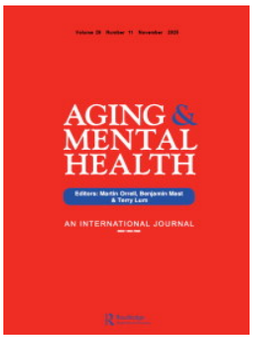

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Dementia-related crisis admissions destabilize regular care: a qualitative study among Dutch nursing-home staff

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ABSTRACT

Objectives: This study explores nursing-home staff experiences with crisis admissions of persons with dementia and their impact.

Method: A grounded theory approach based on semi-structured interviews with healthcare professionals from three Dutch nursing homes. The data were analyzed using Strauss and Corbin's coding paradigm.

Results: Seven doctors and eight nurses participated. They reported that crisis admissions destabilize regular care by disrupting unit structure, workflows, and team dynamics. Causal conditions include the unpredictability and complexity of these admissions, often involving clients with severe behavioral symptoms, limited background information, and urgent care needs. Contextual and intervening conditions, such as client characteristics, prior interventions, unit setup, and collaboration, further influence the extent of destabilization. These disruptions increase workload and challenge routines. To restore stability, staff employee strategies including adjusting schedules and procedures and enhancing collaboration. Despite these efforts, professionals report physical and emotional strain, ethical dilemmas, and feelings of inadequacy. However, crisis admissions also offer opportunities for learning, motivation, and team cohesion.

Conclusion: Crisis admissions can destabilize care, but targeted organizational strategies, such as improved information transfer, acute care protocols, and staff education, can mitigate impact. Tailored approaches are essential to safeguard staff well-being and ensure continuity in long-term dementia care.

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Dementia care; crisis admissions; nursing home; healthcare professionals perspectives; qualitative research

Introduction

Crises and admissions relating to dementia, driven by the need for 24-h care and the inability to live independently, are common and increasing. In the Netherlands, the number of crisis admissions rose between 2015 and 2022, from 2,350 to 4,575 per year (Zonneveld-Heil & van Beek, 2025). A crisis in dementia was previously defined as a situation in which a person with dementia or others are at risk of harm and immediate action is needed (MacNeil Vroomen et al., 2013). Crises are often caused by multiple factors and can be precipitated either by interacting factors or a single traumatic event. Precipitating factors include behavioral and physiological aspects, physical health conditions (e.g. infections, falls), vulnerability, family dynamics, and environmental characteristics (Ledgerd et al., 2016).

Crises disrupt the homeostasis of multiple systems (e.g. healthcare and social), challenging their capacity and coping mechanisms (Aguilera & Messick, 1974). The impact of a crisis thus extends beyond the person with dementia to affect informal caregivers, family members, friends, community members, general practitioners, medical services, law enforcement agencies, crisis intervention teams and support workers. Uncertainty during crises can generate feelings of guilt and helplessness, and conflicts may arise if the person with dementia is unaware of the crisis. Healthcare professionals play a crucial role in minimizing harm during crises and, although home care is preferred, inadequate support may necessitate acute hospital or long-term care admission (Hopkinson et al., 2021; Toot et al., 2013).

The few available studies on the impact of acute admission on hospital staff indicate low job satisfaction in the management of people with dementia, primarily due to feelings of inadequacy, insufficient education in mental health disorders, and inadequate resources in acute ward environments (Digby et al., 2017). The impact of acute admissions caused by a physical, mental or social condition on healthcare professionals working in nursing homes has yet to be investigated. This study explores the experiences of nursing-home

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staff with crisis admissions of persons with dementia, as well as the impact of such admissions. Results could help improve crisis management and mitigate negative impacts on residents and staff.

Materials & methods

Design

A grounded theory approach was used to inductively develop a conceptual model based on semi-structured interviews with healthcare professionals from three Dutch nursing homes. The data were analyzed using Strauss and Corbin's coding paradigm. Strauss and Corbin's coding paradigm was used to define a core phenomenon and identify causal conditions, context and intervening conditions, action strategies and consequences (Glaser, 1978). The study fell outside the remit of the Medical Research Involving Human Subjects Act (WMO file number 2022–13627). Results are reported according to the consolidated criteria for reporting qualitative research (COREQ) checklist for the reporting of qualitative studies (Appendix A) (Tong et al., 2007).

Study population and setting

Healthcare professionals directly involved in crisis admissions of persons with dementia were eligible to participate. In the Netherlands, this includes elder-care physicians (ECPs), ECPs in training, medical doctors (MDs), certified nurse assistants (CNAs), and registered nurses (RN's). In nursing homes, primary responsibility for medical care rests with the ECP, who specializes in geriatric medicine in primary care. Unit caregivers are mainly CNAs and nurses (Koopmans et al., 2010).

Participants were recruited from three nursing homes in the cities of Nijmegen and Eindhoven in the Netherlands, each employing approximately 3,000 staff members. Recruitment was conducted through professional networks, and participants were invited by email, which included information about the researcher, such as personal goals and the reasons for conducting the research. Background information was collected on the roles, work experience, and nursing-home affiliations of the professionals. To assure diversity in experiences and views, purposeful sampling was applied (Patton, 2014), based on gender, age, and working experience. At least one doctor (ECP, ECP in training, or MD) and one nurse (CNA or RN) from each participating nursing home were interviewed.

Data collection and analysis

A thorough review of existing literature on dementia crises informed the development of a preliminary topic list during a meeting among three researchers (MK: female ECP in training; MP: female general practitioner, PhD, and qualitative research expert; TH: female ECP in training, PhD, and experienced qualitative researcher) (Appendix B). The topic list was adjusted after each interview to ensure comprehensive coverage and relevance. The interviews, conducted by MK, were carried out face-to-face, by video, or by telephone, based on the interviewee's preference. Face-to-face interviews were held in private rooms at the nursing home. All interviews were audio-recorded and transcribed verbatim. Data collection and thematic analysis followed iterative and parallel processes, including open coding and axial coding in numerous group meetings between MK, TH, and/or MP. Data saturation was reached when no new relevant knowledge emerged, as confirmed by two additional interviews without novel codes or categories.

To explore and describe relationships between categories, TH and MP employed Strauss and Corbin's coding paradigm, which links categories and subcategories, detailing causal conditions, context, intervening factors, actions or strategies, and consequences relating to the phenomenon under investigation (Glaser, 1978). All analyses were supported by ATLAS.ti 8.4.22. Reflection in the research team on possible biases (e.g. based on personal experiences or professional research background) was performed to improve the trustworthiness and robustness of the data analysis.

Results

Seven doctors and eight nurses participated, with age ranging from 26 to 63 years, work experience in healthcare ranging from 2 to 35 years, and experience in dementia crisis admissions ranging from 3 months to 15 years (Table 1). Seven interviews were conducted face-to face, seven by video, and one by telephone. The average duration of the interviews was 30–45 min. Data saturation was reached after 13 interviews, as confirmed in two subsequent interviews.

The key finding is that healthcare professionals believe crisis admissions destabilize regular care. Using Strauss and Corbin's coding paradigm, the destabilization of regular care was explained in a framework based on the codes and categories identified in this study (Figure 1). Each component of this model is described in the following sections, interwoven with thematic findings. As an illustration, a crisis admission outlined by the interviewees is described in Box 1.

This framework illustrates how the central phenomenon, destabilization of regular care, emerges from various causal conditions, reasons underlying

Table 1. Interviewees characteristics.

Number	Age group	Gender	Professionals' roles	Years of work experience	Work experience with crises
1	1	F	ECP resident	2 years	2 years
2	1	M	ECP	5 years	4 months
3	1	F	MD	2 years	1 year
4	3	F	RN	18 years	14 years
5	1	M	ECP resident	5 years	9 months
6	1	M	CNA	5 years	5 years
7	2	F	Senior social care worker	15 years	5 years
8	3	F	ECP	25 years	15 years
9	1	M	RN	10 years	5 years
10	1	M	RN	10 years	2.5 years
11	3	M	CNA	35 years	5 years
12	3	F	CNA	5 years	5 years
13	2	F	RN	28 years	1.5 years
14	2	F	ECP resident	15 years	3 months
15	1	F	ECP	13 years	2 years

Age group 1 = 21–35 years; 2 = 36–50 years; 3 = 51–65 years.
M: Male; F: Female.
ECP: Elder care physician; MD: Medical doctor; CAN: Certified nurse assistant; RN: Registered nurse.

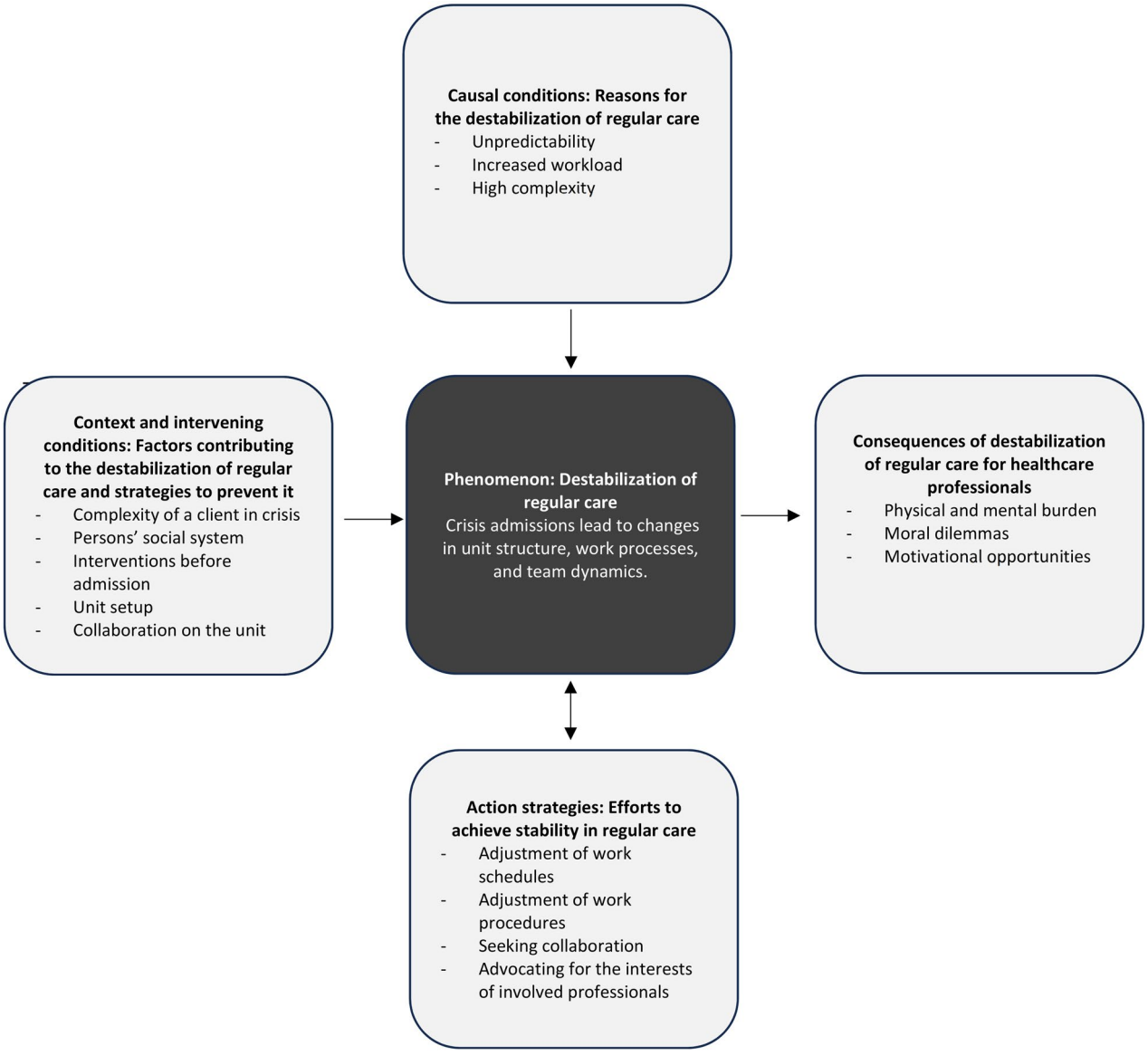

Figure 1. Framework for explaining the destabilization of regular care.

the destabilization. It is shaped by contextual and intervening conditions, which include contributing factors and strategies aimed at prevention. In response, action strategies are employed to restore or maintain stability in regular care. However, these action strategies can also feed back into the system, potentially reinforcing or exacerbating destabilization. Finally, the framework highlights the

Box 1. Description of a crisis admission

Interview 5: "That was a man who was single and, uh, yeah, actually an untenable situation at home. And there was actually never, you know, care-avoiding, never been to a GP, and eventually, well, through all sorts of channels, the home situation—the mental health crisis service got involved, and they actually, yeah, made that diagnosis of dementia almost on the street. And then he all ended up in my department at once. Uhm, but so it actually seemed that there was no health insurance, and no indication. So, uhm, yeah, there was a man who was completely unaware of the disease, with no understanding of it. And, actually, also uhm, with only a very limited social network. Uhm, he actually had just a girlfriend, who wanted to be involved, and he did have children, but they didn't really want anything more to do with him at all. Uhm, so yeah, it's been, uh, quite a puzzle, to do the right things for that man. But it was actually impossible to do it right for that man."

consequences of this dynamic interplay for healthcare professionals.

Phenomenon: destabilization of regular care

The primary perception of healthcare professionals regarding crisis admissions is that they destabilize routine care. Interviewees noted that such destabilization emerges across three dimensions.

Disruption of unit routines

Crisis admissions disrupt unit routines, thereby compromising care for other residents. While basic care is provided, interviewees described a potentially diminishing of focus on the well-being of residents.

> Interview 6: That just takes a lot of energy and a lot of time. It sometimes makes me want to, how do you say, rush—yeah, to plan ahead, because the care tasks keep going, medication keeps going. I have to do that in between, in a hurry and, sometimes, I don't have enough time for those people… Yeah, how do you say that, more participation, yeah, they like that sometimes, a bit of well-being, sitting with people, having conversations, doing activities. Uh, mainly that—yeah, that just doesn't work.

Crisis admissions can also cause distress among other residents, potentially escalating existing challenging behavior. Interviewees reported that family members of other residents often notice such disruptions and express concerns, advocating for additional care and attention for their relatives.

> Interview 7: That the family is also involved. And they have even more concerns. Because, yeah, mother now suddenly has to put up with such a man, who's now walking and shouting in the hallway at night, and mother is afraid: Can you please lock the door?

Deviation from work routines

Deviation from work routines occurs in care planning, where *ad hoc* schedules must be adjusted because of intake interviews or court hearings (in case of involuntary admission). Interviewees observed that planned tasks are postponed and must be addressed later.

> Interview 5: But yeah—I think—in at least half of all crisis admissions, you have to cancel other things because of them. Uh, another consultation or another visit to a regular resident. Uhm and, yeah, then you then have to make time for that again later. So it does kind of snowball, because then the rest of your schedule shifts as well.

In addition, intake interviews for crisis admissions sometimes take place outside office hours, involving an on-duty physician. Interviewees indicated that communication can be more challenging in such cases, particularly if the healthcare providers do not know each other.

The preparations for crisis admissions differ from regular admissions, as no adjustments can be made on the unit to optimize the client's stay. Examples cited include the absence of personal items that provide reassurance and delays in requesting necessary medication, thereby compromising medication safety.

Because crisis admissions are often temporary before transfer to a permanent unit, the healthcare providers involved must determine which care is essential and which can wait.

> Interview 5: And then it gets a bit tense—at least in my opinion—because, yeah, you know it's only a temporary place. So, well, what are you and are you not going to find out, you know, there are obviously sometimes medical issues or things relating to legal representation, uhm, you know, and then it sometimes takes a bit of juggling, something like, yeah, can I just leave this alone for a while, and can it be sorted out in a fixed place, or am I going to sort it all out now? Uhm yeah, but where is the balance; how much time do you want to spend on it? Do you think you should spend on it?

Interviewees indicated that, during crisis admissions, it is not always possible to follow guidelines, as acute situations often require urgent action, and the time and background information available is insufficient (e.g. to initiate non-pharmacological measures).

Altering team dynamics

Interviewees described that the high complexity of crisis admissions evokes different ideas, interests, and experiences in different healthcare providers. These diverse perspectives can change team dynamics, potentially causing friction within the team.

> Interview 1: Yes, that unrest does transfer itself, for example, to a core team, then something has to be done now. Yeah, it can't be like that, because it's all well and good that someone's coming, but if our own residents are bothered by it, yeah, then it does

> go too far. So, yeah, that's how it's presented, even though, yeah, you can't always solve it right away… Yeah, you also understand the concern…and when the issue is there, you feel like you ought to do something about it. But yeah, are you going to do that right away with medication, or in the way that the care system would ideally prefer. Or do you give it some time, so that the person can become acclimated in the department? Uhh so, yeah, that does create some turmoil in some cases, within the team and within the partnership.

Causal conditions: reasons for the destabilization of regular care

According to the interviewees, the following conditions contribute to the destabilization of routine care during crisis admissions.

Unpredictability associated with crisis admissions

The timing of crisis admissions can be uncertain, with admission times sometimes known only hours in advance. Interviewees perceived such unpredictability as a loss of control over schedules. In addition, uncertainty regarding discharge dates often necessitates last-minute paperwork.

The admission of persons with dementia without proper preparation generates unpredictable reactions, due to sudden environmental changes. Such unpredictability makes it challenging to determine the care needs of these persons. The limited availability of pre-admission information results in uncertainty regarding an individual's ability to connect with current residents. Although adherence to the unit's routines often prevents issues, the disruption caused by a crisis admission, combined with challenging behavior, can result in undesirable interactions between the client in crisis and other residents.

> Interview 9: When such turmoil is involved, I notice that clients who normally just sit together in the living room with a certain group, they are already somewhat, yeah, you could say "used to it." And then, all at once, there's a lot of noise in the hallway. Some people have an association with noise—from the past, uhm certain yelling, screaming behaviors that they learned from the home situation… And they sometimes just try to get involved, something like, ah, why are you screaming like that? And then they get even more of it. And then, yeah, that just works together, yeah, disease patterns together. It sometimes just doesn't click.

Increased workload resulting from crisis admissions

Interviewees indicated that the increased workload associated with crisis admissions results from their additional impact on the existing workload. One contributing factor is the frequent turnover of crisis admissions, which creates a heavy administrative burden due to essential tasks (e.g. intake assessments, care plans, and discharge letters).

> Interview 10: So we've really been at it for three full days now… And you're constantly evaluating with colleagues, team coaches, doctors, psychiatrists. But honestly, you're not set up for that. I'm actually supposed to be working in care, so I have to do all this on top of the care moments with clients and all the other tasks I have. That makes it a lot.

Higher complexity of crisis admissions relative to regular admissions

Interviewees emphasized the high complexity arising from frequent problematic behavior among persons with crisis admissions, along with the self-neglect that is common in the home environment. In general, the complexity of crisis admissions has increased over time, with a growing prevalence of combined psychogeriatric and psychiatric cases.

> Interview 2: I think that the crises themselves might have increased, uh, in terms of intensity; the cute, sweet old lady who just doesn't get it all anymore, and who wanders around a bit at night—I'm seeing that less and less. I'm seeing more and more complex cases involving wounds and physical problems, combined with psychogeriatrics or psychiatry—or we don't yet know what it is.

In many crisis admissions, only limited background information is available on the situation at home before admission, thus making it difficult to address both the physical and mental needs of the client immediately.

> Interview 7: Someone is coming, for whom we have requested a life history. We already have those, so, well, that's a tremendous help. Then you know a lot about that client from the past until shortly before admission, but also much earlier. You can facilitate on that… And a crisis is really like (claps hands), okay he's on the way. Well, then you read up on it, you try to create something like a file, and then you welcome the client and go from there.

Furthermore, the limited time available for getting to know the client and providing follow-up care makes it difficult to align care with their needs.

> Interview 13: But really making a good connection to what someone wants and making them feel safe—it just takes a little more time and information to get to know someone. And, in many cases, there just isn't enough.

Interviewees also noted that crisis admissions evoke complex and conflicting emotions in all parties involved, including doubts on the part of family members about the decision to admit their loved ones.

> Interview 2: Uhm and, yeah, you actually see a kind of, say, helplessness in those people. Something like, hey, we're glad that our mother is getting a little break, I think. But somehow you see that woman, and she's saying, yes., now I have to leave him behind, but I had promised to take care of him.

Context and intervening conditions: factors contributing to the destabilization of regular care, and strategies for preventing it

Interviewees described the following factors at both patient and unit level pertaining to the extent of destabilization of routine care.

Complexity of persons in crisis

This sub-category was coded as contributing to the destabilization of care. Crisis admissions can significantly disrupt regular care, especially when behavioral issues or legal measures are involved. Interviewees noted that crisis admissions are not always complex. Persons in crisis often adapt to the existing unit structure, thus minimizing disruptions to regular care. When behavioral issues (e.g. aggression, suspicion, limited awareness of illness) do arise, however, crisis admissions can complicate and significantly impact regular care. Involuntary admission is also destabilizing. Legal measures further compound the impact, requiring additional work. Even without legal measures, handling involuntary admissions is complex for healthcare professionals, who must continually assess the need for legal intervention.

> Interview 5: But, for example, take the admission I did yesterday, then it's described in a crisis letter—gee, yeah, she doesn't really have much of an overview anymore. So, yeah: admission or no admission—she really doesn't have any strong opinion on that. And then if I assess that a little bit, at the admission interview, yeah, it's a very borderline case with a lady, who's saying something like, do I have to stay here, and is everything at home locked up? And, uhm, she immediately gets very anxious—that she has to stay here and, actually, yeah, you get the feeling that she doesn't want to be here. So then, suddenly—from the start, you're thinking maybe we should consider whether detention should be an option after all. So, I think that it's even trickier than if someone comes in under an existing order.

Social systems of persons in crisis

This sub-category was coded as contributing to the destabilization of care. Overloaded or absent social systems complicate information gathering and increase tension during crisis admissions. When overloaded social systems are involved, it is even more challenging to obtain necessary information during crisis admissions. Seeking assistance from the client's family, who know them best, may not always be possible. In some cases, there is no available family support, or it remains unclear who the legal representative is for advocating during a crisis. Family disagreements and unrealistic expectations can also add tension during crisis admissions.

Interventions in the home situation prior to crisis admission

This sub-category was coded as a strategy for preventing destabilization. Early interventions at home, including crisis letters and ECP involvement, help prepare for smoother admissions and more informed care. Interviewees emphasize the importance of a crisis letter—containing comprehensive information about the patient's history, medication use, reason for crisis admission, and the course of events—during intake. They also recognize the value of involving an ECP in the home setting, along with home-care services. This approach provides more information, allows for interventions, and often results in better-prepared care upon admission.

Unit setup

This sub-category was coded as both contributing to the destabilization and as a strategy for preventing it. While crisis admissions outside office hours and inadequate facilities can destabilize care, preferences for dedicated crisis units reflect efforts to mitigate these challenges. Interviewees indicated that crisis admissions outside office hours cause additional distress, as persons in crisis often experience increasing levels of distress throughout the day, reaching their maximum level in the evening. Difficulty transitioning to a regular unit is challenging for both the client in crisis and the healthcare professionals involved. Interviewees also reported having insufficient training to handle complex crisis issues and inadequate facilities to manage behaviors (e.g. aggression).

> Interview 8: I think, and I'm speaking specifically about our psychogeriatric wards, that they're mainly used to providing warm, comforting care. You know, offering a cup of coffee, being kind, pampering, that sort of things. They haven't had any aggression training or anything like that, so they really struggle with how to deal with it.

When asked about preferences, interviewees expressed a preference for a dedicated crisis admission unit for targeted care, trained staff deployment, and customized approaches. Drawbacks of such units included the potential reinforcement of problematic behaviors and difficulty providing the necessary structure for persons in crisis, given their tendency to influence and reinforce each other's behaviors.

Extent of collaboration on the unit

This sub-category was coded as a strategy for preventing destabilization. Multidisciplinary collaboration and managerial support are seen as key strategies to reduce workload and improve crisis care coordination. Interviewees valued multidisciplinary teams and effective coordination among disciplines during crisis admissions. Involving a unit manager was also considered beneficial. Interviewees mentioned that unit managers add value by alleviating certain responsibilities, facilitating team coordination, providing support, and swiftly addressing necessary tasks, thus ultimately reducing the workload and inquiries directed at individual team members.

> Interview 1: Yes, as a whole, that's nice, because [the manager], yeah, then [the manager] also, uh, takes some things away for you. One example could be, the contact with the care system, which provides somewhat more supervision and support to the team. When it was truly necessary for certain things to be taken care of, she really did act quickly. You notice this too. For example, you can see that it's nice for team. And you notice it yourself—that fewer questions are directed to you.

One gap identified concerned the absence of psychologist involvement from the intake stage.

Action strategies: efforts to achieve stability in regular care, focusing on continuity of care

Interviewees mentioned several responses by individuals and teams aimed at ensuring the continuity of routine care and creating stability within the unit and individual work.

Adjustment of work schedules to accommodate crisis admissions

Despite the unpredictability and increased workload associated with crisis admissions, caregivers adjust schedules to ensure continuity of primary care. Non-client-related tasks are postponed. In addition, less attention is devoted to well-being activities (e.g. playing games or going outside for walks with residents).

> Interview 7: Then it really does compromise the care of other residents—or as we say, clients—yes. So, then, you put them to bed a little earlier; then, you're not there for them in activities. And then it's just: how do we get through the day and the evening.

When necessary, staff work overtime, and additional staff are deployed. To allocate time for crisis admissions it may necessary to disrupt daily routines of other residents (e.g. putting residents to bed earlier).

Adjustment of work procedures to accommodate the needs of the person in crisis

During crisis admissions, efforts are made to address multiple issues, including problematic behavior. Interviewees noted that comprehensive reports are generated, prioritizing alignment with the needs of residents. Additionally, if possible, unit selection takes crisis-related requirements into consideration. Although non-pharmacological interventions are sought, medication is also prescribed more readily than during regular admissions.

> Interview 2: …then I have to, uhh, sometimes—without too much information—deploy medicinal intervention to curb aggression, for example. And yes, then you sometimes find yourself giving intramuscular haldol, which is actually normally never used. But it's still a choice that you make, but without knowing, for example, that a major cardiac history is involved. So it's a matter of searching, and an ECG isn't possible. You're left with a measure of uncertainty, according to which you do have to make decisions to keep things safe for the department and for the care system.

Training helps healthcare professionals to manage specific behaviors (e.g. aggression).

Actively seeking collaboration between healthcare professionals

The effective management of challenges during crisis admissions calls for more intense collaboration, relative to regular admissions. Colleagues work across disciplines, and trainees receive direct supervision. Healthcare providers document which crisis beds are occupied and clearly outline the responsibilities of each caregiver.

> Interview 3: Uhm, because also, just…well, it wasn't very clear to others when…uhm…are the crisis beds occupied? Uhm, when will there be a new admission? When is somebody going to leave?…So, it was actually only very recently that we created a bit of an overview of that. These three beds are there. These people are occupying them now. They've been admitted, and then we can look around a bit to see…gee…when another bed will become available and how can we set it up.

Interviewees noted that proactive consultation and streamlined communication enhance collaboration.

> Interview 13: …we have a core team meeting every week, in which we also discuss crisis admissions. Yeah, and we also have good communications—say, with the geriatrics specialist, with Psychology, as well as with other disciplines—which are needed. We have short lines of communication with each other. That's really nice.

Advocating for the interest of professionals involved

Interviewees emphasized the need to support healthcare professionals during crisis admissions, due to increased workload and high complexity. Efforts include assessing transfers when necessary and

suspending admissions if workload becomes excessive. Personal boundaries are also established.

> Interview 7: Yes, because for our team, we also have—for example—a very nice traffic light list of our own. It states that, where we are crossing our own boundaries, what we can do, and how we can help each other in that regard. It also documents, for example, that you quickly notice that your co-workers are more likely to say, yes, while actually feeling like saying, no.

Consequences of the destabilization of regular care

Crisis admissions impact healthcare professionals personally in the following ways.

Physical and mental burden of crisis admissions

Interviewees reported that crisis admissions increase fatigue, due to increased work intensity. Crisis admissions often require healthcare professionals to work overtime, thus affecting their work-life balance. The unpredictability of crisis-admission dates also creates ongoing tension whenever a bed becomes vacant, as a new crisis admission could occur at any moment. The unpredictable behavior of persons during crisis admission contributes to feelings of distress and frustration, as described by interviewees.

> Interview 7: But, at times, that gentleman did exhibit primarily verbal aggression. Which really did make you, at least for a while—he did come into your personal space—and you thought, Okay, and now? What will he do next? Is he going to hit me now? It made you feel fear; you could feel the tension in that.

Frustration can arise when professionals are not heard by their colleagues, especially if they believe medication is necessary to ensure safety on the unit. It is also frustrating when families do not express appreciation for the efforts of healthcare professionals. Interviewees further highlighted emotional strain resulting from the severity of crisis-related issues.

> Interview 12: I try to empathize as much as I can, but I also notice that I take it home with me…and then I do talk about it at home, because it's just very profound, and it's that way with any crisis.

Simultaneously, the distressing and unjust nature of crises creates a sense of powerlessness, particularly when they are unable to create stability for distressed persons.

> Interview 6: Uhm, what I find difficult about a crisis admission? I think it's the part about dealing with behavioral issues. I often see that with people under RM or IBS, people who want to go home. It feels a bit powerless. I mean, we do our best of course, we try everything. Just to name a few things: interaction tips, involving them in activities, but none of it really works. We can't just take away that restlessness. And honestly, I wish every crisis admission could be peaceful. But yeah, there's just nothing we can really do about it.

Moral dilemmas in crisis admissions

Interviewees reported that time constraints and lack of information in crisis admissions sometimes leads them to make decisions that leave them questioning whether they have done the right thing.

> Interview 2: Based on that, you have to make decisions anyway, with someone who is no longer capable of saying what he wants. Uhm, and then, sometimes, there's a transfer from the GP, but if the person's been somewhat of a care avoider, his last contact with the GP might have been, say, two years ago. And then you don't just simply get statements from specialists either, so then you don't really know very well what's going on with this person. And then you get information from neighbors, who have also kind of scrambled it together. So, for me, it can be somewhat, well, a bit like, hey, do I really have a handle on this patient? Yes or no? Am I able to place him properly in context? Do I have the whole picture? So it's sometimes, no. And so I think, with me, it's the fear that I'm missing something.

Such feelings are exacerbated by pressure from their colleagues to implement interventions (e.g. medication) in case of challenging behavior. They also expressed a sense of responsibility for unit safety—for both colleagues and other residents—which could be compromised by instances of distress or aggression.

> Interview 4: Because, look, you want people to be safe living here. This is also our motto: Growing old happily. Here, it's just like you're at home; like it used to be.

Interviewees also described experiencing guilt when unable to conduct admission intakes themselves (e.g. on their days off).

Crisis admissions are motivational opportunities

In addition to their negative impact on healthcare professionals, interviewees noted that crisis admissions offer motivational opportunities, due to their dynamic character. Crisis admissions also provide valuable learning experiences, allowing professionals to acquire new knowledge rapidly. Interviewees expressed that restoring stability during a crisis is highly rewarding and appreciated, and fostering such stability collectively strengthens the team spirit within the unit.

> Interview 7: Uh it's nice to see, which also makes me really, really, really proud. It's that I see that colleagues are still willing to do a lot for each other, that the flexibility is still there. Uh, that we see, that we're thus all putting our shoulders to the wheel;

> that we're taking it on together. Uh, that we're apparently capable of a great deal. That we're still able grow a great deal as a team.

> Interview 11: Every time, it's also a challenge to make sure that this person—this gentleman, this lady—gets acclimated well. To make sure that they can also find their own place and still go on with life, which they have at that time…I always say that I prefer to get a thank you from my client, or from those crisis admissions, at some point, a smile that can be worth more to me than a raise of two or three percent.

Moreover, crisis admissions are always accompanied by uncertainty concerning who will arrive and how the admission will unfold, and unexpected events are often involved.

> Interview 1: Uh, well, that gentleman I was talking about earlier, who is now in the department. He's also uninhibited in his behavior, and I was going to give him a physical exam to see if there might be something that was causing his behavior to be this way. And, yeah, he had magazines hidden everywhere in his clothes, and so on. So, yes, when undressing, there was already some laughter, and he was also able to laugh about it when we made jokes about it.

Discussion

This qualitative study, among nursing home staff reveals that, in addition to disrupting the patient's equilibrium, dementia-related crises lead to crisis admissions, which can destabilize regular care routines, thereby having a substantial impact on healthcare professionals. Drawing on Strauss and Corbin's coding paradigm, results of the study indicate that crisis admissions lead to changes in unit routines, work processes, and team dynamics, due to the unpredictability and high complexity of such admissions and the increased workload they entail. The extent of destabilization is influenced by the complexity of a client in crisis, the client's social system, and pre-admission interventions, as well as by the setup of and collaboration within the unit. To achieve stability despite a crisis admission, healthcare professionals adjust work schedules and procedures and seek collaboration. The consequences of the destabilization of regular care for healthcare professionals include physical and mental burdens, as well as moral dilemmas. They nevertheless also offer motivational opportunities.

Factors contributing to the destabilization of regular care, as described in the model, align with causes of crises at home, including behavioral problems and a lack of education and support for those involved (Ledgerd et al., 2016; Hopkinson et al., 2021; Toot et al., 2013). Strategies aimed at preventing the destabilization of regular care during crisis admissions (and, ideally, preventing such admissions altogether) could focus on training and education for both informal and formal caregivers, the presence of care plans, and well-coordinated care in both primary care and nursing homes.

The experience of uncertainty described by the healthcare professionals interviewed in this study aligns with literature on such experiences in healthcare (Etkind et al., 2022; Han et al., 2011). Uncertainty in crisis admissions encompasses multiple domains, including physical, social, practical, psychological, and existential aspects. Limited information about persons at admission makes it challenging to provide appropriate care, predict responses, and form causal explanations when issues arise. In addition, guidelines are often inappropriate for acute situations, leading to a lack of treatment recommendations (e.g. in case of problematic behavior). Social uncertainty arises concerning how other residents and the families of both the client in crisis and the regular residents might react. Inadequate training, lack of facilities, and uncertainty regarding the transfer of crisis admissions further exacerbate feelings of complete uncertainty.

Results of this study suggest that healthcare professionals feel overwhelmed by crisis admissions, which may negatively affect their job satisfaction and cause physical and mental health distress. The negative impact of crisis admissions involving increased workload and feelings of stress and anxiety, as reported in this study, aligns with previous literature on working in other high-stress environments (e.g. emergency and intensive-care units) and crises (e.g. pandemics) (Doleman et al., 2023; Bayram Deger, 2023). Crisis admissions can present motivational opportunities and offer valuable learning experiences, while being rewarding and enhancing team spirit.

Strengths of this study include triangulation of investigators and data. Two different researchers independently analyzed data from initial interviews. Upon subsequent comparison, differences in their interpretations were discussed with a third researcher until the most suitable interpretation was found, thus best representing the meaning of the data. Data triangulation was achieved by utilizing various datasets (raw material, codes, concepts, and theoretical saturation). Developing the codes, concepts, and the final coding paradigm enhanced the exploration of data characteristics. In addition, the research team engaged in reflection to enhance trustworthiness and robustness in data analysis. A further strength lies in the focus on long-term care settings and their staff, groups that are often underrepresented in dementia-related research. As such, this study contributes novel insights into a crucial yet frequently overlooked domain of care provision.

Limitations of the study include the absence of a member check. Furthermore, bias may have been introduced by the use of the paradigm model to explain the impact of crisis admissions on caregivers through thematic analysis. The paradigm model was selected after the interviews were conducted and coded, however, thereby minimizing any overemphasis on the framework. Additionally, participants were recruited from only three nursing homes, which limits the generalizability of the findings, as the Netherlands has a wide variety of nursing homes. Nevertheless, crisis admissions predominantly take place in medium-sized or large nursing homes, similar to the three included in this study.

In conclusion, this qualitative study highlights the destabilization of regular nursing home care as the core phenomenon of crisis admissions of persons with dementia. It also clarifies the nature, causes, and amplifiers of such destabilization. The study further explores coping strategies employed by healthcare professionals and the subsequent effects on professional conduct. The model developed provides insight and guidance that could assist professionals in optimizing care for persons in crisis and other residents, while maintaining their own well-being.

In clinical practice, addressing the modifiable factors outlined in this article, particularly at the organizational level, has the potential to mitigate the destabilization associated with crisis admissions. Promoting interdisciplinary collaboration, offering targeted continuing education programs, and addressing the internal consequences of crisis admissions could enhance the quality of care delivery. One might think of team-based reflection sessions following crisis events, which can foster shared learning, emotional processing, and improved coordination. While broader systemic improvements (e.g. institutional collaboration and health information infrastructure) may support these efforts, our findings primarily call for practical strategies that resonate with the realities of long-term care settings. Future work should therefore focus on co-developing and evaluating approaches with care professionals to reduce destabilization in regular care during crisis admissions, ensuring that conceptual insights remain closely connected to everyday practice.

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Ethical approval

The study fell outside the remit of the Medical Research Involving Human Subjects Act (WMO file number 2022–13627).

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Data availability statement

The data that support the findings of this study are available from the corresponding author upon reasonable request.

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