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**Investigating the significance of effectively caring for
dementia patients in healthcare**

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Dissertation submitted as part of the requirements for the
award BSc (Hons) Health and Social Care

DECLARATION

This work has not previously been accepted in substance for any degree and is not being concurrently submitted in candidature for any degree

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This dissertation is being submitted in partial fulfilment of the requirements for the degree of BSc.

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STATEMENT 2

This dissertation is the result of my own independent work/investigation, except where otherwise stated. Other sources are acknowledged by footnotes giving explicit references. A bibliography is appended.

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Chapter 1: Introduction:

1.1 Introduction

In the United Kingdom alone, approximately 982,000 people live with dementia as of 2024 (Alzheimer's Society, 2024). Dementia is not a single disease however, but rather the term 'dementia' refers to any condition where there is a loss of brain function, usually manifesting itself in ways such as memory, problem-solving and speech and language (WHO, 2023). This therefore affects a patients' ability to carry out their everyday activities according to their lifestyle . Since it is widely known as a growing global health concern, there is a great need to address the significant potential benefits that are involved with the effective care of dementia.

As dementia progresses, individuals usually experience a drastic deterioration in their cognitive abilities, which inevitably causes a loss of independence, meaning they have no choice but to rely on caregivers. This places a large strain on healthcare systems, limiting their ability to perform to the same ability as they would without the pressure to give care in line with rising dementia cases. Subsequently, the prevalence of dementia presents a seemingly difficult challenge for health and social care services, emphasising the urgency for effective care systems.

Therefore, this dissertation will primarily aim to examine and promote the importance of the provision of productive support for patients. In doing so, it will explore the different types of dementia, while identifying key challenges that healthcare professionals encounter when delivering care for dementia patients in intense health and social care settings (NICE, 2018). Ultimately, this dissertation should highlight how current care practices can be improved to contribute to an increased quality of care that prioritises a person-centred approach (Brooker, 2007).

1.2 Definitions and Terminology

As outlined previously, dementia is a broad term referring to a syndrome identified by a decline in cognitive function. While there are many different manifestations of this syndrome,

characterised by different names such as Alzheimer's, vascular etc), the most common form is Alzheimer's disease. It is also important to identify other variations of dementia. Different types of dementia are characterised by the way in which it alters the brain (National Institute on Aging, 2024). For example, Alzheimer's is a disease identified by the abnormal build-up of proteins surrounding the brain cells (NHS, 2021), which is similar to how dementia with Lewy bodies develop (McKeith et al., 2017). Vascular dementia however refers to dementia caused by reduced blood flow to the brain (NHS, 2023).

For the sake of this dissertation, the term Activities of Daily Living (ADLs) refers to basic daily tasks that involve eating, dressing, bathing and the maintenance of personal hygiene. This is important to outline since individuals with dementia may struggle to perform these ADLs to an adequate standard. This will be used throughout the report to further highlight the importance of PCC, which refers to person-centred care. PCC ensures that individuals with the dignity, respect and empathy that makes them feel comfortable (Kitwood, 1997). Throughout several health and social care institutions, this approach is renowned as crucial in securing an improved standard of living for those living with dementia.

Several more acronyms and abbreviations are used throughout this report to maintain consistency, particularly to refer to health organisations that are involved in the provision of healthcare for dementia patients. The NHS refers to the National Health Service, which provides comprehensive publicly funded healthcare across the UK, which is free for UK residents (BBC, 2018). Similarly, the World Health Organisation (WHO) is also a global organisation that specialises in connecting nations to promote health (World Health Organisation, 2025). These will be referred to throughout this essay.

1.3 Rationale for Research

This topic was chosen as it is a highly relevant topic considering the global life expectancy continues to rise, the number of individuals living with dementia is expected to rise, and it has been established that the illness also gets worse with time (WHO, 2023). This renders dementia as one of the leading causes of disability and vulnerability among older populations. Therefore, the purpose of this research is to explore the increasingly detrimental impact of dementia on individuals, families and healthcare systems. Through highlighting the effect of dementia, the avenues through which the consequences of it can be addressed, such as through improved and effective patient care, become more apparent.

However, even with increased awareness of the need for improvement in patient care, it is likely that significant problems will continue to remain. For example, individuals with dementia may experience confusion, leading to potential resistance to care. This hinders the ability for healthcare professionals to effectively implement improvements in care. Rather than easing the experience of patients, patient care becomes complex (Eggenberger et al,2013). The ongoing NHS staff shortage could exacerbate this counterproductivity by reducing the support and mechanisms available to provide improved patient care. This reveals that although PCC is widely recommended as the most effective framework for caring for patients, there are always hindrances that reduce the consistency of its application in various health and social care settings. Therefore, this research aims to explore and provide strategies to overcome these.

1.4 Aim and Objectives

The primary aim of this research is to highlight the importance of increasing efficacy in patient care. The ways this can be achieved will be explored, as well as the potential challenges.

To achieve this aim, the listed objectives will provide a framework for direction of research:

- **Objective 1:** To outline dementia and its existence of many variations
- **Objective 2:** To analyse the impact of dementia on individuals in their daily lifestyle
- **Objective 3:** To evaluate the significance of effective care in health and social care settings for dementia patients
- **Objective 4:** To identify challenges faced by both healthcare professionals and dementia patients following improvements in dementia care

1.5 Conclusion

In summary, this chapter has established the main issue of the lack of focused and effective care within current health and social care systems, particularly for dementia patients. Key definitions and terminology have been clarified to maintain clarity in the understanding of the condition and its implications in the quality of care. Both the rationale and need for addressing this topic have been established.

Consequently, the following chapter will address the foundations of this research by first establishing the historical and theoretical context behind this issue and how it can be addressed.

Chapter 2: Background Information and Analysis

2.1 Introduction

This chapter aims to establish the contextual basis for the need for an improved understanding and support for dementia-related care within health and social care. It aims to provide a structure for research by exploring the historical development and theoretical influences surrounding the care of dementia patients. By first acknowledging how dementia was once understood, and the evolution of these understandings, this chapter gauges the useful of progression of knowledge and care practices. In particular, key theories will be analysed so they can be used as a model for how to move forward and learn from previous insights.

Furthermore, this chapter will consider both international and national approaches to caring for dementia. It will look at discrepancies between healthcare cultures nationally and internationally to highlight how various healthcare systems address challenges differently.

Ultimately, this broader contextual analysis is crucial in identifying gaps and potential improvements that are necessary in the landscape of health and social care. Altogether, the synthesis of this information will help inform research direction to support to investigation of how dementia care can be improved.

2.2 Historical Background

The perceptions of dementia have gradually evolved. However, it is also important to recognise that early interpretations that dismissed cognitive decline as a normal side effect of ageing healthily. Little distinction was made between normal milestones of ageing and pathological conditons. This highlights how dementia was, and still sometimes is,

misunderstood, meaning its care can also be ineffective. However, in the 20th century, German psychiatrist Alois Alzheimer began to identify what is known as Alzheimer's disease (Alzheimer's Disease International, n.d.). This is a landmark discovery as it formally recognised dementia as a neurological syndrome than a mere sign of ageing. This allowed for further research into its nature.

Therefore, throughout the mid-20th century, dementia was still highly under-researched, meaning individuals were recognised with the disorder, however they weren't followed up with the appropriate care required. However, the rapid advancement of technology within healthcare facilitated the emergence of neuroimaging. For example, CT and MRI scans enabled clinicians to identify structural changes in the brain (McKhann et al., 2011), which enhanced diagnostic criteria. Following this, different types of dementia began to be identified.

The work of Kitwood (1997) catalysed the increased awareness in recognising the importance of quality of life and care for those living with dementia. This is because he emphasised the importance of perceiving individuals with dementia as people with unique qualities, rather than classifying and focusing solely on their cognitive differences. In the 21st century organisations such as WHO and Alzheimer's disease international have played imperative roles in increasing global awareness and proactivity in improving dementia care. For example, WHO's Global Action Plan highlighted the need for improved diagnosis and care (WHO, 2017). This organisation, as well as historical discovery, have played a part in facilitating the provision of increased research investment to promote dementia care.

The gradual recognition of dementia as a serious disorder has meant that it has begun to be treated properly. While these individual and institutional developments reflect a gradual evolution of the recognition of seriousness of the disorder, it is important that the evolution of the care allocated also accompanies it.

2.3 Theoretical Background

The treatment of dementia is underpinned by various concepts and theories that influence the success of research and practice of care. One of the most influential examples of this is the concept of person-centred care (PCC), which was developed by Kitwood (1997). PCC emphasise the importance of treating patients with dementia by acknowledging their differences and preferences, and tailoring the type of care provided accordingly. This approach challenges the standardised model of care by highlighting the importance of

valuing individuals. Applying PCC to everyday treatment of dementia patients will create a supportive social environment, since the patient is likely to feel more understood and valued as a individual, rather than being perceived as simple part of a group of people with the same disorder. Brooker (2007) further developed this concept through the Very Important People Services framework (VIPS), which further exemplifies the practical enactments of this concept. When these PCC models are implemented in health and social care settings, it has shown benefits such as increased wellbeing and reduce behavioural symptoms (Livingston et al., 2020) , as the pateitns inevitably feels more valued. However, some limitations of PCC are revealed when its consistency is assessed. For example, staffing levels and resource availability may significantly limit the provision and subsequent success of PCC.

The biomedical model is a key framework perceiving dementia, since it allows it to be viewed from a medical perspective: it focuses on the physiological and neurological causes of the condition. This is instrumental in the progression of the research behind biological mechanisms of dementia. For example, identifying the role of amyloid plaques and tau tangles was imperative in Alois Alzheimer's discovery of Alzheimer' disease.

The biomedical model therefore contributes the development of diagnostic criteria and subsequently the development of treatment to tackle dementia. While the biomedical model can be praised for its contribution to classic and modern dementia medicine, it tends to overlook psychological and social factors that may also contribute to the exacerbation of the symptoms of dementia.

Evaluating both theories simultaneously provides a complementary view of their limitations. Although both the biomedical and PCC model of assessing dementia care can be useful, it is important to maintain a balance between the two. This is because both medical and social approaches to dementia care must be considered, since an integrated model is paramount to addressing the complexities that dementia care entails.

2.4 International Context

Globally, dementia is health issue that affects many individuals. Therefore, many countries have developed national strategies to combat the difficulties that are associated with dementia. However, approaches to dementia care do seem to vary significantly across different regions, which reflect the differences is income levels, cultural attidues and reosurces. This section will analyse international differences in approaches by classifying and evaluating them based on income level.

High-income countries, such as the UK, the US and Australia, exhibit strong dementia support systems. For example, Australia's National Dementia strategy focuses on improving early diagnosis, which subsequently improves care quality and expedites the speed of improvement (Department of Health and Aged Care, 2023) . Similarly, the USA has aimed to allocate an increased amount of research and development funding and improving access to care services.

Contrastingly, low and middle income countries often more significant challenges in the provision of satisfactory dementia care. This is due to the fact that limited resources, lack of awareness and lack of robust healthcare infrastructure make it more difficult to implement reliable care. As a result, many families will rely on many informal means of dementia care, which are provided by family members (Prince et al., 2015). This arguably places a considerable amount of strain on local resources while highlighting global inequalities in the access to care when compared to higher income countries.

An interesting case study is the country of Japan. This is because Japan has large ageing population, which translates into large proportion of seniors with cognitive complications such as dementia. However, the Japanese government has done well to implement strategies to address the effects of it. For example, the National Framework for Promotion of Dementia policies launched in 2019 displays the proactivity of the Japanese government in mitigating the social effects of dementia. It focuses on two key pillars of inclusion and Risk Reduction – to delay dementia onset and promote social participation (Ishihara et al., 2023) . While these initiatives have been useful in addressing the social aspect of the provision of care, a balance of medical understanding is also needed.

Nevertheless, these diverse examples of how dementia is addressed in various regional contexts highlights the scope of care that is available – it is not limited to one dimension.

2.5 National Context of the UK

Within the United Kingdom, dementia is recognised as a significant issue, since there is likely to be a rise in cases, as seen in countries such as Japan. Therefore, the government has introduced a variety of proposals to improve dementia care. Similar to the Japanese government, the UK government's initiative under Blair was the National Dementia Strategy. This strategy was released to provide a strategic framework through which local services are able to deliver improvements in dementia services, and provide advice for the health and

social care commissioners and providers in the monitoring of services (Department of Health and Social Care, 2009). Ultimately, the objective was to minimise health inequalities manifested in the regional discrepancies of quality of dementia care. However, the extent to which care was standardised for dementia patients is a point of contention- this strategy is no longer active.

Nevertheless, landmark pieces of UK legislation such as the Care Act 2014 further reinforced improvements in dementia care by placing the individual's needs at the centre of the system. It orders that local authorities promote an individual's mental, physical and emotional health (Care Act, 2014) consistent with PCC models of care. This has systematically improved how local services deliver care, as it has highlighted the importance of safeguarding vulnerable individuals in every way.

2.6 Conclusion

The background analysis within this chapter has offered a comprehensive review of the contextual foundations of dementia. The historical evolution of the understanding of dementia as revealed how dementia is a complex disorder, so understanding continues to progress. Theoretical perspectives, such as biomedical and person-centred models, have interacted with these historical insights to complementarily demonstrate the multi-faceted nature of dementia, therefore requiring a nuanced approach to care.

The global contexts in which dementia has been explored in this chapter also reveal the different avenues through which dementia can be addressed. While significant global advancements have been made, regional inconsistencies remain.

This background chapter provides a robust foundation for a deeper analysis of the research methodology in the following chapter, detailing the methods used to collect and interpret data to address the research aim.

Chapter 3: Methods and Search Strategy

3.1 Introduction

The main purpose of this chapter is to provide a debrief of how the research was conducted. While there was no direct primary research that was collected, the secondary research that was collected is directly related to the topic of the significance of caring for dementia patients. The academic methodology poster that accompanies this section provides a visual summary of the secondary research process, while this chapter will expand upon each element of that poster in greater detail. The methods that are mentioned here, such as the search strategy, source validation and thematic coding process, were crucial in identifying and analysing the literature which will form the basis of the thematic findings presented in Chapter 4.

3.2 Search Strategy

A search strategy is a planned approach to locating relevant literature using the combination of keywords using logical operators. In this case, Boolean operators were used to combine terms such as “dementia”, “person-centred care (PCC)”, “biomedical model”, “Activities of Daily Living (ADLs)”, and “dementia care challenges”. Operators such as AND, OR, NOT were used to refine search results. For example, “dementia AND person-centred care” were used to narrow results to sources that discussed both concepts simultaneously. Similarly, “Dementia AND UK NOT paediatric” was used to exclude irrelevant results that concerned childhood conditions. Useful results were recorded throughout the process using a spreadsheet to maintain consistency across databases.

3.3 Searching for Information

Literature was mainly sourced using Google Scholar, PubMed and the UWTSD library database, alongside official publications from the World Health Organisation (WHO), the National Institute for Health and Care Excellence (NICE), and UK government sources.

These platforms were chosen due to their credibility and relevance to the health and social care field. For example, Google Scholar and PubMed provide access to a broad range of peer-reviewed academic literature. Similarly, WHO, NICE and UK government publications offer an authoritative contribution directly applicable to UK health and social care practice.

To narrow the database, filters were applied. This included a date range of the last ten years and a preference for peer-reviewed sources. Data also focused exclusively on the UK to maintain relevance. However, whenever international comparison was introduced, these filters were relaxed to allow relevant international sources to be included.

It is also important to note that the search process tended to be more iterative than fixed. This is because initially, searches returned a large volume of general results, therefore more specificity was necessary, which was done by combining terms.

3.4 Research Validation

Before fully reading the source, skimming was necessary. This was done by gaining information merely from its title, abstract, introduction and conclusion to assess the relevance of source to my chosen research objectives. Potentially relevant sources were then further assessed using the CRAAP test, which evaluates Currency, Relevance, Authority, Accuracy and Purpose. While not every source satisfied all 5 criteria, more emphasis was placed on the categories of Currency, Relevance and Authority, as these were considered most important to creating a credible and applicable evidence base.

This process involved sound, holistic judgement rather than a rigid decision-making. For example, Kitwood's (1997) foundational work on PCC is almost 3 decades old, meaning it scored poorly on the Currency category. However, its high score for Authority and established Relevance to the health and social care field means it remains useful for this dissertation. This illustrates that older sources can contribute where they contribute successfully to the discipline.

3.5 Inclusion and Exclusion Criteria

Inclusion criteria required that sources be published within the last ten years. It also demanded that they be peer-reviewed journal articles or publications from widely recognised bodies such as WHO, NICE or UK government departments, and be fully accessible. While

priority was given to UK-focused sources, the inclusion of international literature, such as Ishihara et al. (2023) on dementia policy in Japan, were included to support the comparative nature of the report.

Sources were excluded if they were:

- more than 10 years old with no industrial significance
- not peer reviewed
- not written in English
- not fully accessible
- unrelated to adult dementia care

Altogether, these criteria ensured that the source base retained credible, relevant and applicable sources to the research objectives.

3.6 Analysing Research

To analyse the sources researched, thematic coding was used. Each source was reviewed meticulously to identify any repeated terminology or topics, which formed initial codes such as 'staffing pressures', 'biomedical versus PCC approach' or 'international disparity in provision'. These thematic codes were then grouped into broader themes which aligned with the research objectives, particularly the type of dementia and the challenges faced by professionals and patients.

This process was executed using a spreadsheet, attached as Appendix 1. Recording each source alongside its assigned codes and themes meant that patterns could easily be identified and referenced.

3.7 Ethical Considerations

Ethical considerations refer to the principles and standards a researcher follows to ensure their research is conducted responsibly to maintain academic integrity (Bhandari, 2022).

Since no primary data was gathered for this dissertation, ethical considerations were focused on academic integrity rather than participant protection. Here are a few ways that that is maintained in this dissertation:

- **Respect for Intellectual Property:**
 - Properly cite and reference (in Havard Style) original sources.

- **Data Integrity and Reliability:**
 - Only validated, credible sources (assessed via CRAAP test) were used to ensure the accuracy of claims made throughout the dissertation
- **Transparency and credibility**
 - Literature was selected and presented fairly without bias, incorporating both PCC and biomedical viewpoints

3.8 Chapter Conclusion

This chapter has outlined the systematic approach taken to review and analyse literature that supports with dissertation. The search process, involving CRAAP, ensured that the evidence base was credible and appropriately focused. This underpins the findings presented in Chapter 4, which is organised into the themes identified through this process.

Chapter 4: Findings and Discussion

4.1 Introduction

This chapter presents and discusses the findings drawn from the secondary research outlined in Chapter 3. Following the thematic coding undertaken to assess the various sources, this chapter will analyse the literature under three key themes: types of dementia and their impact on daily living, the significance of person-centred care compared to the biomedical approach, and the challenges faced in delivering effective dementia care. Each theme is therefore discussed in relation to the dissertation question. This evaluation will aim to highlight how the evidence gathered sufficiently address the original aim of highlighting the importance of increasing efficacy in dementia patient care.

4.2 Thematic Analysis

Thematic analysis is used to identify, organise and interpret patterns within a body of literature or data (Braun and Clarke, 2006). Applying thematic analysis to the process of collecting secondary data involved reviewing existing sources to identify repeated ideas, concepts, or terminology, before grouping these into broader themes to relate them directly to the research objectives.

This approach was identified in Chapter 3, where it was described that each source was read in detail, with recurring codes such as staffing pressures, PCC approaches etc recorded and tracked using a thematic coding table (see Appendix.). These profound codes were then combined to form three clear themes:

- Types of dementia and their impact on daily living
- Significance of PCC care v Biomedical approach

- Challenged faced by healthcare professionals and patients in delivering effective care

4.3 Theme 1: Types of Dementia and Impact on Daily Living

Dementia is not classified as a single disease but instead an umbrella term covering a range of different conditions, all identified by a decline in cognitive function. These conditions typically affect memory, problem-solving and language (World Health Organisation, 2025). While Alzheimer's disease obviously the most recognised form, other variations do exist. This includes vascular dementia and dementia with Lewy bodies, distinguished by the way they alter the brain structure and function. Alongside this, ADLs refers to fundamental daily tasks such as eating, dressing, bathing and personal hygiene. As dementia progresses, an individual's ability to perform these ADLs typically declines. This is an important correlation to identify to understand the scale of care challenge this dissertation addresses.

As laid out in this dissertation previously, understanding of dementia has seemed to evolve rapidly since the condition's first identification. Early clinical observations by Alois Alzheimer laid the foundation for how the disease is understood today (Alzheimer's Disease International, n.d.). Diagnostic understanding since then has progressed. For example, McKeith et al. (2017) provide updated diagnostic and management criteria for dementia with Lewy bodies. This reflects how the development of formal clinical recognition of dementia subtypes has allowed for more appropriately targeted care.

This theme is crucial to the dissertation's research question since effective care cannot be delivered without a solid and firm understanding of dementia and its different manifestations. This is because the dissertation's main aim of trying to increase efficacy throughout dementia patients' care rests on the sole premise that care must be tailored to the specific struggles the patient may have, such as struggling to perform specific ADLs. Without this foundational understanding, the later comparison between PCC and biomedical care in Theme 2 and care delivery challenges outlined in Theme 3 will lack necessary context.

Around 982,000 people are living with dementia in the UK (Alzheimer's Society, 2024). These statistics therefore provide an indication of the severity of the problem within the specific national context of this dissertation, supporting the case for the need to answer the research question. In a broader, international context, Prince et al. (2015) state in the World

Alzheimer Report that dementia has serious global implications, indicating it to be a problem increasingly experienced worldwide within health and social care services as opposed to just one country. It is evident from these statistics that as life expectancy continues to rise, increasing the prevalence of dementia in the community, the subsequent pressure on daily living support and care services is set to continue and escalate, and therefore this is not a static concern.

Underlying the current approach to dementia Diagnosis is a largely biomedical understanding of the condition: that an underlying physical brain deterioration is the cause of dementia, for example, abnormal build-up of proteins leading to Alzheimer's disease. It is crucial for Diagnosis and Classification to adopt this model, as indicated by Gm et al. (2011) and McKeith et al. (2017), but it is important to recognise that this alone fails to describe how the person with dementia actually lives – something that will be revisited in the discussion of a PCC approach in Theme 2. This clinical diagnostic viewpoint, the implications of such diagnosis on an individual, and the ability to engage in activities associated with everyday living are now formalised in legislation through the Care Act (2014) that outlines the legal framework for assessing a person with care and support needs and meeting that need – including need relating to activities in your daily life (ADLs). This is clearly relevant as dementia's effect on a person's capacity to maintain everyday activities therefore leads to a legal right to care.

The implications of this appear to be two-dimensional: improved diagnostic clarity allows healthcare professionals to identify the specific type of dementia, enabling more targeted care. This can support better outcomes and a more efficient use of care resources.

However, a more negative implication is that clinical understanding may not always translate into adequate daily support. Increasing prevalence, as evidenced in the statistics presented by the Alzheimer's Society (2024) put strain on an already over-stretched health care and social services systems, which are already mandated by law through the Care Act (2014) to offer support, but often lack the capacity (workforce, resources) to do this comprehensively - a conflict explored more deeply in Theme 3 below.

The three articles included in the coding table clearly demonstrate this theme. Gm et al. (2011) illustrate that there has been greater specificity of diagnosis for Alzheimer's disease because of standard workgroup recommendations, thus supporting the assertion that identification of a specific dementia subtype should be a prerequisite of provision of optimal care. Extending the diagnosis argument, McKeith et al. (2017) discuss dementia with Lewy bodies and provide evidence suggesting that subtypes of dementia need different diagnostic

and management strategies, supporting the assertion that a generalist approach will be insufficient to address the wide-ranging nature of dementia.

Both articles align strongly with each other, as they contribute evidence to suggest a clinically driven approach to differentiating between various subtypes of dementia is necessary.

Prince et al. (2015), in contrast, work at the system level with data from the global scene showing the extent to which dementia is an issue, and while lacking the detailed diagnostic information present in Gm et al. Or McKeith et al. (2017), offer support to the system-level justification for the need for knowledge in dementia type and effects on daily living. Taken together, these articles supply an important clinical foundation and a systems-level underpinning for the need for greater knowledge of dementia types to improve treatment outcomes.

The link with Theme 2 of the dissertation is direct. The use of a biomedically classified approach to types of dementia underpins and justifies the use of a person-centred understanding and application (Kitwood, 1997; Brooker, 2007), where individual and lived experience must build on the medical models. The connections with Theme 3 are also clear, as it is the increasing burden illustrated here, and the legal responsibility under the Care Act (2014) that contribute significantly to the current workforce and resourcing deficits addressed in the forthcoming theme.

4.4 Theme 2: Person-Centred Care and Biomedical Care

Person-centred care (PCC) refers to an approach to dementia care that places more emphasis on the patients' dignity, identity, and personal preferences, rather than focusing completely on the clinical management of symptoms (Kitwood, 1997). However, this stands in complete contrast to the biomedical model, which outlines dementia as primarily a physiological condition to be diagnosed and managed clinically. Understanding the distinction between these two models, and the arguments that they should work cohesively rather than in opposition to each other, is central to this theme.

Historically, dementia was perceived exclusively through a biomedical lens, in which the individual was understood in terms of their physiological diagnosis. However, this began to shift with Kitwood's (1997) work, arguing that this narrow view meant that the patient's individualistic nature was overlooked. He therefore introduced the concept of PCC as a way to rectify and contribute to previous clinical approaches.

This theme is at the core of the dissertation's research questions, as it seems to directly address what 'effective' dementia care resembles in practice. It builds on the findings of Theme 1, which established the clinical and biomedical understanding of dementia types. However, this theme goes ahead and argues that that clinical accuracy alone is insufficient to deliver truly effective care.

Three sources directly support the above theme. Kitwood (1997) develops the fundamental argument that person-centred care is not an alternative to biomedicine but rather complementary to it. Clinical knowledge of the disease but should at the same time be person-centred on an individual's selfhood and lived experience of being. Brooker (2007) shares and extends Kitwood's assertion and applies Kitwood's theory to the VIPS model, thereby providing consistency rather than contradiction between the two sources.

Livingston et al. (2020) take a somewhat different approach toward the biomedicine-person-centred debate, via an evidence-based and epidemiological perspective; connecting lifestyle and care with some kind of positive, or at least, negative, measurable aspects rather than through philosophy alone.

The sources are consistent, rather than contrary, as Kitwood and Brooker develop the theoretical and practical aspects. In contrast, Livingston et al, with the perspective of empirically derived information on the actual effectiveness of person-centred care, provide empirical data for the theory.

The advantages of using a person-centred approach outweigh the possible negatives; Kitwood (1997) and Brooker (2007) suggest improved quality of life, reduction of distress, and dignity for those with dementia compared to biomedical interventions. A negative implication, and arguably one which presents the biggest difficulty of applying a person-centred approach to practice: person-centred care usually requires more intensive time resource input on an individual level compared to a biomedical focus that involves more task-based activity which therefore has the potential for some difficulties such as not enough care staff, training investment or organisational support due to limited health and social care resources. This difficulty is also closely mirrored by the dilemmas facing Theme 3.

Furthermore, this theme has strong links with Theme 1. First, the biomedical conceptualisation of types of dementia and their consequences for everyday life is the basis on which arguments in the dissertation are made: that person-centred care is a bonus, not a substitute for existing care. This also relates to the challenges of how the resources

identified above will enable PCC, relating to Theme 3 which further explores in a discussion of health and social care workplace pressure and the effects of trying to deliver high standards of person centred care daily.

4.5 Theme 3: Challenges in Delivering Dementia care

Within the context of this theme, “challenges in delivering dementia care” are defined as the pragmatic and systematic obstacles encountered by healthcare professionals and their organisations in the provision of effective, person-centred dementia care. This incorporates workforce pressures, financial restraints, inconsistencies in policy enactment, and discrepancies in healthcare and social care systems within and beyond the UK.

As interest in person-centred care models progressed, dementia care began to be widely recognised as a systemic issue rather than exclusively a clinical one. Britain's Department of Health and Social Care's (2009) National Dementia Strategy was a significant early policy attempt at identifying and tackling this discrepancy. The strategy laid out objectives for improved diagnosis, workforce education and quality of care provision. Subsequently, NICE (2018) delivered detailed policy regarding assessment, management, and patient and carer care support, aiming to satiate the demand for consistent quality of care

Understanding what healthcare and social care systems can deliver versus what effective, person-centred dementia care hypothetically should involve is crucial to addressing the research question, because they represent the gap that must be bridged. The overall premises within this paper rely on this gap; the efficacy of delivering dementia care cannot truly be assessed or enhanced by continuing to focus solely on theory or diagnosis. Therefore, this theme grounds the entire paper in the practical realities healthcare providers face.

Despite a decreased emphasis on prevalence statistics for this theme in comparison with Theme 1, it is crucial to continuously be reminded of the sheer scale of dementia; 982,000 people living with the condition in the UK alone (Alzheimer's Society, 2024) means even relatively small work or budget shortages are amplified considerably. An identical dilemma exists even globally: Australia's Department of Health and Aged Care (2023) describes strains in delivery caused by an ageing population in the form of a National Dementia Action plan. The highly aged Japanese society has even more severe workforce and resource struggles, as reported by Ishihara et al. (2023).

There is no single, globally accepted policy document relating to dementia delivery. However, the Department of Health and Social Care's (2009) National Dementia Strategy identified an approach to improved diagnosis, care delivery, training and workforces in the UK, which was subsequently expanded upon by NICE's (2018) guidelines, exemplifying a suitable starting point. In contrast, Australian efforts outlined in the Department of Health and Aged Care (2023) National Dementia Action plan target better healthcare planning, workforce solutions, and patient awareness.

The work of Ishihara et al. (2023) examines Japan's response to its extreme pressures of a superaged society; their focus on a community-based approach to care differs greatly from Australia's in the way the underlying issues of workforce and funding have been approached.

As previously stated, this theme presents somewhat more mixed implications for future research and policy in this field. The presence of clear policy documents like the one recently produced by NICE (2018) proves that there is at least a formal recognition of dementia's growing impact and associated burdens on the healthcare sector. Nevertheless, ongoing pressures associated with workplace shortages as well as financial issues mean it remains a risk for well-designed care plans and policies to remain as an ambition rather than a daily reality for sufferers of dementia. Therefore, future developments toward improving the delivery of effective dementia care would benefit more significantly from a pragmatic and realistic focus on addressing systemic challenges.

This section strongly ties into Theme 2; without a capacity to deliver care, it's essentially futile to identify the principles of that care in Theme 2. Theme 1 provides context regarding dementia's rise and the establishment of certain legal entitlements through legislation such as the Care Act (2014), thus feeding into the current workforce pressures as outlined in the current theme. The three themes cohesively represent a continuum: an understanding of what dementia means in practice for those suffering it (Theme 1), an identification of the best type of care to deliver (Theme 2) and how such care should be executed (Theme 3).

4.6 Chapter Conclusion

This chapter has outlined and explored the data collected through the secondary research for this dissertation organised by the three themes that emerged from my thematic analysis.

Theme 1 defined dementia subtypes and their impact on a person's ability to fulfil the requirements of everyday living, creating the clinical and Theme 3 showed how various

workforce and systems issues result in difficulty in providing effective care consistently. Comparisons across national and international policy demonstrate the internationality of the difficulties, even in terms of how the issues were addressed.

These themes therefore come together to form a logical argument, whereby through understanding dementia and its consequences (Theme 1), we can then build the case for the application of PCC as part of a cohesive approach (Theme 2). By contrast, Theme 3 identifies the practical challenges which result in it not yet being a consistently offered way of delivering care. Following on from this, the subsequent chapter will analyse this literature to determine whether there are ways in which the effectiveness of dementia care provision could be improved in the future.

CHAPTER 5 – Conclusion and Recommendations

5.1 Overall Conclusion

This dissertation has investigated the role and significance of effective dementia patient care within healthcare services in the United Kingdom, with specific objectives to

- outline dementia and its various manifestations,
- review the effects of the condition on daily life
- evaluate the relevance of good dementia care practice to health and social care settings,
- explore the challenges experienced by patients and providers of dementia care in striving for improvement.

Chapter 2 has explored the development of the concept of dementia, from initial disregard of cognitive decline as a natural age phenomenon, through the formal description of Alzheimer's disease, to the contemporary approach emphasizing person-centred care and

Quality of life (Kitwood, 1997). The conflicting models of biomedical and person-centred approaches to care have been explored with the suggestion that a holistic approach integrating the two is most beneficial. The international as well as the national contexts have been explored, revealing high income countries such as The United Kingdom, USA and Australia seem to have a robust support system, in contrast to the low and middle-income Countries (LMIC), and that even the most mature high-income economies such as Japan need to consider its changing population and associated changing dynamics.

In Chapter 3, an explanation was provided regarding the systematic literature search strategy applied, the application of inclusion/exclusion criteria, the use of CRAAP appraisal with the selected articles, and thematic coding to select the literature base that informs this study.

Three themes emerged in Chapter 4 of the dissertation. Firstly, an explanation of the different types of Dementia (Alzheimer's; Vascular Dementia & Lewy Body Dementia) and the impact on ADL as supported by national data relating to the prevalence of Dementia in the U.K. (Alzheimer's Society, 2024) and a theoretical insight into relevant legal frameworks (Care Act, 2014).

Secondly, Person-Centred Care (PCC), as defined by Kitwood (1997) & practical implications using The VIPS model by Brooker(2007), supported by empirical studies of increased outcomes (Livingston et al., 2020), has been identified as critical, working alongside the medical model rather than replacing it.

Theme 3 has focused on both national and international comparisons demonstrating that the issues surrounding inadequate workforce, resourcing for adequate care delivery for those people who have Dementia remains problematic across the sector (Dept of Health and Social Care, 2009; NICE, 2018,); even more advanced high-income countries, such as Japan's mature age demographic, face specific, although varied challenges regarding these resources.

These combined findings suggest that the objectives have been fulfilled, demonstrating that the characteristics of dementia and the implications on its victims are well-established (Objectives 1 & 2), person-centred dementia care complemented by medical knowledge leads to best results (Objective 3), though some barriers continue to obstruct adequate delivery of that care in practice (Objective 4).

5.2 Recommendations

5.2.1 Recommendation 1: Embed structured person-centred care training, including communication skills, into mandatory staff development.

Given the weight of evidence favouring person-centred approaches in dementia care (Kitwood, 1997; Brooker, 2007; Livingston et al., 2020), the foremost recommendation is that UK health and social care services embed formal, practical Person-centred training systems such as the VIPS approach, alongside communications skill development, into all mandatory staff induction programmes and ongoing professional development. This is also supported by the findings of Eggenberger, Heimerl and Bennett (2013) in their systematic review of evidence showing communications training to be beneficial to dementia patients in a range of care environments. The benefit of this recommendation to practice is that, in this, the VIPS model, and other related communications models exist in a fully developed, ready-to-teach format making this a feasible goal rather than requiring further theoretical conceptualization.

The primary obstacle to implementing this recommendation will be one of resources and time as current workforce pressures mean staff have limited time to dedicate to extra training.

This may be managed by incorporating this training within existing frameworks of mandatory induction and CPD which occur periodically.

5.2.2 Recommendation 2: Strengthen monitoring and accountability mechanisms for existing dementia care guidance.

The finding of the inadequate implementation of existing guidelines such as NICE (2018), and the now outdated National Dementia Strategy (Dept of Health and Social Care, 2009), means it is difficult to judge the impact of a plethora of strategies and policies. The second recommendation, therefore, is that the health and social care sector should incorporate stronger monitoring and accountabilities that link specifically to dementia care, so as to ensure standards of care outlined in guidance can be actively evidenced at the point of service provision. An important consideration in implementing this recommendation will be that monitoring processes themselves represent a resource intensive activity, and to that end, should seek to complement, rather than duplicate, existing quality assurance processes. For example, dementia care standards might be specifically reviewed as part of existing Care Quality Commission (CQC) inspections or audits already undertaken within health and social care.

5.2.3 Recommendation 3: Pilot community-based care models informed by international approaches.

Japan's focus on developing community-based responses for a growing age cohort of its population, as represented through its national plan (Ishihara et al., 2023), represents an alternative model to the predominantly facility based care of the U.K, the third recommendation is therefore to, consider piloting versions of community based care models (akin to Japan's approach) aimed at relieving pressure on formal care facilities as part of the spectrum of care alongside providing additional capacity to support informal care giving arrangements [as discussed in relation to LMIC]. There would of course be a need to critically engage with a model developed in a Japanese context and adapt it to the UK, where existing provision structures and national policy differ. To facilitate this, there should be a series of local pilot initiatives established across different settings in the UK to assess the feasibility and effectiveness of an adapted community-based dementia care model, before wider scaling up of effective designs.

Chapter 6 - References and Appendices:

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6.2 Appendices

Appendix 1- Thematic Analysis Spreadsheet:

Theme Summary

Theme	Number of Sources
Theme 1: Types of Dementia & Impact on Daily Living	11
Theme 2: Person-Centred Care v Biomedical Care	5
Theme 3: Challenges in Delivering Dementia Care	4
Methodology (not a theme)	3

A	B	C	D	E	F	G	H	I
Thematic Coding Tracker — Dementia Care Dissertation								
No.	Author & Year	Source Title	Database/Platform	CRAAP Check (Y/N)	Key Codes Identified	Theme (Chapter 4)	Linked Objective	Notes
1	Alzheimer's Society (2024)	How many people have dementia in the UK?	Alzheimer's Society website	Y	UK prevalence; 982,000 figure	Theme 1: Types of Dementia & Impact on Daily Living	Objective 1/2	Opening UK prevalence statistic, used in Theme 1
2	Alzheimer's Disease International (n.d.)	Alzheimer's Disease International	Organisation website	N	Origin of Alzheimer's disease naming; historical discovery	Theme 1: Types of Dementia & Impact on Daily Living	Objective 1	No publication date; used for historical bi Theme 1)
3	Gm, M. et al. (2011)	The diagnosis of dementia due to Alzheimer's disease: NIA-AA workgroup recommendations	PubMed	Y	Diagnostic criteria; Alzheimer's disease	Theme 1: Types of Dementia & Impact on Daily Living	Objective 1	Author name likely a formatting artefact G.M. et al.' — check original citation
4	McKeith, I.G. et al. (2017)	Diagnosis and management of dementia with Lewy bodies	PubMed / Neurology	Y	Lewy body dementia; diagnostic criteria	Theme 1: Types of Dementia & Impact on Daily Living	Objective 1	Peer-reviewed clinical guideline
5	Prince, M. et al. (2015)	World Alzheimer Report 2015: the global impact of dementia	Alzheimer's Disease International	Y	Global prevalence; informal/family care in LMICs	Theme 1: Types of Dementia & Impact on Daily Living	Objective 1/2	Also used in Ch.2 international context in low/middle-income countries
6	Care Act 2014	Care Act 2014	legislation.gov.uk	Y	Legal duty of care; ADLs; local authority duty	Theme 1: Types of Dementia & Impact on Daily Living	Objective 2	UK legislation underpinning legal right to living needs
7	World Health Organization (2025b)	Dementia (fact sheet)	WHO website	Y	Dementia definition; symptoms; global scale	Theme 1: Types of Dementia & Impact on Daily Living	Objective 1	Core definition of dementia used in Ch.1
8	NHS (2024)	Alzheimer's Disease	NHS website	N	Protein build-up; Alzheimer's disease mechanism	Theme 1: Types of Dementia & Impact on Daily Living	Objective 1	Used in Ch.1 definitions section
9	National Institute on Aging (2024)	What happens to the brain in Alzheimer's disease?	NIA website	N	Brain changes; disease mechanism by dementia type	Theme 1: Types of Dementia & Impact on Daily Living	Objective 1	Used in Ch.1 to distinguish dementia type alteration
10	BBC (2018)	What is the NHS? - CBBC Newsround	BBC website	N	NHS definition; public funding	Theme 1: Types of Dementia & Impact on Daily Living	Chapter 1 definitions	Simplified source used only for basic NH definitions
11	World Health Organization (2025a)	About WHO	WHO website	N	Organisational role; global health coordination	Theme 1: Types of Dementia & Impact on Daily Living	Chapter 1 definitions	Used to define WHO's role, not a research source
12	Kitwood, T. (1997)	Dementia Reconsidered: The Person Comes First	UWTSO Library	Y	Personhood; individualised care; biomedical critique	Theme 2: Person-Centred Care v Biomedical Care	Objective 3	Foundational PCC text; retained despite Authority & Relevance
13	Brooker, D. (2007)	Person-Centred Dementia Care: Making Services Better	UWTSO Library	Y	VIPS framework; dignity; staff attitudes	Theme 2: Person-Centred Care v Biomedical Care	Objective 3	Operationalises Kitwood's theory via the VIPS framework
14	Livingston, G. et al. (2020)	Dementia prevention, intervention, and care: 2020 Lancet Commission report	The Lancet / Google Scholar	Y	Risk factors; PCC outcomes; reduced behavioural symptoms	Theme 2: Person-Centred Care v Biomedical Care	Objective 3	Empirical/epidemiological support for PCC impact
15	World Health Organization (2017)	Global Action Plan on the Public Health Response to Dementia 2017-2025	WHO	Y	International policy; rights-based, person-centred approach	Theme 2: Person-Centred Care v Biomedical Care	Objective 3	International policy backing for PCC as a public health response
16	Eggenberger, E., Heimerl, K. and Bennett, M.I. (2013)	Communication skills training in dementia care: a systematic review	PubMed / Int. Psychogeriatrics	Y	Communication training; staff-patient interaction; care quality	Theme 2: Person-Centred Care v Biomedical Care	Objective 3/4	Supports Recommendation 1 (Ch.5); link practical staff training
17	NICE (2018)	Dementia: assessment, management and support for people living with dementia and their carers	NICE	Y	Diagnosis pathway; staff training; assessment standards	Theme 3: Challenges in Delivering Dementia Care	Objective 4	UK policy-relevant official guidance
18	Department of Health and Social Care (2009)	Living Well with Dementia: A National Dementia Strategy	gov.uk	Y	UK policy; early diagnosis; workforce planning	Theme 3: Challenges in Delivering Dementia Care	Objective 4	Foundational UK policy document; noted no longer active
19	Department of Health and Aged Care (2023)	National Dementia Action Plan	health.gov.au	Y	Australian policy; ageing population; workforce planning	Theme 3: Challenges in Delivering Dementia Care	Objective 4	International comparison — high-income country
20	Ishihara, M. et al. (2023)	A policy overview of Japan's progress on dementia care in a superaged society	Global Health & Medicine journal	Y	Community-based care; superaged society; inclusion & risk reduction	Theme 3: Challenges in Delivering Dementia Care	Objective 4	International comparison — Japan's care response