study (Creswell 2013; Yin 2018). At the end of the study, we will conduct a cross-case analysis to examine the similarities and differences between the perspectives (Creswell 2013; Yin 2018) and synthesise these findings into a framework.

In this article, we focus on the perspective of professional dementia experts. To investigate their perspective, we conducted semi-structured expert interviews (Gläser and Laudel 2010) and performed inductive content analysis to obtain a condensed and comprehensive description of professional dementia experts' understanding of a DFH (Elo and Kyngas 2008). We reported our study according to the consolidated criteria for reporting qualitative research checklist (COREQ) (Tong, Sainsbury, and Craig 2007) (Appendix S1) to ensure transparency, rigour and comprehensiveness.

2.2 | Sample and Setting

We used the purposive sampling technique (Polit and Beck 2021) with the aim of including suitable participants with experience and knowledge in the care of people with dementia in hospitals as well as different characteristics (e.g., professional background and departments). Experts are defined as people who have special knowledge that not everyone has in the field of interest, that is, not all healthcare professionals in hospitals are dementia experts (Gläser and Laudel 2010; Meuser and Nagel 2013). Accordingly, we defined professional dementia experts as healthcare professionals with expertise in caring for people with dementia in hospitals through training and/or practical experience. We included healthcare professionals (e.g., nurses, physicians, therapists and social workers) who had self-reported expertise in the care of people with dementia through training or practical experience and who (a) worked in the direct hospital care of people with dementia or (b) were involved in the development of the hospital care of people with dementia in their function, such as quality management or nursing development.

To reach our target group, we contacted two networks dealing with the topic of people with dementia in hospitals in Germany. These networks are composed mainly of healthcare professionals who improve the care of people with dementia in hospital as part of best practice projects and/or who work as dementia experts in hospital. The study was presented in both networks, and a recruitment flyer was distributed via their mailing lists. Additionally, the flyer was sent out via the mailing list of the faculty of health of Witten/Herdecke University and distributed to other universities with faculties of health, dementia networks and experts using the snowball technique (Polit and Beck 2021). We recruited participants from November 2021 to April 2022. At the end of the analysis, two additional participants with certain characteristics (professional background) were additionally recruited (May/June 2023) to increase the heterogeneity of the sample and to ensure that data saturation had been reached.

Nineteen interested experts contacted the researcher (CM), two of whom decided not to participate due to time constraints.

2.3 | Data Collection

We conducted semi-structured expert interviews (Gläser and Laudel 2010). The interview guide was developed according to Helfferich (2016). First, two researchers (CM and DP) independently collected interview questions by generating ideas and based on the previous literature review (Manietta et al. 2022). After merging the questions and deleting duplicates, these were checked and reduced in two sessions by the researchers for their suitability for the research question, openness and comprehensibility. Subsequently, the questions were sorted in terms of content and subsumed (main questions and follow-up questions).

The draft of the interview guide was discussed and modified in the research team (CM, DP, CK and MR) and by a qualitative methodologist. We decided that specific topics (e.g., environment, daily structure and relatives) would be addressed only if the interviewee brought them up, to keep the interview as open as possible and avoid directing it towards specific topics. For this reason, we included a checklist of keywords in the interview guide to document the topics addressed by the interviewee and to be able to ask specific follow-up questions. The interview guide was pre-tested with one participant regarding the understandability and relevance of the questions, after which few modifications were made because of repetition of answers and question-comprehensibility (Appendix S2). The pre-test was included in the data analysis.

The interviews were conducted by one researcher (CM). Two of the participants who responded to the recruitment already knew the researcher through the university network. With the other participants, the researcher had initial contact as part of the appointment

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arrangement and informed consent. The researcher has experience in conducting interviews and a professional background as a hospital nurse (for further personal characteristics see Appendix S3). The participants were informed about the researcher's professional background. The interviews were conducted face-to-face in the hospital, by telephone or by video conference depending on the participants' preference and the COVID-19 restrictions at the time. All interviews were audio recorded, transcribed verbatim by a professional transcription agency and checked by one research assistant against the audio file to ensure transcript accuracy.

Additionally, we sent participants a questionnaire to collect sociodemographic, professional and hospital-specific data. Furthermore, a postscript was written after the interviews to record the interview situation, observations and contextual information.

2.4 | Data Analysis

We used inductive content analysis (Elo and Kyngas 2008) and analysed the interviews in a participatory way involving a group of three researchers (CM, DP and CP) and two professional dementia experts working in the hospital (LF and MF). The researchers had experience in qualitative research, expertise in the research topic and a professional background as hospital nurses. We met for 120 min once a week from February 2022 to July 2023 to analyse the interviews virtually or in person. The analysis was performed using the qualitative software program MAXQDA 2022 (VERBI Software 2021).

The analysis process consisted of open coding, category creation and abstraction, and was performed in an iterative process until the category system was finalised. We started with open coding, discussing ideas and initial headings and freely generating categories. After coding the first interviews, we created categories to reduce the number of freely generated categories. Similar or related categories were discussed and grouped into broader, higher-level categories. Category naming was performed according to the content of the text passage. Subsequently, abstraction was conducted, meaning that categories were merged, resulting in aspects, subcategories and main categories. A coding example is presented in Appendix S4. Between meetings, one researcher (CM) continued the analysis and adjusted the category system based on the group discussions. We assumed that we had reached data saturation when no new categories were identified during the analysis of the last two interviews.

2.5 | Trustworthiness

To ensure the trustworthiness of our results, the analysis was carried out by a heterogeneous participatory team of researchers and professional dementia experts. This enabled a broader and more complex understanding of the research topic and ensured the credibility of the results. Furthermore, this heterogeneous team served to reduce personal bias and ensure reflexivity (Tong, Sainsbury, and Craig 2007). Moreover, the two professional dementia experts contributed to increasing the validity of the data interpretation. Additionally, the category system was discussed in a peer review with three researchers (MRM, CK and MR) from the research team not directly involved in the analysis and with different proximity to the research topic to ensure trustworthiness and comprehensibility (Yadav 2021).

2.6 | Ethics Statement

Ethical approval for our study was granted by the ethical committee of Witten/Herdecke University (application number 209/2019). Written informed consent was obtained from all participants.

3 | Findings

We interviewed 17 professional dementia experts working in 10 different hospitals. The participants had a range of expertise in caring for people with dementia in hospitals based on training and/or practical experience. Most participants had contact to people with dementia several times a week or always. Few participants who (further) developed the concept of caring for people with dementia in hospitals had never, or had seldom had contact to people with dementia. Three participants stated in the interviews that in addition to their professional dementia expertise, they had experience as a relative of a person with dementia. The characteristics of the participants and hospitals are shown in Table 1 and Appendix S5.

In total, we conducted 16 interviews: two face-to-face interviews in the hospital, six interviews via telephone and eight interviews via video conference. Except for one interview that took place with two experts at their request, all interviews were conducted individually. The duration of the interviews ranged from 44 to 104 min, with an average of 72 min.

We identified six characteristics of a DFH: *Proud to be dementia-friendly—That's what we want*; *Seeing the human being—Taking care of everyone*; *Having everyone on board—It's a collective task*; *Being professional—It takes more than being nice and kind*; *Rethinking the 'running' system—We have to change, not them*; and *Being part of the community—Thinking beyond the hospital* (Figure 1). Examples of interview quotes are shown in Table 2.

3.1 | Proud to Be Dementia-Friendly—That's What We Want

A DFH is characterised by the hospital leadership and staff wanting to be dementia-friendly and being proud of it.

3.1.1 | Willingness to Become a DFH

For the experts, it is essential that the hospital as a whole organisation is aware of the disease of 'dementia' and the patient group.

> That one is aware of this in the first place. I once worked in a university hospital and somehow, when I look back now—it was not a topic at all. It never came up in the conversation: 'The patient has dementia'. It was never taken into consideration; it was never looked at whether that was the case. Accordingly, from my point of view, it was not noticed at all that there are so many patients with cognitive impairment.
>
> (Interview 1)

To raise awareness for this patient group, dementia experts suggest making the patient group more visible, for example, highlighting

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TABLE 1 | Characteristics of the experts and hospitals.

Variable	Category	*n* (%)
Expert characteristics ($N = 17$)		
Professional background	Nurse	12 (70.59)
	Physician	3 (17.65)
	Physiotherapist	1 (5.88)
	Social worker	1 (5.88)
Gender	Female	10 (58.82)
	Male	7 (41.18)
Age	≤ 20 years	0 (0)
	20–40 years	6 (35.29)
	41–60 years	10 (58.82)
	≥ 60 years	1 (5.88)
Working hours	Full-time	12 (70.59)
	Part-time	5 (29.41)
Qualification level	Academic degree	10 (58.82)
	Non-academic degree	7 (41.18)
Working experience	< 1 year	0 (0)
	1–5 years	2 (11.76)
	5–15 years	5 (29.41)
	> 15 years	10 (58.82)
Direct patient care	Yes	14 (82.35)
	No	3 (17.65)
Additional dementia training/ qualification	Yes	15 (88.24)
	No	2 (11.76)
Average frequency of contact with people with dementia in a professional context	Never	1 (5.88)
	Seldom (a few times a month)	2 (11.76)
	Occasionally (several times a week)	5 (29.41)
	Often (several times a day)	6 (35.29)
	Always	3 (17.65)
Average frequency of dealing with the topic of people with dementia in hospitals in a professional context	Never	0 (0)
	Seldom (a few times a month)	1 (5.88)
	Occasionally (several times a week)	5 (29.41)
	Often (several times a day)	5 (29.41)
	Always	6 (35.29)
Hospital characteristics ($N = 10$)		
Hospital ownership	Private	1 (10.00)
	Non-profit	4 (40.00)
	Public	5 (50.00)

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TABLE 1 | (Continued)

Variable	Category	*n* (%)
Hospital size	< 200 beds	0 (0)
	200–399 beds	1 (10.00)
	401–399 beds	3 (30.00)
	≥ 600	6 (10.00)

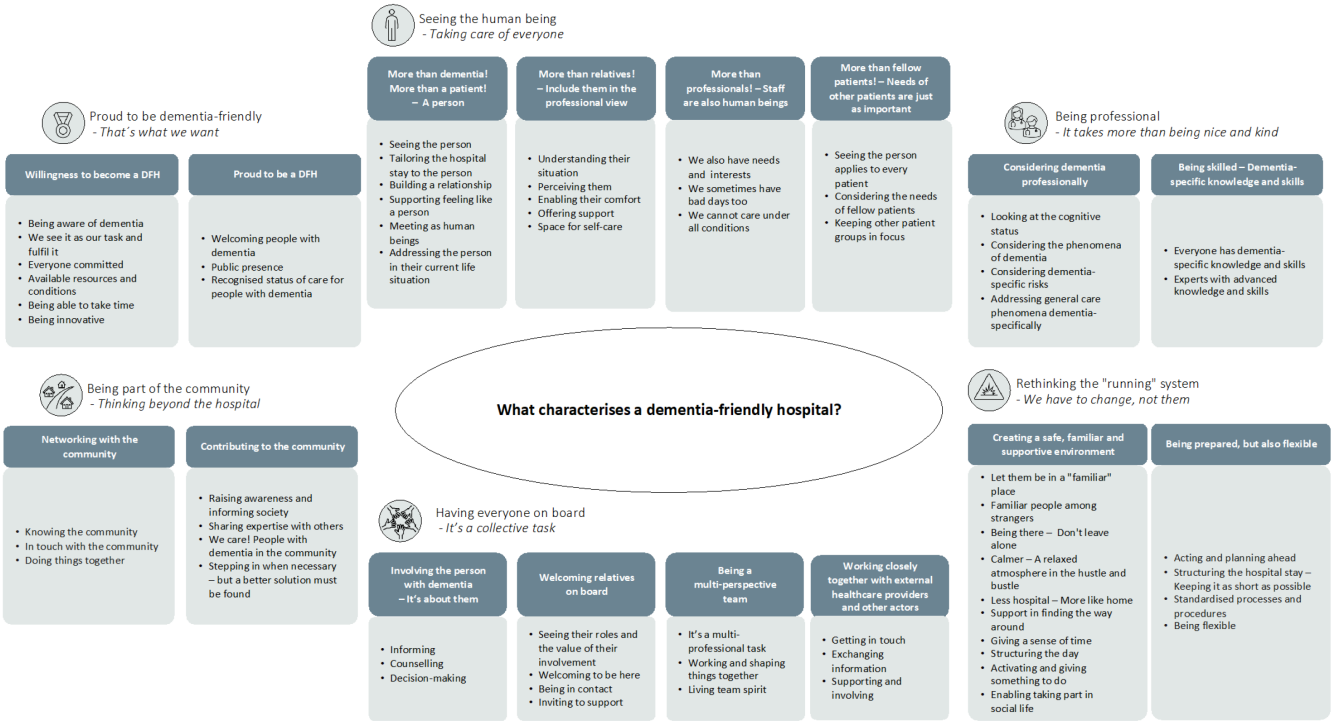

FIGURE 1 | Overview of the DFH characteristics.

dementia in documentation and appointing dementia experts in hospitals. According to the experts, a DFH defines dementia-friendliness as its mission, which it lives and fulfils. This includes fulfilling obligations that result from being a DFH and providing resources and conditions for a DFH, such as learning opportunities (e.g., training and multipliers), aids (e.g., low-low beds, watches and coloured tableware), staff (e.g., sufficient and qualified) and the environment (e.g., common room). From the experts' perspective, time is an essential component of a DFH, that is, the staff are able to and do take time for the care of people with dementia.

Furthermore, the experts emphasised that a DFH needs the commitment of everyone, including the leadership, to stand behind and support it by providing resources and acting as a role model. Becoming a DFH is a constant journey and a task for all healthcare professionals, not just nurses. Physicians' commitment was particularly stressed, as it is difficult to obtain for this purpose. A DFH needs interest and openness from all healthcare professionals regarding the topic, and the willingness to try new things.

3.1.2 | Proud to Be a DFH

People with dementia are welcome as patients in a DFH, and staff have a positive attitude and are not judgemental towards them. Public presence and advertising services for people with dementia, dementia-expertise and specifications (e.g., on the website) are important for the experts. They emphasise the need to value the care of people with dementia and its complexity, which requires skills, time and personnel resources. The experts highlighted that a DFH needs recognised status for the care of people with dementia that is equal to other medical areas and is associated with a positive image. Nursing and psychosocial interventions (e.g., relationship building), which are essential for the care of people with dementia, need to be recognised as professional actions that are as important as medical interventions. The same applies to non-medical outcomes (e.g., quality of life and patient satisfaction).

3.2 | Seeing the Human Being—Taking Care of Everyone

For the experts, it is essential that in a DFH, everyone is seen and treated as a human being and 'everyone's needs [are] on the radar' (Interview 2).

3.2.1 | More Than Dementia! More Than a Patient!—A Person

In a DFH, people with dementia are seen and recognised as individuals and not reduced to their diseases and the patient role. Being a person is described by one expert as follows:

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TABLE 2 | Examples of interview quotes.

Subcategory	Example interview quote
Proud to be dementia-friendly—That's what we want	
Willingness to go become a DFH	Primarily, for me it is the statement: That is what we want. [...] We want to do justice to these people. (Interview 2) [We see it as our task and fulfil it] And this also applies to all professional groups, so that not only nursing takes on this topic, but also all other services, be it physicians, therapists, but also the waste disposal services, for example. (Interview 4) [Everyone committed] And this culture, it's okay, we'll manage and you'll get the time for it from me as a colleague. And not saying, oh, do you really have to spend so much time with the patient today? Can't you somehow calm them down with a glass of water or a game? (Interview 5) [Being able to take time]
Proud to be a DFH	And that's what I meant earlier with this welcoming culture, with this open culture. Every patient with dementia is not a burden but is a patient like any other. (Interview 5) [Welcoming people with dementia] That it is just as important, for example, to have a reputation as a hospital for this topic of dementia. Like saying that we have the latest bone marrow centre and research centre and we bring people from all over the world to us who get a bone marrow transplant here, right? So, you also advertise and try to get the patients into a centre here. (Interview 6) [Public presence] [...] I would like an element on the home page: 'We are dementia-friendly. If you would like more information, click here'. [...] that would be crucial. [...] that would make another strong impact, that's how you have to present yourself. (Interview 16) [Public presence]
Seeing the human being—Taking care of everyone	
More than dementia! More than a patient!—A Person	Hospitals are always somewhat characterised by the diagnoses. You don't say Mrs. XY but the neck of femur in room 12, and I find it so difficult in the case of dementia that the word dementia is always there in a big way in the room and no, we're now getting a patient who has dementia. Oh no. And then everyone is already so negative. They don't see the person behind it at all. So—what the person brings with him in terms of biography and what concerns him—is somehow pushed into the background by the word dementia. (Interview 7) [Seeing the person] Perhaps only the handbag is moved into the field of vision, that on the bed-side table are the personal things, which are—memory anchors, instead of the care utensils, perhaps there are pictures, which also show the nurse: Hey, this is a person with a history and biography lying here, not simply—the hospital gown wearer, the anonymous being. (Interview 2) [Supporting feeling like a person]
More than relatives!—Include them in the professional view	So the family simply has to feel that the healthcare team—perceives the needs that this family has and that they also try to solve them somehow or give them some kind of offer as to how they can cope better. That would be the claim of a dementia-friendly hospital, that the customer, no matter whether the customer is the patient or the relative, because for me it is a—team, this family is a system and this family must feel that we also recognise them as such a system and that we make them an offer together, that we not only treat the patient, but also perceive and serve them as a family. (Interview 8) [Perceiving them] That you have a social worker on the ward who talks to the relatives—psychologists perhaps, maybe not necessarily only for the patients with dementia, [...] but rather to support the relatives. (Interview 14) [Space for self-care]
More than professionals!—Staff are also human beings	I think we need to have everyone's needs on the radar. The needs for effectiveness, for being seen, for dignity, for a sense of accomplishment, for relationships and resonance. As a nurse, I also like it when the person I'm caring for smiles at me. [...] And that actually applies to all people. [...] that—it succeeds that the essential— people there are not only functionaries, but are also seen as human beings [...]. (Interview 2) [We also have needs] These are human beings who care for human beings. (Interview 1) [We also have needs] But none of us are Florence Nightingales, and we also have our problems at home, we have our—personal environment that we can't always leave behind us when we close the door, and that is human, and I don't see that as a problem. We are not superhuman, because we are nursing staff, and we have to be able to accept that a nurse may not have come across as good or as empathetic during the day. (Interview 10) [We sometimes have bad days too]

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TABLE 2 | (Continued)

Subcategory	Example interview quote
More than fellow patients!—Needs of other patients are just as important	For example, we now have a three-bed room, one patient has severe dementia, two are in their mid-40s and—with full mental capacity. Now, however, the patient with dementia has a completely reversed day-night rhythm. He is completely awake at night and is screaming loudly for Lieselotte, because Lieselotte should finally come and pick up the children. Of course, the other patients [...] can't sleep, they can't recover, they don't have any rest, and during the day they might have a programme again, which means that their treatment is not as optimal as it could be. If this patient were adequately cared for, which he then hopefully is in the end, such things would of course optimally no longer occur, and if it occurred, there would be possibilities to address it, [...]. (Interview 13) [Considering the needs of fellow patients]
Having everyone on board—It's a collective task	
Involving the person with dementia—It's about them	We—have to talk with the—people, with the patient, [...] what we can offer him, how long he is there, how it can be designed. (Interview 2) [Informing] No, with us it is like this: the patient is addressed directly, and then we try to respond precisely to the person there, [...], I do not think that it is like that everywhere. I sometimes have patients who say, yes, I was at some consultation or other. And then I say and, what did the colleague say to you? Oh, he didn't actually talk to me at all, they say then, yeah? So I mean, whether you have dementia or not, that's not nice for anyone. (Interview 15) [Informing]
Welcoming relatives on board	And allowing people [relatives] to be there, giving them security. We can try as much as we want to take care of the people, to look after them, but we are not—the daughter and son. [...] And they have to be there. And must be allowed to be there. (Interview 10) [Welcoming to be here] [...] we sometimes call the relatives at 11 p.m., according to the principal, we can't do it alone. And—that we call them in quickly and that they then—have a calming effect on the patients, that also exists in every form. There are cognitively impaired patients who are so fixated on their relatives that, for example, they don't want to eat with us unless their relative is present. Then they are allowed to come outside visiting hours [COVID-19 restriction] so that the patients can eat here. So we are, as far as that is concerned, there—we adjust to each patient. (Interview 9) [Inviting to support]
Being a multi-perspective team	I am a great fan of dialogue, that is, learning something together, acquiring common knowledge by asking questions, and that can actually come about via dementia sensitivity, where many people talk to each other. I learn a lot from social services about what is possible, and they learn a lot from us, so I'd say it's through this kind of attitude. (Interview 11) [Working and creating together]/[Living team spirit] [...] so that care can really be provided on an eye-level basis, and not that there is somehow a physician who stands above it and determines that this is the way to go, and this is how we provide care, i.e. that nursing, physicians, therapists, and discharge or case management are really involved, [...]. (Interview 4) [It's a multi-professional task]/ [Living team spirit]
Working closely together with external healthcare providers and other actors	In principle, it would be nice if everyone were informed. That is, the patient is on board, the relatives—and—it would be nice, of course, also all post-acute providers. If they had a comprehensive picture. When it comes to nursing home admission, I think it would be really nice if staff from the nursing homes came to us and took a look at the patients on site [hospital]. I always find that totally charming. Then—you get to know each other, so that, a greater exchange between—all disciplines—would be there. (Interview 9) [Exchanging information]/[Supporting and involving]
Being professional—It takes more than being nice and kind	
Considering dementia professionally	And when we identify a patient, then a structure also has to be there, a process that ensures that the patient is also accompanied through this hospital stay. (Interview 5) [Looking at the cognitive status] [...] looking at the patient who is agitated, where the dementia is known, to find out what could be the cause. [...] if you start looking and don't find anything and can't eliminate the cause, to work with other possible solutions, such as involving relatives. (Interview 12) [Considering the phenomena of dementia]

(Continues)

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TABLE 2 | (Continued)

Subcategory	Example interview quote
Being skilled—Dementia-specific knowledge and skills	The whole staff must know about this [dementia]. And I'm really not talking about nursing staff or just the direct healthcare staff. Everyone should know about it, because often enough it can happen that we find a patient somewhere on a ward who seems clearly disoriented, [...]. It is absolutely important to be able to respond to these people in an appropriate manner, regardless of which professional group you belong to. [...] from admission to discharge, [...] everyone should know what they are doing, and this should now be mandatory training for each person who works in a hospital. As the saying goes, the chain is only as strong as its weakest link. (Interview 13) [Everyone has dementia-specific knowledge and skills] [...] that you also have staff, be it in nursing or in the medical field, also as experts, so to speak, who really only deal with this, disease [dementia], [...]. (Interview 4) [Experts with advance knowledge and skills]
Rethinking the 'running' system—We have to change, not them	
Creating a safe, familiar and supportive environment	[...] because every change, or every change of location, even within a hospital, is—sometimes scary, confusing, that should be kept to a minimum. (Interview 9) [Let them be in a 'familiar' place] [...] then I would accompany him from that moment on through everyday hospital life. And here it's about providing a bit of structure, giving security, (.) being there as a fixed contact person. (Interview 3) [Familiar people among strangers] In that sense, I think the daily structure is very important. I don't want to say that a sense of community is the right expression, but it's like in a family, getting up in the morning, sitting down at the table, eating meals together, so that you also offer normality with a daily structure that you can hold on to. (Interview 9) [Structuring the day] In this quiet period, you could establish a dementia café [...] where relatives are present and a lot of volunteers and voluntary services, for example. And that is nothing but a café, nothing else. It's a café where you can spend time, eat, have coffee, be occupied, have conversation and as a person with cognitive impairments, can spend time much more pleasantly than on the ward. (Interview 12) [Enabling taking part in social life]
Being flexible, but also prepared	The patient is not called until it is sure that he is expected downstairs, then diagnostics are carried out and in half an hour he is back in his room. (Interview 11) [Structuring the hospital stay—Keeping it as short as possible] Or that you don't simply say: 'Everyone has to be washed, dressed and given breakfast by ten o'clock in our hospital'. Instead, you have more chance to adapt to the individual. (Interview 3) [Being flexible]
Being part of the community—Thinking beyond the hospital	
Networking with the community	And, what is also once again very important and what we now also just notice, is that one must be much more open as a hospital for outpatient care, [...] that one is just open for what regions also offer so that one networks much, much more, because that is always such a thing, which until now, here everyone has just done his own thing and has not looked to the right and left. And that's what I understand by dementia-friendly. (Interview 4) [Knowing the community]/[Doing things together]
Contributing to the community	It's just that, this social care that we have, is often like, what do I know, an older couple at home, he takes care of his wife with dementia at home, he now has a heart attack, he has to go to the hospital and the wife cannot stay alone at home. Then they are both admitted as inpatients. Although that's not the point and that's not supposed to be, that he comes into hospital because he has his heart attack and she's supposed to come in to an—emergency care system. (Interview 1) [Stepping in when necessary—but a better solution must be found] It's all well and good if we can reach people through the fact that patients have been here or that people have come here voluntarily to find out about it. That's great, of course. [...] I would find it difficult to call yourself dementia-friendly if you say, yes, we treat the patients, but if anyone wants to know about it, no, we don't say. (Interview 13) [Sharing expertise with others]

> To be a person means for me—to have personal interests, to have preferences, to have a biography—to have things that interest me now, that are important to me, to have hopes and fears. All of which have nothing to do with the case but are essential to what it means to be human.
>
> (Interview 2)

From the experts' point of view, it is necessary to be interested in the person as a human being, to get a feeling for them and get to know them, for example, their physical and psychosocial needs, feelings, competencies, skills, life story and preferences. This requires more information than the usual medical facts; it also requires personal information, pictures of them in everyday life situations and experiencing the person.

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According to the experts, in a DFH, the person is addressed in different ways, for example, by tailoring the hospital stay (e.g., daily structure, activities, therapy and visiting times), building a relationship or supporting them in feeling like a person. The experts gave examples of how the person can be supported in feeling like a person by personalising the environment with their own things (e.g., photographs and handbag), dressing in normal clothes, creating special moments (e.g., celebrating a birthday with a birthday song) and talking to the person rather than not about them. This makes it possible to support the person with dementia in being a person by strengthening their identity and helping the staff to see them as a person. Furthermore, the experts stated that it is essential to meet the person with dementia as a human being without prejudice and with kindness, respect and esteem and to consciously be in the moment and responsive to their feelings, concerns, current condition and life situation.

3.2.2 | More Than Relatives!—Include Them in the Professional View

The experts described that the relatives of people with dementia are themselves often affected by fears and worries in the acute hospital situation as well as by home care and the resulting burden. They often reach their limits and use the hospital stay to gain new strength or to do other things and cannot always be there. From the experts' point of view, it is important to understand their situation and include them in the professional view. This means perceiving and addressing their needs, preferences, fears, worries, excessive demands and burden in a professional way.

Accordingly, the experts see the support of relatives as a task of a DFH and outline various ideas, such as making relatives' stay comfortable by providing places to stay (e.g., lounges, armchairs and beds), scheduling of counselling and services oriented towards the relatives' possibilities of participation (e.g., flexible timing, in the afternoon and during hospital stay), or offering opportunities to spend valuable time with the person with dementia. As an example of an opportunity to spend valuable time together, one expert suggested providing highlights in the hospital, such as pictures of the city from the past on the ground floor and pictures of famous people from the past on another floor, which can be explored together on a walk with a route map. Other ideas include providing support through a contact point, actively offering support services, informing, educating and empowering relatives (e.g., home care, dementia and self-care) and finding tailored solutions. A DFH can also create space for self-care by letting relatives decide how much they could or would like to be involved, providing retreat options, giving space for talking and listening with professionals and creating space for exchange with other relatives.

3.2.3 | More Than Professionals!—Staff Are Also Human Beings

The experts emphasised that in a DFH, the staff must also be seen and treated as human beings and not merely as 'functionaries'. The experts highlighted that staff also have needs, such as '[...] needs for effectiveness, being seen, dignity, successes, relationships and resonance' (Interview 2) which need to be considered. Staff are sometimes overwhelmed, burdened, or in a bad mood. They sometimes have problems in their own private life and are under stress due to the care situation or current hospital conditions: 'We must also see this side. We cannot only say that nurses should offer and do everything, but we must also look at their limitations as human beings' (Interview 2).

3.2.4 | More Than Fellow Patients!—Needs of Other Patients Are Just as Important

From the experts' perspective, the hospital in general must become more 'human' for all patients and place the person and their individual needs, rather than economic efficiency, at the focus of hospital care. A DFH must also consider the needs of other patient groups (e.g., other chronic diseases) and fellow patients since sharing a room with a person with dementia can be a burden in the case of an acute health issue.

3.3 | Having Everyone on Board—It's a Collective Task

In a DFH, everyone must be on board to shape the hospital stay of people with dementia.

3.3.1 | Involving the Person with Dementia—It's About Them

The experts stressed the importance of involving people with dementia by informing them about what is happening, the hospital treatment and procedures, and involving them in counselling and decision-making. One expert provided the following example of involvement:

> [...] always have an appreciative approach when dealing with patients also not to bypass them. So, as long as they can answer, if it is somehow possible, I also always ask my patients what they would like, what they want. If I have the feeling that they don't understand the extent of my question or they don't understand when it comes to therapies, I have to get the relatives on board, so that one addresses the patient at every level, so to speak, and—yes, then develops a joint concept in the team and, as I said, doesn't patronise the patient, but involves them in everything at all costs.
>
> (Interview 9)

3.3.2 | Welcoming Relatives on Board

The experts described the different roles of the relatives of people with dementia and the added value of their involvement. Relatives are anchors, experts and advocates for people with dementia and can support them and their care during hospitalisation, thereby also supporting the staff. Furthermore, they often play an important role in post-acute care and are also affected by the acute situation. From the experts' perspective, it is necessary to get relatives on board and support them in their roles.

To get relatives on board, it is essential that they are allowed to be with the person with dementia and welcome in the hospital. Flexible visiting hours oriented to the patient's and relatives' needs, technology-assisted visits, being welcome during care and rooming-in were mentioned. Moreover, health professionals' contact with relatives, actively developed by the professionals, was mentioned as important. This includes actively informing relatives and keeping them up to date (e.g., information sheets, information during admission and

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telephone calls after operations), asking them for information and valuing this information. Additionally, relatives should be invited to actively support and be involved in the care and decision-making processes.

3.3.3 | Being a Multi-Perspective Team

According to the experts, all hospital staff and volunteers play an important role in the care of people with dementia and must be brought 'on board'.

> I need them all. [...] All of them. [...] From the kitchen staff, who have to prepare very well, [...], I need the management, which stands behind it, I need the physicians, who recognise that it's about a person in a special situation and not about a broken bone. [...], the social workers, who look at an early stage, what the social environment of this person is like, [...], then the whole crowd of therapists, which I lump together with the nurses [...]. The receptionist, who has to watch out that nobody runs away. Then the gardener, who perhaps puts up a raised flowerbed outside, [...].
>
> (Interview 2)

The experts described the care of people with dementia as a multi-professional task, for which various healthcare professionals and non-professionals (e.g., nursing assistants) with different expertise and qualifications are needed. They emphasised the importance of close co-operation and joint care arrangements. They mentioned sharing information, being in contact, looking together at the patient and their care, reflecting together and seeking expert support as essential aspects. One example of this type of close co-operation was mentioned as regular multi-professional case conferences in which individual patients and their care are discussed and critical events are jointly reflected upon. The basis of this co-operation is a team spirit characterised by 'everyone pulling together', working as equals, having open and respectful communication, working towards a common goal, and helping and learning from each other.

3.3.4 | Working Closely Together With External Healthcare Providers and Other Actors

Close and well-functioning co-operation with pre- and post-acute healthcare providers and other actors (e.g., district courts) is necessary for a DFH from the experts' perspective. This includes contacting these externals and exchanging information in writing, by telephone or in person. Moreover, they described the involvement of and support from them in different ways, for example, close consultation, hospital visits, involvement in decision-making and discharge processes, taking over examinations, fast processing of enquiries, and provision of feedback. One expert described the following example:

> [...] getting the general practitioners on board according to the motto, the relatives wanted to try it again at home. We see the challenges. We know about it, the relatives know about it too, but still want to try it so that the general practitioners then also have a bit of an eye on it and can intervene and provide support at an early stage.
>
> (Interview 9)

3.4 | Being Professional—It Takes More Than Being Nice and Kind

From the experts' perspective, it is essential for a DFH to provide professional care for people with dementia. In addition to professional care of the acute health condition, dementia is considered professionally, which requires dementia-specific knowledge and skills.

3.4.1 | Considering Dementia Professionally

According to the experts, it is necessary to look at the cognitive status of older patients in hospitals to identify cognitive impairments and/or dementia as early as possible, even if this is not the reason for admission. In this context, information provided by pre-acute healthcare professionals or relatives, screenings, and patient records are seen as important by the experts. In the case of probable dementia without a diagnosis, most experts do not consider comprehensive dementia diagnostics (e.g., lumbar puncture) to be useful or the task of a DFH during hospitalisation for another health condition. Rather, they see the role of a DFH as initiating diagnostics and making recommendations for post-acute healthcare providers. However, they consider the differentiation of dementia from other diseases (e.g., delirium, depression and visual/hearing impairment) necessary to exclude or treat them. From the experts' perspective, identification and information are the starting point to be able to consider dementia professionally.

The experts mentioned different phenomena of dementia (e.g., memory, orientation, anxiety, agitation), dementia-specific risks (e.g., related to medication, delirium and getting lost) and general care phenomena that need to be addressed in a dementia-specific way (e.g., nutrition) or have greater relevance or risks for people with dementia (e.g., mobility). According to the experts, these phenomena must be professionally considered in a DFH through the staff's actions (e.g., screening, prevention and psychosocial interventions) as well as the hospital's structures (e.g., clinical pathways and assessments), procedures (e.g., operations without long waiting times to reduce fasting times), services (e.g., night café) and environment (e.g., space for movement and lights that are off/dimmable at night), and thus linked to the characteristic of *Rethinking the 'running' system—We have to change, not them*.

3.4.2 | Being Skilled—Dementia-Specific Knowledge and Skills

Dementia-specific knowledge and skills of the staff are viewed by the experts as an important component of a DFH. They described the need for basic knowledge for all staff, including service staff, receptionists, volunteers and interns, and enhanced knowledge and skills for the healthcare staff involved in care. Required knowledge and skills range from basics about dementia (e.g., symptoms) to specific interventions (e.g., validation). Additionally, human skills and attributes, for example, patience, serenity, self-reflection and empathy, are considered important by the experts. One expert answered the question 'What do you associate with a dementia-friendly hospital'?:

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> A lot. —First and foremost, what comes to my mind is that above all the hospital staff, by which I don't just mean nurses, but doctors, medical assistants, service staff, everybody there, is really properly trained regarding this disease, how it presents itself and how to deal with this disease in an appropriate way.
>
> (Interview 13)

The experts outlined the need for staff with advanced dementia expertise who are integrated into ward teams or work all over the hospital. This role can be performed by geriatricians, geriatric nurses, or other healthcare professionals (e.g., therapists, social workers and pharmacologists) with extensive training in dementia. The experts mentioned different tasks and roles for these staff in the care of people with dementia depending on their professional background (e.g., identification/diagnosis, dementia-specific intervention and supporting/advising staff) and in the implementation of a DFH (e.g., conducting training, acting as role models and developing concepts).

3.5 | Rethinking the 'Running' System—We Have to Change, Not Them

According to the experts, a DFH is characterised by changing and rethinking existing hospital structures, procedures, environments, services and care to support people with dementia and make their hospital stay successful. A detailed description of the subcategories with examples of practical utilisation is shown in Table 3.

3.5.1 | Creating a Safe, Familiar and Supportive Environment

For the experts, a DFH includes a safe, familiar and supportive environment for people with dementia that is less institutional and more connected to everyday life. From their perspective, it is important to let people with dementia be in a 'familiar' place surrounded by familiar people among strangers. Creating a calmer, relaxed atmosphere in the hustle and bustle of the hospital, with a less hospital-like and more home-like environment, with support to find their way around and give them a sense of time, is also essential for the experts. Additionally, they consider a fixed, repetitive daily structure that focuses on the person's preferences and routines and that puts hospital routines in the background to be important. In this context, the experts indicated that it is necessary to help people with dementia be active and to offer them opportunities to spend time with other people, to talk and have company.

3.5.2 | Being Prepared, but Also Flexible

From the experts' perspective, it is essential for a DFH to be prepared and to plan and act ahead of time according to the principle: 'prevent this whole issue instead of running after it to solve problems' (Interview 1). Structuring the hospital stay and procedures (e.g., monitoring of schedule and waiting times) as well as standardised processes for people with dementia were considered as important. However, hospital care for people with dementia must also be flexible and not provided 'in pre-set formular' (Interview 3). The experts emphasised that standard processes and routines (e.g., routine blood tests, step training after hip fracture and ward routines) must be adapted flexibly in relation to the person's needs, wishes, circumstances and treatment goals.

3.6 | Being Part of the Community—Thinking Beyond the Hospital

A DFH is characterised by being part of the community, that is, networking with and contributing to the community. The community may be the region, healthcare providers, hospitals or citizens that are connected by a topic (e.g., care of people with dementia, DFH).

3.6.1 | Networking With the Community

According to the experts, networking regarding the care of people with dementia is an important aspect. The experts stated that it is important to know the community, for example, regional pre- and post-acute healthcare providers and services. Furthermore, it is important to be in touch with the community through network meetings with regional healthcare providers, regional dementia networks or other hospitals that deal with the further development of dementia care in hospitals, and to do things together with the community. The experts' ideas included the joint further development of care for people with dementia in the community, the organisation of joint events and the development of joint services for people with dementia.

> And, what is also very important [...] is that as a hospital you have to be much more open to what is happening in outpatient care [...] that you are open to what districts offer, that you network much more because that is always a thing, up to now everyone has just done their own thing here and you hasn't looked to the right and left. And that's what I mean by dementia-friendly.
>
> (Interview 4)

From the experts' point of view, by joining forces and changing care together, it is possible to learn from each other, draw attention to the topic and exert more impact on politicians and funding organisations.

3.6.2 | Contributing to the Community

Some experts indicated that part of a DFH's role is to provide a social contribution to the community. They suggested contributions to educate and raise awareness among the community about dementia and avoiding hospitalisation. To this end, the experts recommended information events or media contributions, for example. Other contributions described were sharing expertise with other hospitals and supporting the care of people with dementia in the community. The experts described services offered by the hospital after discharge (e.g., visits, counselling, training and treatment) and hospital services for people with dementia and/or their relatives living in the region (e.g., exercise programmes, contact points and self-help groups).

Moreover, from the experts' perspective, a DFH steps in when there is no other option. A DFH admits people with dementia if the acute health condition cannot be treated on an outpatient basis due to a lack of structures or if the care situation at home is not guaranteed and prolongs the

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TABLE 3 | Detailed description of the characteristic *rethinking the 'running' system.*

Aspect	Description
Creating a safe, familiar and supportive environment	
Let them be in a 'familiar' place	• Transfers within the hospital are avoided or reduced to a minimum. • Diagnostics and therapies are performed in the patient's room or ward (e.g., electrocardiogram and physiotherapy).
Familiar people among strangers	• Reduction in the number and fixed assignment of healthcare professionals involved in care and other hospital staff. • Reference person who regularly visits and accompanies the person with dementia during the hospital stay from admission to discharge.
Being there—Don't leave alone	• People with dementia are accompanied by a person, at best a reference person, who can take time, for example, dementia experts and volunteers; they are accompanied during their hospital stay in general, during admission, examinations, and operations or in case of excessive demands, fear, uncertainty, agitation or an exceptional situation.
Calmer—A relaxed atmosphere in the hustle and bustle	• Staff slow down during contact with people with dementia, avoid being hectic, are calm and patient. • An undisturbed, calm, relaxed hospital environment is created, for example, by having small wards, two-bed rooms, places of retreat and reduced noise (e.g., no alarms, closing doors and radio/TV), no shadow-formation, lights that are off/dimmable at night and bright during the day, an undisturbed sleeping environment, relaxation measures (e.g., soothing music and pictures/patterns). • Hospital procedures are arranged in such a way that they do not overwhelm, that is, avoidance of many examinations in 1 day, scheduling rest breaks.
Less hospital—More like home	• A less functional and more homelike, familiar and cosy environment. • Examples: having one's own objects (e.g., bedding and pictures), colours (e.g., walls and bedding), enough light, daylight, pictures, large windows with a view, small pillows, smaller units, patient rooms with toilet/bath, pleasant smells (e.g., waffles) and comfortable chairs.
Support in finding the way around	• Support in finding their way around the patient room, the ward and the hospital. • Examples: Signs, pictograms, colour coding, information boards for contact persons, colour contrasts (e.g., for cups, light switch, floors and walls), path lighting or short distances (e.g., toilet in room and examination rooms close together).
Giving a sense of time	• Giving a sense of time—time of day/night, date and time of year. • Examples: Large clocks with date display, lighting adapted to the daytime, time-oriented conversations or activities and daily structure.
Structuring the day	• Fixed, repetitive daily structure designed with the help of activities, social participation, environment (e.g., light). • Daily hospital routine moves into the background (e.g., examinations in the morning, activities in the afternoon, rest times and out of bed). • Day structure considering individuals' daily structure and preferences.
Activating and giving something to do	• Activation via activities (e.g., playing games, singing/music, walking, reading aloud, gardening and memory training). • Activation via activity items (e.g., newspaper, (crossword) puzzles, geriatric tablet and nest blankets/rings). • Activation via the environment, for example, beds, flowers, animal enclosures, art, experience stations, or smells (e.g., waffles). • Distinction from the 'normal' hospital routine takes place, and a bit of normalcy in the hospital is made possible.
Enabling taking part in social life	• Opportunities are created to spend time, interact, talk and have company with other people (e.g., other patients, relatives, healthcare professionals and volunteers). • The focus is on social interaction in the form of opportunities (e.g., dementia café, group activities and common meals), places on the ward/hospital to get together (e.g., common rooms and sitting areas) and people to engage in activities and provide company (e.g., volunteers).

(Continues)

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TABLE 3 | (Continued)

Aspect	Description
Being prepared, but also flexible	
Acting and planning ahead	• Hospital care for people with dementia is planned ahead, early and preventive measure initiated. • Examples: getting everyone on board early, early information, preparations for admission (e.g., room planning and staff scheduling), initiating dementia-specific interventions early, delirium prevention and early discharge planning.
Structuring the hospital stay—Keeping it as short as possible	• Hospital stay is well-structured according to the principal of 'keeping it as short as possible'. • Examples: timely examinations, monitoring if the treatment procedures are on track/delays, not too many examinations in a row, short/no waiting times for examinations, surgeries and emergency room.
Standardised processes and procedures	• Standardised processes and procedures, for example, in form of clinical pathways for people with dementia depending on their acute health condition. • Standardised processes and procedures/clinical pathways include dementia-specific interventions, automatic involvement of diverse healthcare professionals, schedule.
Being flexible	• Hospital care for people with dementia is flexible and not provided in a 'pre-set formular'. • Standard measures and routines (e.g., laboratory on the third postoperative day, step climbing training, daily ward routine, routinely venous cannula or urinary catheter) are weighed up in relation to the patient's needs and wishes, risks, ethical components, and treatment goals and are adapted flexibly.

hospital stay if post-hospital care is not ensured. However, they emphasise that this is not a solution and that other structures in the community are needed to avoid the hospitalisation of people with dementia and to keep the hospital stay as short as possible.

4 | Discussion

We investigated the professional dementia experts' understanding of a DFH and contributed to its conceptualisation. Our results show similarities to our integrative review results (Manietta et al. 2022) and to the definition of the concept of dementia-friendliness in the context of hospitalisation by Munsterman et al. (2024). Moreover, our results provide a new overall picture of a DFH and highlight new aspects. For the experts, a DFH is characterised by professional care that includes the consideration of dementia together with the acute health condition. Professional care comprises a safe, familiar and supportive environment for people with dementia, is prepared but also flexible, has everyone on board, and sees the human being. Moreover, in addition to skills and expertise, our results highlight that professional care for people with dementia requires a rethinking of the hospital system, including the care focus, intended outcomes, structures, processes, environments, services and sector boundaries. The disease-oriented focus, fragmentation of care and traditional hospital system have been repeatedly described as fundamental issues for the adequate hospital care of people with dementia for years (Digby, Lee, and Williams 2017; Pinkert et al. 2018; Scerri, Innes, and Scerri 2020). However, according to a systematic review by Karrer et al. (2021), most intervention studies examine individual interventions to improve the care of people with dementia in hospitals, for example, educational interventions for healthcare professionals. There is a lack of evidence of multi-component interventions that address the broader contextual conditions and challenges of care of people with dementia in hospitals (Karrer et al. 2021). Moreover, there is a lack of research about the implementation of comprehensive concepts for people with dementia in hospitals (Lourida et al. 2017; Petry, Ernst, and Naef 2023; Rommerskirch-Manietta et al. 2023) and the implementation of interventions at the meso and macro levels (Janerka, Leslie, and Gill 2023; Lourida et al. 2017). Furthermore, patient-related outcomes in intervention studies focus mostly on medical conditions (e.g., mortality or cognitive function) or economic-related outcomes (e.g., length of hospital stay) (Karrer et al. 2021; Rosvik and Rokstad 2020). In the future, it will be necessary to develop meaningful outcomes from the perspective of people with dementia for research and hospital care. A study by Oksnebjerg et al. (2018) examining the views of people with dementia on meaningful outcomes of psychosocial interventions in other settings revealed controversial views on cognitive and functional ability as an outcome and positive views towards outcomes such as mental health. Studies have shown that people with dementia in hospitals experience anxiety, uncertainty, discomfort, a lack of self-determination and social exclusion (Digby, Lee, and Williams 2018; Jensen et al. 2020; Reilly and Houghton 2019), indicating that well-being in particular may be a meaningful outcome for them.

For the experts, a DFH is characterised not only by interventions for the care of people with dementia but also by implementation components. For example, staff and leadership commitment, available resources and conditions, time, learning opportunities or priority of the topic mentioned by the experts are determinants of the successful implementation of innovations (Damschroder et al. 2022) and are essential for the implementation of dementia-specific interventions in hospitals (Abbott et al. 2022; Petry, Ernst, and Naef 2023; Rommerskirch-Manietta et al. 2023). Accordingly, both intervention and implementation research are important for a DFH in terms of complex intervention research (Skivington et al. 2021).

Our results also draw attention to seeing the human being and include many components of person-centred dementia care (Fazio et al. 2018), for example, seeing the person, tailoring the hospital stay and building a relationship. Moreover, the results highlight focusing on seeing all individuals: people with dementia, their relatives, staff and fellow patients. This view is consistent with the WHO definition of dementia-friendly initiatives, which focus on the quality of life of carers and the broader community in addition to people with dementia (WHO 2023), and corresponds to the key component of person-centred care valuing care providers (Fazio et al. 2018). Accordingly, a DFH should address relatives, staff and fellow patients as well. Healthcare professionals could be addressed through person-centred leadership (Cardiff, McCormack, and McCance 2018), workplace interventions, for example, mindfulness-based interventions such as yoga, acupuncture, coaching or organisational interventions such as workload reductions, which is increasingly important to address the well-being and burnout risk of healthcare professionals (Cohen

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et al. 2023). Additionally, the changes that a DFH bring could have a positive impact on their outcomes. A systematic review by Rasmussen et al. (2023) found a positive effect of dementia education on the satisfaction, knowledge, attitudes, self-efficacy, well-being and job satisfaction of healthcare professionals working in hospitals.

Moreover, our results highlight that a positive image of dementia care, a welcoming culture for people with dementia and pride in being dementia-friendly are essential for a DFH. Studies have shown that dementia and the care of people with dementia still have negative connotations in society and in healthcare based on stigmas and stereotypes (Bacsu et al. 2022; Herrmann et al. 2018). To reduce stigma and create a positive attitude, various interventions exist, for example, educational interventions involving people with dementia as educators, collaborative art or storytelling (Bacsu et al. 2022). These types of interventions can be promising for a DFH but still need stronger evidence. Furthermore, the DFH itself is seen as having a responsibility to raise awareness and to contribute to destigmatisation in society.

4.1 | Limitations

Experts with a nursing background were predominant in our sample. The reason could be that nurses play a major role in dementia care in hospitals in Germany (Pinkert et al. 2018). Nevertheless, it should be noted that the nurses in our sample worked in various areas and departments, so different facets of the hospital were illuminated. Furthermore, it needs to be considered that the experts' perspective is affected by their knowledge, experience, position, and dementia-specific interventions in their own hospital and partly through their experiences as a relative of a person with dementia. Nevertheless, their perspectives overlapped and were consistent.

5 | Conclusion

Overall, the concept of a DFH seems complex and requires a rethinking of the traditional hospital system and a positive image of dementia care. Our comprehensive results can be used to generate ideas for individual interventions in practice and research, but they also demonstrate the interdependence of the characteristics of a DFH. Therefore, a singular consideration and implementation of characteristics seems useful only to a limited extent. Nevertheless, our results can be used to take a first step towards becoming a DFH. For the further conceptualisation of a DFH, it is necessary to involve the people with dementia themselves and their relatives.

6 | Implications for Clinical Practice

A DFH is characterised by the professional care of people with dementia that comprises a safe, familiar and supportive environment, is prepared but is also flexible, has everyone on board, and sees the human being. To achieve this level of care, individual interventions such as training courses can be a starting point but are not enough to become a DFH. A DFH requires a rethinking of the traditional hospital system and an overall concept, which, in addition to the content-related components of professional care, also includes components that contribute to successful implementation. Accordingly, becoming a DFH is a task for the entire organisation. Nurses have an important role in the care of people with dementia in hospitals, and this needs to be strengthened in the future. In particular, the recognition of nursing and psycho-social interventions and non-medical outcomes in hospitals are essential. Furthermore, hospital leadership seems to be of crucial importance for a DFH, as resources are needed, structures need to be changed, and a welcoming culture for people with dementia needs to be established. These are changes at the organisational and decision-making level and require the willingness and commitment of hospital leadership. Additionally, a DFH addresses both patients and relatives as well as healthcare professionals; hospital leadership is essential to provide person-centred leadership and to focus on staff well-being. However, the commitment of the entire organisation and all healthcare professionals is a central component of a DFH. In this respect, it is important to gain their commitment and to improve the image of care for people with dementia in hospitals through destigmatisation and raising awareness.

Author Contributions

Christina Manietta: conceptualization (lead), data curation (lead), formal analysis (lead), funding acquisition (lead), investigation (lead), methodology (lead), project administration (lead), visualisation (lead), writing – original draft (lead). **Daniel Purwins:** formal analysis (equal), methodology (supporting), visualisation (supporting), writing – review and editing (equal). **Christiane Pinkert:** formal analysis (equal), visualisation (equal), writing – review and editing (equal). **Lisa Fink:** formal analysis (equal), visualisation (equal), writing – review and editing (equal). **Mike Rommerskirch-Manietta:** formal analysis (equal), visualisation (supporting), writing – review and editing (equal). **Melanie Feige:** formal analysis (equal), visualisation (supporting), writing – review and editing (equal). **Christiane Knecht:** conceptualization (equal), formal analysis (supporting), methodology (equal), supervision (equal), visualisation (supporting), writing – review and editing (equal). **Martina Roes:** conceptualization (equal), formal analysis (equal), funding acquisition (lead) investigation (equal), methodology (equal), project administration (equal), resources (lead), supervision (lead), visualisation (equal), writing – review and editing (equal).

Acknowledgements

We would like to thank the professional dementia experts for their interest and participation in our DEMfriendlyHospital study. In addition, we thank the dementia networks for their support in recruiting participants. We also thank our students Anneke Reinhard and Annika Kliemannel for their support. Open Access funding enabled and organized by Projekt DEAL.

Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

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