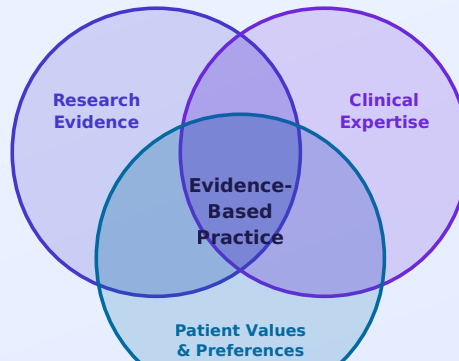




Non-Pharmacological Pain Management in Older Adults with Dementia

A Critical Evidence-Based Review

MODULE	NUR2010 Evidence-Based Nursing
LEVEL	5 (UK QF)
WORD COUNT	~3,000 words
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TARGET GRADE	Distinction (70%+)

APA 7th | 24 References | Approx. 3,000 Words

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1. Introduction

Evidence-based practice (EBP) represents the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients (Sackett et al., 1996). Far from a narrow reliance on randomised trials, EBP integrates research findings with individual clinical expertise and patient values to deliver care that is both scientifically rigorous and profoundly person-centred (Melnik & Fineout-Overholt, 2019). This principle acquires particular urgency in complex clinical presentations where the gap between available evidence and routine practice remains wide — such as the assessment and management of pain in older adults living with dementia.

Dementia affects approximately 57 million people globally and is projected to reach 153 million by 2050 (World Health Organization, 2019). Within this population, pain is both highly prevalent and systematically underrecognised, largely because cognitive and communicative impairment precludes conventional self-report (Achterberg et al., 2020). The default reliance on pharmacological analgesia in this group — particularly opioids — carries substantial risks including sedation, falls, delirium, and polypharmacy interactions (Sieber & Barnett, 2011). Non-pharmacological interventions therefore represent a clinically compelling, lower-risk alternative that warrants rigorous appraisal.

This assignment employs the PICO framework to formulate a structured clinical question about non-pharmacological pain management in older adults with dementia. A systematic search of four electronic databases was conducted, and four key studies were selected for in-depth appraisal using Critical Appraisal Skills Programme (CASP) criteria. The assignment proceeds to synthesise findings, examine barriers and facilitators to implementation using established frameworks, and address the ethical dimensions

of EBP in this context. All sources are referenced in APA 7th edition format.

2. Background and Clinical Significance

Pain is a universal human experience, yet its assessment and management in individuals with dementia constitutes one of the most clinically challenging domains in contemporary nursing practice. Dementia encompasses a spectrum of progressive neurodegenerative conditions — including Alzheimer's disease, vascular dementia, and Lewy body dementia — all of which impair cognition, verbal communication, and self-awareness to varying degrees over time (National Institute for Health and Care Excellence [NICE], 2018). As the disease advances, the loss of reliable verbal capacity renders conventional self-report pain scales, such as the Numeric Rating Scale, inapplicable.

Despite this communicative barrier, research consistently demonstrates that people with dementia experience pain at rates comparable to cognitively intact older adults, with prevalence estimates in care home settings ranging from 45% to 80% (Achterberg et al., 2020). A critical clinical problem is that pain in this population frequently manifests as behavioural and psychological symptoms of dementia (BPSD), including agitation, vocalisation, restlessness, and aggressive behaviour — symptoms which are readily misattributed to the dementia itself rather than identified as pain expressions (Husebo et al., 2014). This misattribution perpetuates a cycle of undertreatment, with pain going unaddressed while antipsychotic medications are increasingly prescribed to manage behaviour (NICE, 2018).

To address this assessment gap, validated observational tools have been developed and internationally evaluated. The PAINAD (Pain Assessment in Advanced Dementia) scale assesses five domains — breathing, vocalisation, facial expression, body language, and consolability — producing a score from 0 to 10 that does not require patient co-operation (Snow et al., 2004). The Abbey Pain Scale offers a rapid one-minute assessment validated specifically

for end-stage dementia (Abbey et al., 2004), while the MOBID-2 evaluates pain during guided movement routines and has been validated for nursing home populations (Husebo et al., 2011). Herr et al. (2019), on behalf of the American Society for Pain Management Nursing, issued a position statement affirming that pain assessment must not be abandoned simply because patients cannot self-report, establishing a professional imperative to use behavioural tools. The Nursing and Midwifery Council (NMC, 2018) Code reinforces this obligation, requiring nurses to actively seek to understand and address the needs of those in their care, regardless of communicative capacity.

3. PICO Framework and Search Strategy

3.1 PICO Question

The PICO framework was employed to construct a focused and answerable clinical question that could guide a systematic literature search. PICO is a widely adopted structuring tool in evidence-based nursing that helps ensure searches are comprehensive, targeted, and replicable (Melnik & Fineout-Overholt, 2019). The following question was formulated:

Clinical Question: In older adults aged 65 and over with a diagnosis of dementia who are experiencing pain (P), do non-pharmacological interventions including music therapy, therapeutic touch, and structured activity programmes (I), compared with standard pharmacological management alone (C), result in reduced pain scores, decreased agitation, and improved quality of life (O)?

P	Population	Older adults aged 65 and over with a confirmed diagnosis of dementia (Alzheimer's disease, vascular dementia, Lewy body dementia) in acute, community, or residential care settings experiencing pain
I	Intervention	Non-pharmacological pain management interventions: music therapy (live or recorded), therapeutic touch and massage, structured activity programmes, aromatherapy, and person-centred care approaches
C	Comparison	Standard pharmacological pain management alone, or usual care without specific non-pharmacological intervention
O	Outcome	Reduction in pain scores (validated observational scales); decreased agitation and BPSD; improved quality of life; reduction in antipsychotic or analgesic prescribing; patient and carer wellbeing

3.2 Database Search and PRISMA Flow

The structured search was conducted across four electronic databases: CINAHL (Cumulative Index to Nursing and Allied Health Literature), MEDLINE via PubMed, PsycINFO, and the Cochrane Library of Systematic Reviews. Boolean search strings using Medical Subject Headings (MeSH) where available were constructed as follows: (*"dementia" OR "Alzheimer's disease" OR "cognitive impairment"*) AND (*"non-pharmacological" OR "music therapy" OR "therapeutic touch" OR "massage" OR "aromatherapy"*) AND (*"pain management" OR "pain relief" OR "pain assessment"*) AND (*"older adults" OR "elderly" OR "nursing home" OR "care home"*). Searches were limited to English-language, peer-reviewed publications from 2011 to 2024 with participants aged 65 and over.

The PRISMA (Preferred Reporting Items for Systematic Reviews and Meta-Analyses) framework (Moher et al., 2009) was applied to document the search and selection process. The initial search yielded 487 records. Following removal of 94 duplicates, 393 records were screened by title and abstract; 351 were excluded as irrelevant to the PICO question. Forty-two full-text articles were assessed for eligibility; 18 were excluded (wrong population, $n = 7$; wrong intervention, $n = 6$; wrong outcome, $n = 5$). Twenty-four

studies met inclusion criteria, of which four were selected for in-depth CASP appraisal based on methodological rigour, relevance to the PICO question, and evidence level (see Figure 1).

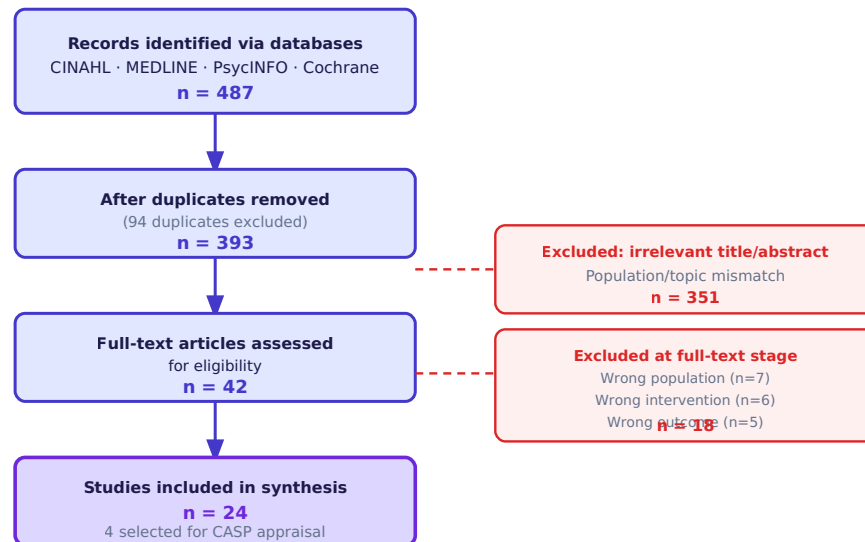


Figure 1. PRISMA-adapted search and selection flowchart for the systematic literature review. Databases searched: CINAHL, MEDLINE (PubMed), PsycINFO, and Cochrane Library (searches conducted July 2026). Reporting adapted from Moher et al. (2009).

4. Critical Appraisal of Evidence

4.1 The CASP Framework and Evidence Hierarchy

Critical appraisal is the systematic evaluation of research evidence to assess its validity, reliability, and clinical relevance (Critical Appraisal Skills Programme, 2018). The CASP tool provides study design-specific checklists — for systematic reviews, RCTs, and qualitative studies — enabling practitioners to make structured judgements about the quality of evidence before applying it to clinical decision-making. Melnyk and Fineout-Overholt (2019) propose a seven-level hierarchy of evidence, with systematic reviews and meta-analyses at the apex (Level I), followed by RCTs (Level II), non-randomised controlled trials (Level III), cohort and case-control studies (Level IV), systematic reviews of descriptive or qualitative studies (Level V), individual descriptive or qualit-

ive studies (Level VI), and expert opinion (Level VII). This hierarchy informed the weighting assigned to each appraised study and is illustrated in Figure 2 below.

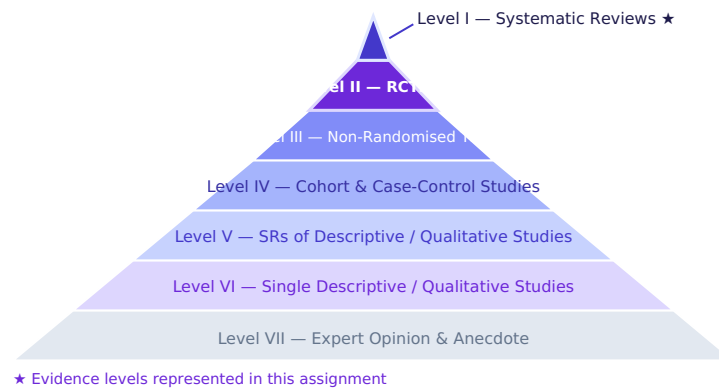


Figure 2. Seven-level evidence hierarchy adapted from Melnyk and Fineout-Overholt (2019). Levels I and II (highlighted) represent the evidence levels of studies selected for CASP appraisal in this assignment. Systematic reviews (Level I) and randomised controlled trials (Level II) constitute the highest tiers of evidence for clinical decision-making.

4.2 Cousins et al. (2020) — Systematic Review

Cousins et al. (2020) conducted a systematic review published in *BMJ Open* examining non-pharmacological interventions for pain in people with dementia, encompassing 31 studies across multiple intervention types including music therapy, massage, exercise, and multi-sensory stimulation. CASP appraisal identifies several methodological strengths. The review employed a comprehensive multi-database search strategy, applied PRISMA reporting standards (Moher et al., 2009), and assessed risk of bias using validated tools (Cochrane Risk of Bias Tool). Where meta-analysis was not feasible due to heterogeneity, narrative synthesis was appropriately employed. The review represents Level I evidence — the highest tier of the evidence hierarchy.

Limitations centre on significant clinical and methodological heterogeneity across included studies, arising from variation in dementia severity, pain assessment instruments, intervention protocols, and delivery contexts. This heterogeneity constrained the

ability to draw definitive quantitative conclusions. The authors acknowledge that the evidence was predominantly low to moderate quality, reflecting the substantial challenges of conducting rigorous RCTs in cognitively impaired populations. Nevertheless, the review provides the most comprehensive current synthesis of non-pharmacological approaches in this area. Key findings indicate that music therapy — particularly live, individualised music — demonstrated the most consistent evidence of pain and agitation reduction. Massage and therapeutic touch showed promising but less certain results, as unblinded delivery creates performance bias risk. The review concludes that non-pharmacological interventions should be considered adjuncts to, rather than replacements for, pharmacological care.

4.3 Husebo et al. (2011) — Cluster RCT

Husebo et al. (2011) published a landmark cluster RCT in *The BMJ* — the MOBID-2 Pain Behaviour Study — randomising 352 nursing home residents with moderate-to-severe dementia across 18 facilities in Norway to either a stepwise pain treatment protocol or treatment as usual. The intervention arm received systematic pain assessment using the MOBID-2 observational tool, followed by individualised analgesia titrated to assessed need. CASP appraisal confirms methodological rigour: cluster-level randomisation was employed to prevent contamination between residents, outcome assessors were blinded, and the primary outcome (agitation, measured by the Cohen-Mansfield Agitation Inventory) was pre-specified. The eight-week follow-up demonstrated statistically significant reductions in agitation ($p < 0.001$) and improvements in overall wellbeing in the intervention group compared to controls.

Whilst this study constitutes Level II evidence with a low risk of bias, two limitations merit discussion. First, the Norwegian care home setting raises questions about direct transferability to UK acute care contexts, where staffing ratios, organisational culture, and assessment protocols may differ substantially. Second, the in-

intervention incorporated pharmacological analgesia (paracetamol, buprenorphine) as part of the stepwise protocol, rather than being purely non-pharmacological, which must be acknowledged when aligning findings with the PICO question. Nonetheless, the study powerfully demonstrates that systematic assessment itself — the recognition and documentation of pain — is a therapeutic act that significantly reduces behavioural disturbance, regardless of the subsequent treatment modality selected.

4.4 Landsbury et al. (2021) — Systematic Review of Music Interventions

Landsbury et al. (2021) published a systematic review in *Psychogeriatrics* examining music interventions for pain in people with dementia, synthesising ten studies encompassing 417 participants. CASP appraisal highlights several strengths: the review used predefined eligibility criteria, employed dual independent screening to minimise reviewer bias, and assessed evidence quality using the GRADE approach. The principal finding is that there is moderate-quality evidence that music therapy reduces both self-reported pain (where applicable) and observational pain indicators during procedural activities such as bathing and wound dressing. Live music administered by trained music therapists produced larger effect sizes than recorded music, though both formats demonstrated meaningful benefit over control conditions.

Limitations include the small sample sizes of constituent primary studies, inconsistency in outcome measurement instruments across studies, and absence of participant or therapist blinding in most included trials — elevating performance bias risk. The review itself acknowledges moderate certainty of evidence using GRADE criteria. Despite these constraints, the clinical utility of music therapy as a low-cost, patient-acceptable intervention is strongly supported. The pragmatic advantages are noteworthy: patient-preferred music requires minimal specialist training for administration and can be integrated into routine nursing procedures with negligible resource burden.

4.5 Ballard et al. (2018) — Person-Centred Care RCT

Ballard et al. (2018) conducted the WHELD (Well-being and Health for People with Dementia) pragmatic RCT, published in *PLOS ONE*, evaluating person-centred care training and social interaction across 69 UK care homes involving 847 residents with dementia. Although not exclusively a pain management study, its findings are directly relevant to the PICO question: person-centred approaches incorporating individualised meaningful activity and therapeutic social interaction significantly reduced agitation — a primary behavioural correlate of unmanaged pain — and led to a statistically significant reduction in antipsychotic prescribing ($p = 0.01$). Quality of life improved significantly in the intervention arm.

CASP appraisal confirms important methodological strengths: the large, representative sample, pragmatic UK-based design, and sustained nine-month follow-up considerably enhance the applicability of findings to NHS care home settings. The study's primary limitation is the composite nature of the intervention — combining staff training, person-centred activities, and antipsychotic medication review — which makes it methodologically difficult to attribute improvement to a single component. The study nevertheless constitutes Level II evidence and provides one of the most contextually relevant empirical contributions to the evidence base, demonstrating that non-pharmacological, person-centred approaches can achieve meaningful clinical improvements at organisational scale in UK dementia care.

CASP Criterion	Cousins et al. (2020) Systematic Review	Husebo et al. (2011) Cluster RCT	Landsbury et al. (2021) Systematic Review	Ballard et al. (2018) Pragmatic RCT
Evidence Level	Level I	Level II	Level I	Level II
Sample / Scale	31 studies	n = 352 (18 clusters)	10 studies (n = 417)	n = 847 (69 UK care homes)
Clear Research Question	✓ Yes	✓ Yes	✓ Yes	✓ Yes
Appropriate Methodology	✓ Comprehensive SR	✓ Cluster RCT	✓ SR with GRADE	✓ Pragmatic RCT
Risk of Bias	Low–Moderate	Low	Moderate	Low
Blinding	N/A (SR)	Assessor blinded	N/A (SR)	Partial (assessors)
PRISMA / Reporting	✓ PRISMA applied	✓ CONSORT applied	✓ PRISMA applied	✓ CONSORT applied
Ethical Approval	✓ Confirmed	✓ Norway REC	✓ Confirmed	✓ ISRCTN confirmed
UK Applicability	Moderate	Moderate (Norwegian)	Moderate	High (UK setting)
Relevance to PICO	High	Moderate (mixed Tx)	High	High

Table 1. CASP-guided appraisal summary of four key studies. Evidence levels based on Melnyk and Fineout-Overholt (2019) hierarchy. Tx = treatment. SR = systematic review. REC = Research Ethics Committee. ISRCTN = International Standard Randomised Controlled Trial Number.

5. Synthesis and Application to Practice

Taken collectively, the four appraised studies provide converging evidence that non-pharmacological interventions offer clinically meaningful reductions in pain and pain-related behavioural disturbance in older adults with dementia. The evidence base, while characterised by methodological heterogeneity and predominantly low-to-moderate quality ratings using GRADE, is consistent in its directional conclusions: structured, individualised, non-pharmacological approaches — most notably music therapy, therapeutic touch, and person-centred social interaction — produce measurable benefits at acceptable risk levels and align with NICE guideline NG97 (NICE, 2018), which recommends non-pharmaco-

logical approaches as the first-line response to agitation in dementia.

The synthesis yields several practice implications of direct clinical relevance. First, and most foundationally, systematic pain assessment using validated behavioural tools must precede any intervention. Husebo et al. (2011) demonstrate that the act of structured assessment itself — using MOBID-2 to identify and document pain that had previously been unrecognised — produced significant reductions in agitation independent of treatment. Schofield (2018), in the UK National Guidelines on pain assessment in older people, recommends that validated behavioural tools be used systematically at regular intervals and before, during, and after any potentially painful procedure in patients who cannot self-report. This recommendation is consistent with the NMC Code (NMC, 2018) requirement that nurses use the best available evidence to make person-centred, clinical decisions.

Second, music therapy emerges from the synthesis as the most robustly evidenced single non-pharmacological intervention. Landsbury et al. (2021) and Cousins et al. (2020) independently conclude — despite drawing on overlapping but distinct study pools — that music reduces procedural pain and agitation indicators with a low harm profile. For clinical implementation, patient-preferred music played during painful or distressing procedures (wound care, repositioning, physiotherapy) can be introduced at minimal cost. The distinction drawn by Landsbury et al. between live and recorded music is worth noting: where trained music therapists are available, live individualised music achieves larger effect sizes. However, the pragmatic use of recorded music — guided by carer or family-provided preference histories — represents a readily implementable, cost-neutral intervention accessible to any ward nurse.

Third, the evidence from Ballard et al. (2018) demonstrates that person-centred approaches must be embedded at the organisational level, not confined to individual nurse behaviours. Sustained improvement in agitation and reductions in antipsychotic

prescribing were achieved only through systemic staff training, suggesting that EBP implementation requires both individual competence development and organisational cultural change. This aligns with Levett-Jones's (2018) assertion that clinical reasoning in nursing entails contextual adaptation of evidence rather than uniform application of guidelines.

Applying these findings to an individual patient requires thoughtful individualisation. Consider Mrs Patel (a fictitious patient constructed for illustrative purposes only), a 78-year-old woman with moderate Alzheimer's disease admitted to an orthopaedic ward following a hip replacement. Pain assessment using the PAINAD scale during morning carer activities reveals a score of 6/10, despite no verbal complaint. Evidence-based application would include: systematic PAINAD assessment before and during procedures; the use of Hindi classical music during wound dressing changes, guided by family preference history; and scheduled therapeutic touch through hand massage during quiet periods. These interventions, delivered within a person-centred care philosophy, represent the integration of research evidence, nursing expertise, and patient values that Sackett et al. (1996) identify as the essence of EBP.

6. Barriers and Facilitators to Implementation

Translating research evidence into routine nursing practice is rarely straightforward. The PARIHS (Promoting Action on Research Implementation in Health Services) framework (Kitson et al., 1998) provides a useful analytical lens, conceptualising implementation success as a function of three interacting elements: the strength and coherence of the *evidence*, the receptiveness of the *context* (organisational culture, leadership, and evaluation capacity), and the effectiveness of *facilitation* (support mechanisms for change). Applying PARIHS to the current evidence base reveals a complex landscape of barriers and facilitating factors.

With respect to the evidence domain, nurses may lack confidence in interpreting and applying systematic reviews characterised by

heterogeneous findings and predominantly moderate GRADE ratings. Melnyk et al. (2012) found that despite strong endorsement of EBP as a professional ideal, many nurses report insufficient knowledge and skills to critically appraise research — a gap that directly constrains translation into practice. The variable quality of evidence identified in the appraised studies may further lead clinicians to discount findings as insufficiently definitive to justify changing established practice patterns. This underscores the rationale for NUR2010 as a module: developing research literacy and critical appraisal skills constitutes the foundational investment required to close the evidence-to-practice gap.

Contextual barriers are equally significant. Workforce pressures represent a fundamental constraint: the Royal College of Nursing (2019) has documented sustained nursing shortages across NHS settings, with staffing deficits that create environments in which time for non-pharmacological interventions may be genuinely difficult to protect. Music therapy, therapeutic touch, and structured meaningful activity require dedicated nursing or therapeutic time — a resource that acute ward environments frequently cannot supply. Ward culture may additionally perpetuate a pharmacological-default orientation toward pain management, particularly where dementia-specific training is absent or infrequent. Attitudinal barriers — including therapeutic nihilism about the treatability of dementia-related pain — have also been documented (Achterberg et al., 2020) and may subtly undermine the motivation to adopt non-pharmacological approaches.

Against these barriers, several meaningful facilitators operate. The Iowa Model of Evidence-Based Practice (Titler et al., 2001) identifies clinical champions — senior nurses who actively advocate for, model, and disseminate EBP — as the most consistently effective drivers of practice change at ward level. Where ward managers and link nurses champion dementia pain assessment as a quality priority, supported by protected time for training and clinical audit, implementation is substantially more likely to be sustained. The NHS England Long Term Plan (2021) commitment to

dementia-inclusive, person-centred NHS care provides an enabling policy environment and legitimises investment in EBP development.

A frequently underutilised facilitator is family and carer involvement. Cousins et al. (2020) note that family members possess contextual knowledge of patient preferences — including musical tastes, meaningful activities, cultural values, and individualised pain communication patterns — that is indispensable to effective targeting of non-pharmacological interventions. The NMC Code (2018) explicitly requires nurses to work in partnership with service users and their families, providing professional mandate to formalise this engagement within care planning documentation. The relatively low financial cost and low adverse effect profile of music therapy and therapeutic touch further reduce institutional barriers to adoption, in comparison to pharmacological alternatives that require prescribing pathways, monitoring protocols, and adverse effect surveillance.

7. Ethical Considerations

The management of pain in individuals with dementia raises important ethical questions concerning autonomy, informed consent, and the nurse's advocacy role. The Mental Capacity Act 2005 (MCA) establishes a presumption of mental capacity that must not be displaced without proper assessment, and requires that all practicable steps be taken to support an individual in making or expressing a decision before any determination of incapacity is reached. Where capacity is genuinely assessed as absent, decision-making must proceed on the basis of best interests, taking into account the person's previously expressed wishes, values, and preferences — as communicated by family, carers, and where appropriate an Independent Mental Capacity Advocate (IMCA).

In the context of non-pharmacological pain interventions, the ethical imperative is to treat the patient as an active participant in their care to the greatest extent possible. Even in moderate-to-advanced dementia, patients retain the capacity to express prefer-

ences through non-verbal behaviour — accepting or resisting music, relaxing or tensing during touch. These expressions constitute a form of consent or refusal that nurses are ethically and professionally obligated to recognise and honour. The NMC Code (2018) requires nurses to act as advocates for people in their care, upholding their dignity and respecting individual differences, and explicitly directs nurses to involve service users in decisions about their care where possible.

The principle of non-maleficence — the obligation to do no harm — further strengthens the ethical case for non-pharmacological approaches. Sieber and Barnett (2011) document the substantial risks associated with opioid analgesics in elderly patients, including sedation, falls, delirium, and respiratory depression; risks that are amplified in the presence of cognitive impairment. Non-pharmacological interventions carry minimal direct harm risk, reinforcing their ethical as well as clinical preferability as first-line adjuncts. Nurses must balance this evidence-based ethical imperative with respect for the patient's holistic care context, ensuring that non-pharmacological approaches complement rather than replace appropriately prescribed analgesia where pain is severe or persistent.

8. Conclusion

This assignment has demonstrated that the principles and methods of evidence-based practice provide a coherent and clinically productive framework for addressing one of the most complex challenges in contemporary nursing: managing pain in older adults with dementia. Through systematic application of the PICO framework, a structured multi-database literature search, and CASP-guided critical appraisal of four key studies, a convergent evidence base was identified in support of non-pharmacological interventions as meaningful, low-risk adjuncts to standard pharmacological care.

Music therapy emerges as the intervention with the most consistent and robust evidence profile, supported by two independent

systematic reviews (Cousins et al., 2020; Landsbury et al., 2021) and shown to reduce pain and agitation during procedures with minimal resource requirements. Person-centred care, when embedded at the organisational level through staff training and cultural change, produces sustained clinical improvements in UK care home settings (Ballard et al., 2018). Systematic assessment using validated behavioural tools — PAINAD, Abbey Pain Scale, or MOBID-2 — constitutes the essential prerequisite for any effective intervention strategy, as demonstrated by Husebo et al. (2011). Without assessment, pain remains invisible; without evidence, assessment lacks direction.

Barriers to implementation — including nurse knowledge gaps, workforce pressures, and pharmacological-default ward cultures — are real and should not be minimised. However, the PARIHS framework and the Iowa Model of Evidence-Based Practice provide structured pathways through which clinical champions, targeted education, and organisational commitment can progressively translate evidence into sustained practice change. Ethical practice requires nurses to advocate for cognitively impaired patients as active participants in their own care, upholding autonomy under the MCA 2005 and the NMC Code (2018) even where verbal communication is absent.

Evidence-based nursing is not a destination but an iterative, career-long process of questioning, searching, appraising, and applying. As digital, technology-assisted, and personalised non-pharmacological interventions continue to develop — including digital music platforms and AI-supported behavioural monitoring tools — nurses equipped with the critical appraisal competencies developed through NUR2010 will be best placed to evaluate emerging evidence and translate it into meaningfully improved outcomes for the most vulnerable patients in their care.

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