

# **The Provision of Care for Older Adults in the Acute Care Setting**

Ghodsii Kashfi

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# Abstract

## **The Provision of Care for Older Adults in the Acute Care Setting**

Research indicates that the needs of older adults in acute healthcare settings are often not met. Various models of care, such as Person-Centred Care (PCC) which positions the individual at the centre of healthcare decisions, provide guidance for nurses and suggest various strategies to improve the quality of care. However, in older adult patients, PCC cannot be successfully implemented in an acute setting without exploring all the factors involved. Therefore, this dissertation sought to answer the research question: “What are the enablers and barriers to the delivery of PCC to the older adult (65 and over) in an acute hospital setting?”

An interpretative post-positivist approach was used in conducting a thematic analysis and resulted in the identification of four main themes: experience of older adults in acute settings, models of care, ageism and attitudes, and nurse’s challenges.

Barriers to care were identified and included those that reflected the older adult’s experience of physical care (e.g., lack of assistance with activities of daily living, lack of adequate pain management and age-unfriendly physical settings) and of relational care (e.g., poor verbal and non-verbal communication). Negative attitudes of nurses towards the older adults may also result in barriers to care and may be a reflection of the ethnic or cultural background of the nurse, or their lack of knowledge around caring for this patient group. Additionally, the increased challenges faced by nurses erect barriers to delivery of care such as a lack of time and resources, overwhelming patient loads, and lack of effective leadership, and organisational support.

In contrast, the enablers of delivering quality care that are relevant to the patient’s experience included utilizing the client’s own knowledge, building respectful and empathic interactions and relationships with patients and family by carefully listening and communicating. The provision of a secure and emotionally safe physical environment also enhances the patient’s experience of care. Enablers that help to counteract negative attitudes of nurses include increased education around the needs of the older adults. Enablers that minimise the challenges nurses face include providing an

aged friendly environment, adequate resources, a collaborative working environment, appropriate leadership, and organisational support.

Although the original focus was on PCC, this review of literature indicated that introducing PCC into the acute ward setting was challenging and complex. In order to resolve these issues, a more co-ordinated approach may be required using elements of other models that encourage relational care. Such an approach will develop and sustain effective nursing leadership, promote and assist in the development of a healthy organisational culture, and support nurses to practice in the way that older adults indicate is their preference.

Relational care models which are of significant for older adults have been identified. However, these models were developed based on research from countries other than New Zealand and their implementation within New Zealand hospitals may not be culturally appropriate. Therefore, there is a need to explore the perceptions of New Zealand older adults and nurses toward the cultural propriety of the recommendations of these models of care.

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# Table of Contents

|   |             |
|---|-------------|
| <b>Abstract.....</b>  | <b>i</b>    |
| <b>Acknowledgements.....</b>  | <b>iii</b>  |
| <b>Table of Tables .....</b>  | <b>vii</b>  |
| <b>Declaration.....</b>   | <b>viii</b> |
| <b>CHAPTER 1. Introduction and Background .....</b>                         | <b>1</b>    |
| <b>1.1. Introduction .....</b>  | <b>1</b>    |
| <b>1.2. Motivation for the Study .....</b>                                  | <b>2</b>    |
| <b>1.3. Background.....</b>   | <b>3</b>    |
| <b>1.3.1. Demographics. ....</b>  | <b>3</b>    |
| <b>1.3.2. Illness presentation in older adults. ....</b>                    | <b>5</b>    |
| <b>1.3.3. Care of older people. ....</b>                                    | <b>5</b>    |
| <b>1.3.4. Needs of older adults and nursing care. ....</b>                  | <b>7</b>    |
| <b>1.3.5. Study aims and objectives.....</b>                                | <b>8</b>    |
| <b>1.3.6. Structure of dissertation. ....</b>                               | <b>8</b>    |
| <b>CHAPTER 2. Methodology and Method .....</b>                              | <b>10</b>   |
| <b>2.1. Methodology .....</b>   | <b>10</b>   |
| <b>2.2. Method .....</b>  | <b>10</b>   |
| <b>2.2.1. Research question.....</b>  | <b>11</b>   |
| <b>2.2.2. Research strategy. ....</b>                                       | <b>11</b>   |
| <b>2.2.3. Key words used.....</b>   | <b>12</b>   |
| <b>2.2.4. Inclusion and exclusion criteria. ....</b>                        | <b>12</b>   |
| <b>2.2.5. Recommendations. ....</b>   | <b>13</b>   |
| <b>2.2.6. Summary.....</b>  | <b>13</b>   |
| <b>CHAPTER 3. Older Adults' Experience in Acute Hospital Settings .....</b> | <b>14</b>   |
| <b>3.1. Physical Care of Older Adults .....</b>                             | <b>15</b>   |
| <b>3.1.1. Assistance with activities of daily living. ....</b>              | <b>16</b>   |
| <b>3.1.2. Management of pain.....</b>                                       | <b>17</b>   |

|  |    |
|--|----|
| 3.1.3. Physical environment.....   | 18 |
| 3.2. Relational Care.....  | 20 |
| 3.2.1. Building respectful relationships. ....   | 20 |
| 3.2.2. Getting to know the patient. ....   | 21 |
| 3.2.3. Communication and sharing information.....  | 23 |
| 3.2.4. Older adult’s control and autonomy. ....  | 24 |
| 3.2.5. Coordination and integration of care across the healthcare sectors. ....  | 26 |
| 3.3. Summary .....   | 26 |
| CHAPTER 4. Care Delivery Models .....  | 28 |
| 4.1. Introduction.....   | 28 |
| 4.2. History of the Centeredness Relationship.....   | 29 |
| 4.3. Person-Centred Care .....   | 30 |
| 4.3.1. Personhood.....   | 31 |
| 4.3.2. Individualism. ....   | 32 |
| 4.3.3. Autonomy.....   | 34 |
| 4.3.4. Evaluation and measurement of PCC. ....   | 36 |
| 4.3.5. Clinical evidence for effective PCC evaluation.....   | 38 |
| 4.3.6. Limitations of Person-Centred Care. ....  | 41 |
| 4.4. Relationship-Centred Care .....   | 42 |
| 4.5. The Senses Framework.....   | 44 |
| 4.6. Māori Health Model – te whare tapa whā .....  | 46 |
| 4.7. The Magnet Model .....  | 48 |
| 4.8. Releasing Time to Care – Productive Ward Programme.....   | 51 |
| 4.9. Summary .....   | 53 |
| CHAPTER 5. Ageism and Attitudes.....   | 54 |
| 5.1. Background.....   | 54 |
| 5.2. Attitude of the Nurse Towards Older Adults and Factors Affecting Nurses’<br>Attitude in Acute Care Settings ..... | 56 |

|   |           |
|---|-----------|
| <b>5.3. Summary .....</b>   | <b>61</b> |
| <b>CHAPTER 6. Challenges for Nurses in Acute Care Settings.....</b> | <b>64</b> |
| <b>6.1. Theoretical Background .....</b>                            | <b>64</b> |
| <b>6.2. Physical Environment Features Influencing Care .....</b>    | <b>66</b> |
| <b>6.3. Organisational Environment Affecting Care .....</b>         | <b>68</b> |
| <b>6.3.1. Resources.....</b>  | <b>68</b> |
| <b>6.3.2. Collaborative working relationships. ....</b>             | <b>69</b> |
| <b>6.3.3. Leadership support. ....</b>                              | <b>70</b> |
| <b>6.3.4. Organisational support. ....</b>                          | <b>72</b> |
| <b>6.3.5. Nurses characteristics. ....</b>                          | <b>73</b> |
| <b>6.4. Summary .....</b>   | <b>74</b> |
| <b>CHAPTER 7. Discussion and Recommendations .....</b>              | <b>76</b> |
| <b>7.1. Conclusion.....</b>   | <b>83</b> |

# Table of Tables

|               |    |
|---------------|----|
| Table 1 ..... | 14 |
| Table 2 ..... | 29 |
| Table 3 ..... | 54 |
| Table 4 ..... | 58 |
| Table 5 ..... | 65 |
| Table 6 ..... | 66 |



# Declaration

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning.

Auckland, 2015

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## **CHAPTER 1. Introduction and Background**

### **1.1. Introduction**

This chapter sets the scene for the dissertation, introducing the concept of an ageing population and their need for appropriate care when interacting with the healthcare system. The worldwide phenomenon of ageing populations has created a surge in the use of healthcare resources. Consequently, healthcare systems are confronted by an ageing population, with increasing short- and long-term conditions (multiple co-morbid conditions), complex psycho-social needs, and often requiring hospitalisation. Acute hospital settings may not meet the individual needs of the older adult which can lead to adverse health outcomes, as well as increased demands and pressure on healthcare systems. Thus, there is a need to shift to a model that positions older adults and their needs at the centre of care. One such approach is the provision of Person-Centred Care (PCC). This model focuses on the strengths and abilities of the individual rather than their weaknesses and disabilities (Hebblethwaite, 2013).

As mentioned above, older adults are seldom hospitalised with just one condition, but instead may exhibit interacting signs and symptoms with various presentations and co-morbidities Brown (2010, p. 8). Each individual can present with a heterogeneous response to an illness that can be specific to his/her life experiences, culture, and gender. Older adults with the same disease can have different concerns, contexts, and health beliefs (Zeliadt et al., 2006). According to Francis (2009), older adults suffer more diagnostic complications, medication reactions, therapeutic mishaps, and falls than younger inpatients. In addition, admission of the older adults to the alien environment of the hospital can create feelings of vulnerability, anxiety, and loss of personal control. This is further exacerbated for those with cognitive impairment and frailty (Sturdy, 2010).

Healthcare organisations strive to deliver quality care, but this can often prove difficult to achieve and services can sometimes fail to meet the older adults' needs (Buetow, 2014; Department of Health and Human Services, 2014; Freeman & Parke, 2010; Ministry of Health, 2004; Tadd et al., 2011a; The Regulation and Quality Improvement Authority, 2015). In New Zealand, the Health and Disability Commissioner has recognised that the improvement of the quality of care and patient experience is one of

the challenges facing the health system (Health Quality and Safety Commission New Zealand, 2014). The improvement of care of the older adult in the acute setting is part of this challenge. However, the acute setting in a hospital commonly has a strong medical focus built on medical routines and organisational efficiency, which may contrast with a PCC philosophy (Nilsson, Rasmussen, & Edvardsson, 2013; Tadd et al., 2011b). PCC aims to provide care which meets all the unique physical, psychological, spiritual and social needs through taking into account personal histories in order to optimise the sense of well-being (Kitwood & Bredin, 1992). Nurses can play a pivotal role in the delivery of PCC, especially within the acute care setting (Champion, 2013; Nilsson, Lindkvist, Rasmussen, & Edvardsson, 2013). How the delivery of such care to older adults in this setting translates into to everyday nursing practice within New Zealand has yet to be fully explored (Freeman & Parke, 2010). It is timely to conduct a literature review to answer the research question “What are the enablers and barriers to the delivery of PCC to the older adult (65 and over) in an acute hospital setting?”

## **1.2. Motivation for the Study**

As a Clinical Resource Nurse in a 34-bed acute adult medical ward of a public hospital in New Zealand, I was involved in a project which aimed to improve standards of care and support. The project also sought to educate the nursing staff caring for older adults whose needs had been identified as high and complex. I was impressed with the effective and committed delivery of the PCC that was achieved on many occasions. However, sustaining the delivery of PCC was challenging due to the task-centred nature of care in the acute care setting. Organisational factors resulted in the nurses being confronted with challenges on a daily basis. At times, the environment was chaotic with multi-medical teams coming and going, and the poorly designed physical setting of the ward presented various barriers. Time constraints often meant rushed, perfunctory physical care, and nurses often did not interact with patients or attend to their emotional needs. Conversations with patients indicated that some older adults experienced uncertainty, distress, reduced coping ability, and felt deprived of essential care. These observations prompted me to examine more closely, nursing practice in acute settings and how the care of the older adult in this setting could best be addressed.

I will first begin by discussing the current context and background of the ageing population in New Zealand. In the following sections, I will consider the key aspects of

demographic change and its consequences for the care of the older adult population. Importantly, I will provide information on the current barriers and enablers in the delivery of care, as well as outline existing strategies for the delivery of PCC of older adults in acute medical settings. Key demographic changes and their consequences for care of the older adult population will be discussed. These include current barriers and enablers in the delivery of healthcare, as well as existing strategies used in the delivery of PCC of older adults in acute medical settings.

### **1.3. Background**

#### **1.3.1. Demographics.**

As in the rest of the world, New Zealand is becoming an increasingly ageing society (Statistics New Zealand, 2012). Those aged 65 years and over are defined as “older adults” in New Zealand, as this is the age at which New Zealanders are currently eligible for National Superannuation (Zangaro & Soeken, 2007). However, Maori, Pasifika, and those with pre-existing disabilities are defined as older adults at the age of 55 years and over, since their life expectancy is shorter than other population groups (Ministry of Health, 2006). The older adult population aged 65 years and over is expected to increase from 14% in 2012 to 21% by 2031, thereby outnumbering the youth and child populations (Statistics New Zealand, 2012). The fastest growing group will be those aged 85 years and over, as the large number of “baby boomers” turn 85 years in 2031. This population is estimated to increase from 67,000 in 2009 to 144,000 in 2031, and then to approximately 330,000 by 2061 (Ministry of Social Development, n.d.). Hence, by 2061, those aged 85 years and over age will comprise around 25% of adults aged over 65 years compared to 12.5% in 2012 (Statistics New Zealand 2014). This means that New Zealanders can expect to live longer and have better health, but projections show that, on average, about 40% of the additional life years gained over this time will be lived in poor health. This expansion of morbidity suggests that disabling conditions – that is, multiple comorbidities, functional impairments and frailty – will become increasingly important drivers of health expenditure (Ministry of Health, 2013a).

Māori and Pasifika have younger age structures than other ethnic groups due to higher fertility and mortality rates. Life expectancy at birth by 2026 for the Māori population

will increase to 75.4 years for males and 79.2 years for females. For the Pacific population, life expectancy will increase to 77.0 years for males and 80.4 years for females compared to the European/New Zealander's life expectancy which will increase to 82.2 years for males and 85.4 years for females (Statistics New Zealand, 2014). Pasifika refers to those born in New Zealand to Pacific families or those who migrated from Samoa, Tonga, Tokelau, the Cook Islands, Niue, Tuvalu, and Fiji. Other smaller Pasifika groups include those from Kiribati, the Solomon Islands, Papua New Guinea, and American Samoa (Brown, 2010).

According to the 2010 ethnic population projections, in 2026 the older adult population with a European or other ethnicity will comprise 81% of those aged 65 years and over, Māori 7%, Asian 9%, and Pasifika 3% (Ministry of Social Development, n.d.). Therefore, one of the key considerations in the future for the provision of healthcare for the older adults will be that services will need to be culturally safe and appropriate to meet the diverse needs of a multicultural NZ society.

The rise in the older adult population is even reflected in the terminology to describe this population demographic, such as the 'Silver-tsunami' (Bartels & Naslund, 2013). Current health services, and possibly society in general, are unable to cope with the surge in the numbers of older adults. In addition, the Ministry of Health (MOH), the major government health planning and funding agency in New Zealand, has a challenge to address the health needs of the increasingly ethnically diverse population (Ministry of Health, 2014). Numerous studies have established that in Western nations, minority communities typically suffer from greater levels of ill health and have poorer health outcomes than patients identifiable within dominant cultural norms (Hooker & Noonan, 2011). The reason for these outcomes is debated, but is believed to arise in part from a lack of access to appropriate medical care, and in part as a result of experiencing discrimination and prejudice. Health services and government will need to ensure that quality and appropriate measures are in place to meet the health needs of older adults' from all cultural communities. In this respect, it is important that nurses who are caring for older adults, especially within an acute medical setting, respect that these patients may feel not only physically, and socially vulnerable, but also culturally isolated as well.

### **1.3.2. Illness presentation in older adults.**

Even though ageing is not synonymous with illness, an increasing number of older adults will develop adverse health conditions, disability or decreased health status (Ministry of Health, 2013a). The New Zealand Burden of Diseases, Injuries and Risk Factors Study, 2006–2016, conducted by the MOH, reported that in 2006, older adults sustained 37% of the total health loss (Ministry of Health, 2013b). However, this group only formed 12% of the total population and this figure is projected to increase to 13.4% by 2016. The leading causes of health loss for the older adult demographic (65–74 years) are cancers (29%), vascular disorders (24%), and musculoskeletal conditions (11%). For those aged  $\geq 75$  years, health loss resulted from vascular disorders (35%), cancers (18%), and neurological (10%) (Ministry of Health, 2013b). Thus, nurses will find themselves increasingly having to appropriately care for the older ill adult, many of who may present in the acute medical setting with acute symptoms resulting from these illnesses.

### **1.3.3. Care of older people.**

Older adults are often described as “frail”, an ill-defined term for those highly vulnerable to adverse health outcomes, at higher risk of falls, and with deteriorating mobility, and declining functional ability (Boeckxstaens & De Graaf, 2011). Older adults are at risk of increased episodes of hospitalisation, institutional care, and death. However, older adults have high and complex needs, with health losses that are often related not only to physical but also to psycho-social health. Thus, the majority of the older adults in medical wards may require higher levels of care during hospitalisation (Edvardsson & Nay, 2009).

As previously mentioned, the non-homogenous older adult population in New Zealand is ethnically diverse and Maori and Pasifika tend to experience functional and environmental ageing at an earlier chronological age. This group have specific cultural and spiritual needs that require consideration (Wilson, 2008). Nurses are well placed to recognise individual cultural and values, as opposed to many others working within the prevailing culture of the healthcare system (Hellwig, Yam, & DiGiulio, 2003).

In addition, an increasing number of older adults appear to exhibit some form of dementia, which is a major concern, not only for health policy planners, but also for

family/whanau and healthcare professionals (Moyle, Borbasi, Wallis, Olorenshaw, & Gracia, 2011; Nilsson, Lindkvist, et al., 2013; Siddiqi, House, & Holmes, 2006). Cognitive impairment can be the result of a presenting condition e.g. hypoxia, depression, delirium, or infection, which can be mitigated if effectively treated. In contrast, patients with dementia experience poorer health outcomes, longer hospitalisation, and tend to be discharged into residential care rather than independent living (Alzheimer's Society, 2009; Banerjee, 2009; Royal College of Nursing, 2014).

Care models in the health sector have not always adapted to the increasing patient requirements and expectations of the older adult population in acute settings. However, one model of care that positions the individual at the centre of healthcare decisions is PCC. Ryall (2010) maintains that PCC ensures all New Zealanders receive healthcare of a high standard and it should be equally available to all. In 2009, the Ministerial Review Group recommended that District Health Boards (DHBs) concur to establish protocols and agreements with contractual and financial incentives, among community, primary, and secondary providers to develop new care models that are patient-centric, less fragmented, and more cost-effective (Ministerial Review Group, 2009). However, there are certain factors in acute hospitals that make the delivery of such PCC difficult, including the strong medical focus, based on the need for rapid diagnosis and therapeutic intervention, and the short lengths of stay.

Nurses are essential participants in the provision of clinical front-line care (i.e. 24 hours), as well as the management and coordination of that care. The latter neither follows a linear progression nor is it based on a single diagnosis to conform to the majority of healthcare services. If it is acknowledged that older adults know what is acceptable or detrimental to their health, then the empowerment afforded by PCC is well suited to providing for their cultural needs. However, nurses are also expected to balance patient needs with an organisation driven by financial and resource constraints. It is reported that nurses cannot manage or implement practices central to PCC unless the same are endorsed at an organisational level (Kramer et al., 2009). The New Zealand Ministerial Review Group reports that the culture, structures, systems, and processes inherent in the health sector must be addressed if the public health system is to be maintained (Ministerial Review Group, 2009).

#### **1.3.4. Needs of older adults and nursing care.**

Frequently, admission to an alien hospital environment with the accompanying sensory impairment or poly-pharmacy can result in the older adult behaving as though cognitively impaired or even demented (Schoenenberger & Exadaktylos, 2014). The rapidly increasing number of older, hospitalised patients prohibits the assignment of the older adults to specifically designed units for the geriatric patient. Most acute hospitals are not suited to the needs of their major users (i.e., older, frail adults with multiple co-morbidities and often some degree of cognitive impairment). Current medical practice tends to conform to the traditional disease model of medicine by focusing mainly on the presence of disease, so that geriatric syndromes can be overlooked or ignored in the care of the older adults (Buurman et al., 2011).

The high prevalence of geriatric syndromes such as delirium (Inouye, Schlesinger, & Lydon, 1999; Siddiqi et al., 2006), incontinence, falls, pressure areas (Mecocci et al., 2005), malnutrition (Archibald, 2006; Marco et al., 2011), reduced mobility (Covinsky et al., 2003) functional decline (Boltz, Capezuti, & Shabbat, 2011; Sands et al., 2002), longer hospital stays, increased mortality (Allen, Hutchinson, Brown, & Livingston, 2014) and poly-pharmacy (Buurman et al., 2011) in older patients can result in complications that lead to poorer health outcomes.

During hospitalisation, older adults often experience reduced mobility and activity levels. Although bed rest is beneficial during acute illness, it can have deleterious effects for the older adults. Bed rest reduces aerobic capacity, muscle strength, vasomotor instability, and respiratory function, thereby resulting in the older adult being at risk of complications, such as deep vein thrombosis, syncope, atelectasis, falls, and constipation (Gillis, MacDonald & MacIsaac, 2008). Importantly, muscular deconditioning occurs within days of imposed bed rest. The most affected muscles are those in the legs. Therefore, to live independently and enjoy a satisfactory quality of life, the older adult needs to be able to mobilise within, and around, their environment as well as engaging with that environment. To ensure the most appropriate delivery of care, health planners need to consider the specific needs of the older adult, so that within an acute setting the unique physical, psychological, spiritual and social needs of the older adult are met by using a PCC approach.



### **1.3.5. Study aims and objectives.**

The aim of this dissertation is to conduct a literature review in order to answer the research question “What are the enablers and barriers to the delivery of PCC to the older adult (65 and over) in an acute hospital setting?”

The research question was pursued through the following study objectives:

1. To critically review:
  - a. Older adults' experience of care in acute settings;
  - b. Models of care (including PCC) to determine how these models could improve the care of older adult in the acute setting;
  - c. Nurse's attitudes and beliefs towards the care of older adults;
  - d. Nurse's challenges in caring for older adults in acute settings.
2. To develop evidence-based recommendations and guidance for the delivery of PCC for older adults in acute settings.

### **1.3.6. Structure of dissertation.**

I provide an overview of the New Zealand demographic context and then proceed to discuss interrelated themes that underpin PCC as well as the enablers and barriers to the provision of the PCC in everyday nursing practice in acute healthcare settings. The dissertation concludes with recommendations for the provision of effective PCC in an acute setting.

The dissertation is organised into seven chapters. After the introductory chapter, I outline the methodology and methods for the thematic analysis of the literature in Chapter 2. In chapter three, I discuss the older adults' experience in acute settings. In chapter four, I critically analyse the details of care models such as PCC, Relationship-Centred Care and various organisational models such as the Māori Health Model – te whare tapa whā, the Magnet model, and Productive wards. In chapter five, the attitude of nurses and ageism is examined. In chapter six, I critique nurses' challenges in acute healthcare settings. Finally, in chapter seven, I consolidate information identified in the preceding chapters and make recommendations for the provision of PCC. Within each chapter, there are comparisons and contrasts among the approaches and outcomes of reviewed studies, as well as the inter-relationship with studies reviewed in other

chapters. In addition, within each chapter, I identify deficits and gaps in knowledge within the research in this area.

## **CHAPTER 2. Methodology and Method**

### **2.1. Methodology**

This chapter will discuss the methodology underpinning my literature review followed by the research method. The literature review indicates that PCC in the acute setting for older adults is complex and subjective in nature, and factors affecting PCC are inter-related and not appropriately reduced to measurable components. A positivist approach in which an objective and reductionist view is held is not appropriate. Therefore, I used a post-positivism approach which I believe is congruent with the aim of this literature review and can address the dissertation research question in an insightful and valid manner.

Proponents of post-positivism believe there is no absolute truth, but there can be multiple interpretations of the truth (Mutch, 2005). Furthermore, they maintain that there is a reality and accept that things can be quantified and this reality can lend itself to multiple interpretations. Using a post-positivism lens, I emphasise multiplicity and complexity as hallmarks of humanity. Therefore, I investigate barriers and enablers in quantitative and qualitative studies to define those factors that could inhibit and support PCC for older adults in the acute care setting. Post-positivist approaches are interpretive and this can lead to an emphasis on meaning, seeing the person, experience, and knowledge as “multiple, relational and not bound by reason” (Ryan, 2006).

### **2.2. Method**

The themes were identified from the selected papers using an inductive thematic approach. Six phases were included in this process and included: (1) familiarisation with the content of the publications by reading and re-reading the publications; (2) generation of concise labels to identify important findings of each publication and its relevance to the research question; (3) a search for themes by the examination of labels and collated publications to identify potential themes; (4) a review of the themes by checking the themes against publications to determine if they answered the research aim and question. The themes required some modification in terms of refinement, or combination with other themes; (5) definition and naming of the themes by detailed analysis of each, working out the scope and focus of each; (6) writing up by weaving

together the analytic narrative and data extracts and contextualising the analysis in relation to existing literature (Braun & Clarke, 2006).

Based on the review of the literature, the refined four main themes developed in this dissertation that answer the research aim and question are: ‘Experience of older adults in acute settings’; ‘Models of care’; ‘Ageism and attitudes’; ‘Nurse’s challenges’. The following chapters will discuss the analytic narrative and data extracts and contextualise the analysis in relation to these themes and literature

### **2.2.1. Research question.**

In this dissertation, I critically analyse the provision of PCC for older adults in acute hospital settings, using a thematic analysis of the literature in order to develop body of evidence, and related discussion and recommendations. This was derived from a critical analysis of the literature together with my nursing experience and consultation with both academia and clinicians. Therefore, my research question was “What are the enablers and barriers to the delivery of PCC to older adult (65 years and over) in acute healthcare settings?” Using a definition similar to that used by Gibson et al. (2015), barriers and enablers were defined as those factors that inhibited or supported respectively, the implementation of interventions aimed at providing PCC for the older adults in the acute healthcare setting,

### **2.2.2. Research strategy.**

In this review, I used a systematic approach to critically evaluate and synthesise relevant international and New Zealand research publications related to the concept of PCC of older adults in acute settings. I searched the most relevant electronic databases, internet, websites of government offices, and official organizations, as well as consulting experts in the field.

I accessed databases for articles via Auckland University of Technology’s Library and searched the subject area of “Health Sciences and Nursing” using Scopus and CINAHL Plus databases for the period of 2006-2015. In addition, I reviewed additional important and influential publications outside the search period, while focusing mainly on peer-reviewed journals. I also manually accessed reference lists of relevant articles prior to 2006 to expand my search.

In addition to journal articles, I consulted non-research articles, books, guidelines, and international, national, government, and non-government health websites, as well as official websites related to healthcare policies such as the World Health Organization, the New Zealand Ministry of Health, New Zealand Nursing Organisation (NZNO), Ministry of Social Development, the New Zealand Nursing Council, and the DHBs to identify current issues, key themes, and key funding organisations.

### **2.2.3. Key words used.**

The key words used for this search included ‘hospitals’, ‘hospitalisation’, ‘older adult’, ‘elders’, ‘older people’, ‘old age’, ‘geriatric’, ‘aged’, ‘seniors’, ‘geriatrics (above 65years)’, ‘acute care setting’, ‘medical ward’, ‘hospitalised’, ‘experience’, ‘perception’, ‘views’, ‘attitude’, ‘nurse’, ‘Person centred care’, ‘Relation centred care’, ‘Magnet model’, ‘productive ward’, ‘nurses’ experiences/perceptions’, ‘acute care’, ‘hospitalisation’, ‘inpatient’, ‘older adults’, ‘aged care’, ‘geriatric nursing’, and ‘skills and professional development’. Multiple terms are used internationally to describe some of these key words, however, in this dissertation some key words are specifically defined for example, ‘acute care’ is defined as medical units or wards in a hospital.

### **2.2.4. Inclusion and exclusion criteria.**

Primary research qualitative or quantitative articles were selected to ensure the latest information was included in the study. Studies that involved the care of older adults ( $\geq 65$  years) admitted to an acute setting and published in English were included. My secondary search concentrated on issues around ‘geriatric and/or gerontological care’ in acute care settings. The same databases were searched, but I included more search terms such as ‘geriatric syndromes and assessment’, ‘delivery of healthcare’, ‘organisational policy’ and ‘professional–patient relations’ to refine the search and determine dimensions that could not be captured by the current key words.

The study was limited as I include a few ‘non-research papers’, such as studies conducted in nursing home settings for the age group under 65 years, undefined samples, and in content-specific medical conditions.

The reference management software, EndNote version 6.0.1 (USA) was used for citation management.

#### **2.2.5. Recommendations.**

Following a critical analysis of the relevant literature, I formulated recommendations to inform the provision and delivery of PCC to older adults in acute settings, as well as the nursing practice within those settings.

#### **2.2.6. Summary.**

A total of 28 papers were selected for this dissertation: 12 quantitative and 16 qualitative studies. In addition, grey literature sources including Ministry of Health and DHB reports were included.

### CHAPTER 3. Older Adults' Experience in Acute Hospital Settings

Patient experience is increasingly regarded as an indicator of quality of care in healthcare systems worldwide (Aharony & Strasser, 1993; Browne, Roseman, Shaller, & Edgman-Levitan, 2010; New Zealand Health Quality and Safety Commission, 2013a; J. A. Wolf, Niederhauser, & L, 2014). However, in practice and within the medical literature, there are widely divergent definitions of patient experience (J. A. Wolf et al., 2014). A definition offered by The Beryl Institute is, “The sum of all interactions, shaped by an organization’s culture, that influence patient perceptions, across the continuum of care” (The Beryl Institute, n.d., para. 1). J. A. Wolf et al. (2014) in their literature review of 18 sources (articles or organisational websites), identified three subthemes related to the theme of the patient’s experience; “active patient and family partnership and engagement”, “the integral need for person-centredness”, and the “acknowledgement of the broad and integrated nature of the experience overall” which they suggested would further enhance the patient experience definition, making it more useful and far-reaching. In a similar manner, this chapter will critically review studies that look at one of the main themes i.e. the “experience of the older adult”. Then two subthemes will be explored, namely the “physical care” and the “relational care” that the older patient experienced as. In the reviewed literature, these subthemes were highlighted as being of importance to older adults (see Table 1).

**Table 1**

*Subthemes Relating to the Delivery of PCC as Experienced by Older Adults in the Acute Healthcare Setting*

|  |
|--|
| Theme 1: Experience of Older Adults                                |
| Subtheme 1: Physical care  |
| Assistance with ADLS   |
| Management of pain   |
| Physical environment   |
| Subtheme 2: Relational care  |
| Building respectful relationships                                  |
| Getting to know the patient  |
| Communication and sharing information                              |
| Older adult’s control and autonomy                                 |
| Coordination and integration of care across the healthcare sectors |

Understanding the experience of patients provides insight into the quality of healthcare provision, as well as being a crucial first step toward partnering with patients to drive

improvement. Historically, quantitative patient surveys with predetermined criteria, such as “patient satisfaction”, have been used as a measure of patient experience (Aharony & Strasser, 1993; New Zealand Health Quality and Safety Commission, 2013a). However, the criterion of “patient satisfaction” is a multidimensional concept, and it can, subsequently, be difficult to identify what is behind poor ratings of satisfaction (New Zealand Health Quality and Safety Commission, 2013a). Moreover, results from such surveys may be prone to bias or lack of specificity. Consequently, there is a move to more accurately measure the overall concept of patient experience to determine what actually happened to the patient, as opposed to the patients’ evaluation of what actually happened. Thus, the measurement and understanding of “patient experience”, as well as using quantitative measures, should also employ a qualitative approach. However, currently in New Zealand, there is no consistent approach to measuring, reporting, and managing patient experience at the national or local level (New Zealand Health Quality and Safety Commission, 2013a). By building on international experience, New Zealand is ideally positioned to create an approach that best helps patients while creating minimum application burden. International experience can be considered in the development of a process that ensures a high quality of care in the unique New Zealand setting.

Campbell, Roland, and Buetow (2000) define the process of care as involving the interactions between patients and the healthcare professionals; in essence, the actual delivery and receipt of care. Moreover, this process is context-specific to individuals (Campbell et al., 2000), so that the quality of care for older adults requires the consideration of their circumstances, goals and preferences. The next section begins with a focus on physical care followed by relational care.

### **3.1. Physical Care of Older Adults**

Physical care is considered an essential part of the care experience for older adults in acute wards. Patients have been socialized by the media to expect the nurses’ work to centre on the practical aspects of care (Gardner et al., 2001). Essential physical care is perceived as more important when older adults are physically weak and require more hands-on assistance (Bowers, Fibich, & Jacobson, 2001). Early into their hospitalisation, the independence of older adults is often restricted (Scanlon & Lee, 2007). Many older adults require assistance to meet basic needs and some are too



unwell to get out of bed (Jacelon, 2004). Functional decline is a common complication in hospitalised older adults, associated with low mobility and physical activity (Boltz, Parke, Shuluk, Capezuti, & Galvin, 2013). Often frail and dependent older adults regard quality care in terms of the practical support they receive from staff (Bowers et al., 2001). The subtheme of physical care given to older adults can be further subdivided into other sub-themes related to the assistance with Activities of Daily Living (ADLs), pain management, and environmental factors such as noise, warmth, cleanliness, and comfort levels.

### **3.1.1. Assistance with activities of daily living.**

Older adult patients may require assistance with many aspects of daily living. A qualitative study by Attree (2001) in 34 acute medical patients found that many older adults wanted to be supported physically for essential care such as toileting, showering, and mobilising. However, studies indicated that not just physical care mattered to older adults, but the manner in which the physical care was carried out was also important (Attree, 2001; Canzan, Heilemann, Saiani, Mortari, & Ambrosi, 2014). Alongside the physical aspect of their care, older patients valued its relational aspect. For example, in the study by Attree (2001), older adults complimented staff who were available, approachable, and demonstrated a calm, unhurried approach whilst attending to their essential needs. Older adults reported nurses who did not anticipate patient needs as ‘uncaring’. Negative comments regarding the inability of staff to meet basic physical needs included: “I needed help getting up, dressed and going to the toilet...nobody came to help me, no-one took me, walked me anywhere.”; “I needed a lot of help, I was helpless.....but I didn’t get enough help here...no one seems to care” (Attree, 2001, p. 461). Similarly, older adults (n=20), in a more recent qualitative descriptive study conducted by Canzan et al. (2014), participants complimented nurses (n=20) who paid attention to their physical needs through caring gestures, especially during bathing, toileting, and feeding. Bowers et al. (2001) in their study of the quality of care in 26 older adults living in residential settings also demonstrated the overlap of physical and relational care.

Not all older adults respond to relational and physical care in a similar manner. An observational study of older adults (n=10) in an acute hospital acknowledged the importance of having a good relationship with staff for the provision of timely and

individualised care related to their physical needs (Koskenniemi, Leino-Kilpi, & Suhonen, 2013). However, this study also reported that there were differences in the manner in which older patients responded within this relationship; some older adults perceived that it was degrading to have to ask for help, while other patients and their relatives were afraid to disturb the staff to seek assistance. Other older adults or families only wanted to ask for help from the nurses with whom they had a relationship, commenting that “It’s very difficult to ask for help ... you feel like you are stirring up a hornet’s nest ... You have to choose very carefully from whom you dare to ask help...” (Koskenniemi et al., 2013). Such differences in the manner in which patients express their need for care can impact on the management of their physical symptoms, including pain.

### **3.1.2. Management of pain.**

Quality care for many patients is about the management of pain. As with assistance with ADLs, older adults reported different experiences. Pain is an individual experience where patient participation is of uttermost importance for recovering (Manias, 2003). However, pain management can often follow a routine approach as opposed to an approach that is sensitive and responsive to the needs of patient and/or family. For example, in the study in the older adults (n=10), in an acute hospital, some patients provided positive feedback about nurses being proactive in providing pain relief without having to ask for it, whilst others reported the opposite (Koskenniemi et al., 2013). In this study, a daughter was stressed to see her mother in pain and commented on the timing of pain relief; “I couldn’t understand why the blood tests had to be taken before the patient could have pain killers ... It made me feel bad to see how painful it was for her...” (Koskenniemi et al., 2013, p. 10). This statement illustrates the diminished control of older adults/ families to schedule their preferences. There appeared to be limited attention paid to the knowledge family members possessed relating to the older adult.

Medication administration for pain management may not necessarily be directed at the individual’s needs, but rather can be a time when ward policies and protocols seem to be emphasised. This is illustrated in a study by Larsson, Sahlsten, Segesten, and Plos (2011) that assessed nurses’ behaviour in inpatient care in Sweden. The study employed the Critical Incident Technique (CIT) and interviewed 17 patients. In many instances,

the nurse left it to the patient to decide what tablet dosage for pain treatment was appropriate. In other instances, the nurse provided no tablets for sleeping problems, routinely interrupted pain infusion treatment, with little or no consideration towards the individual patient.

The way a nurse communicates during administration of pain medication can be important to the patient's sense of well-being. In the study by Larsson et al. (2011, p. 4), a nurse disparaged a patient with baby talk: "The nurse talked to me like I was a child; that belittles me as a person and gives an impression of insincerity." Similarly, another nurse made ironic remarks about an experience: "I was told to point at a ruler and got the answer: my dear, you can't be in that much pain. If you were, you'd be both in a cold sweat and more affected. Now, you just think about it one more time" (Larsson et al., 2011, p. 4).

Conversely, when the nurse starts with, and utilises the patients' own knowledge, then the patient becomes an asset as they co-operate (Larsson et al., 2011). As the patient commented, "She (nurse) always included me in discussions because she needs my knowledge, said I was an expert. Nothing was done until we had had a discussion. I was involved and in control." The nurse also handed over responsibility to the older adult patient who said, "I have been allowed to decide on my pain treatment and I take the pills when I need them. That means I do not have to press the call button as soon as it hurts and then I can wait longer so that I do not get so drugged and constipated" (Larsson et al., 2011). The above studies illustrate the importance of staff being facilitative in their approach, listening, and responding to the verbal prompts and cues provided by patients. Nurses should be encouraged to move away from the constraints of a system where the staff control the environment towards care based on the belief that the patient is an autonomous individual.

### **3.1.3. Physical environment.**

Aspects of the physical environment can be important to older adult patients (and/or their relatives) in acute settings. Such aspects, including the cleanliness of the room, and bed space will be discussed in this section, drawing on examples from relevant clinical studies. Having 'a clean environment' was considered to be important by many patients or relatives in a qualitative study involving 34 older adults with dementia in an acute dementia hospital (Clissett, Porock, Harwood, & Gladman, 2013). In this study, one

family member, who was upset about the lack of cleanliness and tidiness of both her mother and the hospital room commented "...I questioned every time, why she was in a grotty, it was filthy, I took pictures on my phone, the room was dirty" (Clissett et al., 2013, p. 2711). For many patients (and/or their relatives) having a sense of space around them was seen as being important for their overall wellbeing. For example, in a study of hospitalized patients (Radley & Taylor, 2003), patients photographed their hospital ward, their room, other spaces, and objects that they found salient. After researchers interviewed the patients about the meaning of their photographs, a sense of claustrophobia due to curtains being around the bed was identified as an important feature for many patients. It is important to design wards to address these features. While most of these factors are outside the ability of the nurse to change, nevertheless, small changes around the bed space are important and one of the aspects of nursing care which could be delegated and supervised.

For many patients, the change in space resulting from room sharing can have a significant impact. For many patients, room sharing can be experienced as providing companionship and a sense of looking out for each other, but for other patients it could also be experienced as a source of stress and anxiety. The positive effect of other patients in term of support has been identified in other studies for terminally ill patients (Chochinov et al., 2004; Douglas & Douglas, 2004). An older adult in the study of Koskeniemi et al. (2013) was disturbed by the younger patients' noisy discussions and phone calls. They also felt annoyed when their roommates were demented and provided no company for them. Finding what 'little things matter' to the older adults not only helps to challenge existing practice but also enables nurses to become more attuned to patient needs. In the above case, the nurse could negotiate with younger patients so they do not disturb the older adults by offering another space or common area.

For many patients, being able to choose the type of space they occupy and who they occupy it with was important. For example, a study in older adults who were accommodated in a community hospital as part of their post-acute care enjoyed the 'freedom' or 'choice' they had during their stay (Green, Forster, Young, Small, & Spink, 2008). Compared with a general hospital study, those in the community hospital enjoyed the choice of where, or with whom, to sit, and of being alone in a single bedroom or in company. A secure environment in which patients could interact socially and have a sense of control over their actions was also reported by the participants as being important. The provision of a physical environment that is both physically and

emotionally safe for older adults could thus be seen as an enabler of PCC in the acute setting.

### **3.2. Relational Care**

In reviewing qualitative studies, I identified the second subtheme of relational care. Relational care has been defined as those activities, which are necessary to the development and sustaining of interpersonal relationships and incorporates the essential characteristics of emotional connection and collaboration (Dewar & Nolan, 2013; Ministry of Health, 2013c). It includes the following various aspects of building respectful relationships; getting to know the patient communicating and sharing information, the loss of control and autonomy, relational knowledge shaping practice, the welcoming of family involvement, and the coordination and integration of care across the health and social care sector.

#### **3.2.1. Building respectful relationships.**

Interactions that are based on respect and address the patient's and family's emotional needs are an important determinant of how older adults experience their care. Respectful and empathic interaction demonstrates a willingness to engage in a relationship (S. Williams, Nolan, & Keady, 2009). Frequently, older adults bring to the hospital either a damaged sense of identity (Bridges, Flatley, & Meyer, 2010) or a loss of that identity in this alien environment (Cohen-Mansfield & Parpura-Gill, 2008; Tadd et al., 2011b). Acute hospitals can be disempowering places for both older adults and their families (Tadd et al., 2011b). Together with feelings of hopelessness and inadequacy, older adults and their families may find themselves forced into a passive role. Forming emotional connections between the nurse and patients plays an important role in establishing relationships which influence older adults' experience of care (Dewing, 2004).

Koskeniemi et al. (2013) recognised the importance of the relational aspect of care in their qualitative study. Older adults who felt nervous, even panicky on admission, were helped by nurses, who were warm, genuine, respectful, and had a sense of humour. Because of this care, patients were able to allay their fears and to discover their strengths. In contrast, other nurses who appeared unmotivated and unfriendly made older adults' experiences more daunting (Koskeniemi et al., 2013). Such relational

interactions, be they negative or positive, have the potential to influence older adults' experience of care.

### **3.2.2. Getting to know the patient.**

Both PCC and Relationship-Centred Care (RCC) highlight the importance of getting to know the person so as to achieve a human connection which is often defined as 'being with' the patient (Dewing, 2004). The older adults themselves also place emphasis on nursing care that recognises them as unique individuals and does not simply focus on physical assessments and the performance of tasks (Scanlon & Lee, 2007).

Engagement between patient and nurse can reduce the risk of over emphasising the technical aspects of care at the expense of the experiences of the individual. As a relative from the study by Clissett et al. (2013, p. 2711) remarked, " ... staff nurses just doing their jobs and machines and bloods or what do you call them, injections and things but then where is the care of getting someone motivated, there isn't any". The relative of this patient also did not regard the physical and technical activities of nurses as care, and appeared distressed when staff did not connect with her husband or motivate him. For her, relating to the patient and nurturing a relationship and partnership was equated with quality care.

Getting to know the patient as a person, even during a brief encounter, can form the initial building blocks for relationship. Both patients and family tend to respond negatively to nurses who adopt a hurried, perfunctory approach to physical care without expressing any interest in the patient/family. In the study by Attree (2001), older adults reported incidences of inadequate care from staff who appeared uninterested in developing a relationship. Some nurses were described as distant which prevented any development of a close, social relationship. Older adults reported that "they (staff) don't chat...they gone into silence" "don't want to get involved" or "don't care" (Attree, 2001, p. 461). This type of approach to physical care is not responsive to the needs of either the older adults or their families as it gives the impression that the nurses are more concerned with prioritising tasks. As noted in the observational study of Jonasson and Berterö (2012), it is important to focus on ways to approach older adults; if the approach of nurses does not address older adults' needs, the prerequisites for good relationship are diminished.

When interactions between older adults and nurses are based on getting to know each other, where older adults feel that they are being listened to and that their opinions and preferences are being taken into account, then the emotional needs of patients and families can be addressed. The older patient's chance of achieving positive physical, mental, and social involvement depends on the nurse's approach strategy (Jonasson & Berterö, 2012). Developing a relationship between the nurse and patient, based on the emotional support of the patient and an effort to understand him/her, can alleviate distress, suffering, or concerns of the patient (Lown, Rosen, & Marttila, 2011).

By engaging in purposeful interactions, the nurse demonstrates a willingness to form a bond and establish a friendly relationship. Zikorus (2007) maintains that sometimes caring can be revealed in the quiet simplicity of the nurse just being present, i.e., just being there, sharing time, and having a social chat. Older adults in the study by Attree (2001, p. 460) gave positive comments on those nurses who "sit on the bed and have a little chat", "stay...have a talk". The knowledge and understanding of the benefits of these caring encounters should encourage nurses to make a careful and reciprocal approach. As Berg, Berntson, and Danielsson (2006) noted this will reduce the patient's sense of vulnerability, thus leading to increased self-confidence.

These findings echo those of the study by Shattell, Hogan, and Thomas (2005) in which 20 patients, including the older adults, from an acute hospital environment described the importance of physical proximity to nursing staff. Such close connections developed the relationships with nurses, and contributed to the pleasure and satisfaction of the patient being in an acute care environment. Research participants spoke repeatedly of the positive impact that "just checking-in" had on them during their hospitalisation. Social conversation that lasted "just a couple of minutes" was reported to be extremely beneficial. One participant said, "Chitchat is good; it makes me feel less afraid, less alone." Nurses who "stuck their head in the door to see how I was doing" increased patients' sense of safety and security (Shattell et al., 2005). Participants noted that the human-to-human contact aspects of relationships increased their feeling of security. Similarly, the study by Edwards, Duff, and Walker (2014) found that the patient's feeling cared for was linked to the physical presence of the nurse.

### **3.2.3. Communication and sharing information.**

Effective communication is fundamental to nursing practice and can foster the development of a positive nurse-patient relationship. Older adults and families identified the need to truly be listened to and not have others' views imposed upon a situation. "It's important that older patients are given a chance to speak ... and the nurse should listen to them with patience ..." (Koskenniemi et al., 2013, p. 8). When older adults' and families' need for information is not satisfied, according to Jonasson and Berterö (2012), they react in different ways; either they become passive or actively seek information from the medical team. Nurses can reverse this feeling of insecurity by giving the required information. This finding regarding participation was confirmed by Skott (2003), who found that it is important that the nurse takes time to respond and interact with older patients, treating them with respect so that they feel that they are valued individuals.

Importantly, patients and family members need staff to provide information on clinical status, progress, prognosis, and processes of care. In the study by Koskenniemi et al. (2013), information was not proactively provided to patients or relatives as a feature of everyday practice. Just asking questions was difficult for some relatives as they were usually unfamiliar with medications or treatments. Having staff explain clinical aspects of the older patients' care, so patient and family could understand and ask questions, seemed crucial to their care experience. As one relative remarked, "I don't understand medical things and what they have done ... and what's going to happen next. It would be nice if the nurse could ask, is there anything you would like to know" (Koskenniemi et al., 2013, p. 10). Feeling in control by communicating and staying informed is essential for patients and family (especially when the older adult is cognitively impaired). Older adults and families want information about illnesses, as well as the results of investigations. In a personal story of a nurse with a life-threatening illness, Zikorus (2007) noted that it was important to have the opportunity to discuss options and express thoughts and feelings about symptoms and the illness. Similarly, communication and staying informed was important to a family member in the study of Clissett et al. (2013) who reported that, if they did not ask, they did not get any information. Such a communication failure could leave both patient and family feeling distressed and lacking control.



Furthermore, older adults described non-verbal communication as equally important as verbal. As noted by a patient in the study by Koskenniemi et al. (2013, p. 8) , “It feels good when a nurse’s gestures and expressions are friendly. Words are not so important ... what is seen in a human being is more important”. Similarly, in the study by Canzan et al. (2014), older adults were particularly sensitive to nurses’ facial expressions and esteemed nurses who smiled while they did their work. These finding echoes those of Shattell et al. (2005) where participants described many positive connections made by nurses through nonverbal actions. For example, "It was made clear to me [by the nurses] ... this wasn't said, but actions speak louder than words” (Shattell et al., 2005, p. 162).

The communication and then application of relational knowledge from the family are also important to the patient’s experience of care. For example, in the study by Clissett et al. (2013), one relative used her knowledge of her mother to influence the care her mother received. She was able to shape that care when she felt the hospital was too slow. “I was trying to push everybody to get her on her feet, get her back to the care home, given they weren't going to operate” (Clissett et al., 2013, p. 2711). Similarly, in the study by Koskenniemi et al. (2013), a family member felt her help was important in terms of her husband’s meals. Every day, she assisted in the feeding of her husband to ensure that he received warm food. She had noticed that the food tray given to her husband’s neighbour was left to get cold. By the time the nurse came to feed the patient, the food was so cold, that the patient refused to eat it and the tray was just taken away. Such examples, reflect the importance of an older patient’s family being part of the communication and sharing of knowledge surrounding their care. Additionally, they indicate the importance of the older individual having some control and autonomy within an environment in which they may already feel alienated.

#### **3.2.4. Older adult’s control and autonomy.**

The older adult’s sense of control can be diminished by hospital structures. Jacelon (2004) defines control as a mental process that most individuals feel when they can exert their will over a given situation which contributes to their conception of autonomy. However, older adults can easily lose control and autonomy, illustrated by the remark of an older patient in the study by Jacelon (2004). ‘It just seemed like they [staff] took away everything. It was just like you were at everybody's mercy, and you didn't count....I guess their word was law’ (Jacelon, 2004, p. 31).

Such psychological control of the patient can be experienced as a result of the routines and protocols of nurses' practice. This can create a negative relationship between staff and patient (Dagnan, Trower, & Gilbert, 2002). The individual can feel dominated and subordinated which can cause feelings of alienation, marginalisation, and internalised oppression (Canales, 2000). A comment from a patient in the Jacelon (2004) study illustrates this point. The older adult reported that he was waiting to be discharged when an orderly came into the room with a wheelchair and said, "I'm ready to take you downstairs for your test" (Jacelon, 2004, p. 31). The patient had no knowledge of the nature or reason for any tests.

Ignoring patients' and relatives' wishes and preferences can impact and prevent the older adult from having some degree of control in shaping the way care is delivered. In one study (Koskenniemi et al., 2013), an older patient expressed her objection to the routine of medication administration. She commented that "I have medicines which I have to take at different times of day. At first it was very difficult to make the nurses understand that the timing of these medicines is very important. The hospital has its own rules ..." (Koskenniemi et al., 2013, p. 10). Such removal of choice from the patient is more to do with the smooth running of the system, even though the lack of choice de-individualises him/her (Scanlon & Lee, 2007). Similarly, handing over medications to the hospital staff to administer was seen as a loss of control by a patient in the study by Edwards et al. (2014). As noted by this patient, "I just accepted they had to take it off us. I probably would have liked to look after my own medications, cause I'm used to that (Edwards et al., 2014, p. 127).

Although consent laws recognize that patient preferences ultimately determine interventions (Perez-Carceles, Lorenzo, Luna, & Osuna, 2007), there is real concern that paternalistic health professionals can push their agenda by adopting a routine approach to care. Similarly, patient choice may be reduced because the normal running of the ward can only accommodate those options which are routine to the ward's culture. Decisions regarding how and when care is delivered are often those of the health professionals and may not concur with those of the patient. Overall quality of care can be compromised if the intervention does not comply with patient's preferred mode of care. To enhance patient autonomy, involving the patient much sooner in the decision-making process should occur, rather than presenting him/her with accept or reject options.

### **3.2.5. Coordination and integration of care across the healthcare sectors.**

Quality of care is also be perceived as a continuum and sometimes the structural characteristic of the hospital does not lend itself to the management of care. Haggerty et al. (2003, p. 1221) defines continuity as, “the degree to which a series of discrete healthcare events is experienced as coherent and connected and consistent with the patient’s needs and personal context.” Moreover, Freeman and Parke (2010) introduced two different aspects of continuity. The first aspect is continuity of relationship, which refers to continuous therapeutic relationships with one or more clinicians. The second aspect is continuity of management, which refers to continuity and consistency of clinical management and includes the provision and sharing of information and communication about care-planning, as well as the co-ordination of the care required by the patient.

Continuity of care matters to patients and their families at every step of their journey within the hospital environment. Breakdown in continuity of management was experienced by an older adult in the Clissett et al. (2013) study. In this study, one family member found that the care received was a source of stress and upset when her mother’s community service was discontinued after a fortnight in hospital and the restarting of service entailed having a new community caregiver. She stated “..... I was very concerned that she should stay with the same carers because she had a relationship with them, they're doing very personal things for her and it worked really well.... (Clissett et al., 2013, p. 2710).

### **3.3. Summary**

The findings from this chapter depicted the care experience of older adults in acute settings as mainly negative and the quality of care for individual patients and family is defined by the nurse’s ability to take a relationship approach to care. The two key subthemes were the physical and relational care and these frequently overlapped. Physical care was influenced by healing relationships. The review of literature presented here suggests that elevating the importance of relational care through interpersonal relationships and giving attention to the needs and expectations of older adults and their families may afford them a positive experience of care. Inclusion of the families’ views is important, allowing the older adults and their families to be considered as a unit.

Furthermore, if nurses are to provide relational care, an understanding of their responses to the needs of older adults, is required. Now we have insight into the needs of older adults, so that we can best meet these needs, we should explore different models of care to use as guidelines. In the following sections, I will explore PCC to see if this model can provide guidance for nurses to practice care, and meet the needs of, older adults in acute settings.

## **CHAPTER 4. Care Delivery Models**

### **4.1. Introduction**

Person-Centred Care is becoming a ‘buzz’ word within some health organisations at a global level and in New Zealand (Australian Commission on Safety and Quality in Health Care, 2011; Rose, Bowman, & O’Toole, 2007; Standards New Zealand, 2005). This illustrates the healthcare sector’s aspiration to move to a holistic care response recognising that illness involves more than purely physiological manifestation. In order to discuss the move towards PCC, I want to profile the historical philosophy of centredness, starting from the biomedical model. I will then critically review relevant elements of the PCC concept, namely personhood, individualism, and autonomy, in order to add clarity to the discussions about the term in the context of gerontological nursing in an acute healthcare setting. Various tools have been used to evaluate and measure PCC, and these will be reviewed, along with a brief discussion of clinical trials where these tools have been applied. I also will explore the limitation of PCC in acute settings.

Given the limitations and debate surrounding PCC (which I will briefly outline), there has been a shift towards care that is ‘relationship-centred’. I will review the concept of RCC to examine whether it reflects the realities of working with older adults within acute healthcare settings. The importance of relational care has been captured in the ‘Senses Framework’ and, consequently, this framework will be briefly examined as a potential therapeutic direction for nurses working with the older adult in the acute setting. A Maori healthcare model, *te whare tapa whā*, has anticipated many of the aspects of PCC, RCC, and the Senses Framework, and so this model will be briefly discussed within the limited scope of this dissertation. Adapting these models to the needs of the acute hospital is challenging, and needs organisational changes. Consequently, in the later sections of this chapter, I will critically review two specific organisational frameworks (namely “Magnet Models” and “Releasing Time to Care”) to determine their contribution to PCC practice in the acute setting (see Table 2).

**Table 2**

*Subthemes Relating to the Models of Care as Experienced by Older Adults in the Acute Healthcare Setting*

|  |
|--|
| Theme 2: Models of Care                            |
| Subtheme 1: Person-Centred Care (PCC) models       |
| Personhood   |
| Individualism                                      |
| Autonomy   |
| Evaluation and measurement of PCC                  |
| Subtheme 2: Relationship-Centred Care (RCC) models |
| Senses Framework                                   |
| The Maori Health Models (the New Zealand context)  |
| Subtheme 3: Organisational models of care          |
| Magnet Model                                       |
| Releasing time to care                             |

#### **4.2. History of the Centeredness Relationship**

In the late 18th century, hospitals became the basis for medical treatment for the general population and were expanded, with a rapid increase in the fields of microbiology and surgery (Conti, 2014). This development gave rise to a new medicine model (the biomedical model of illness) which focused on accurate diagnosis of pathology, rather than on symptoms (Kaba & Sooriakumaran, 2006). It was not until the 1960s, that the Hippocratic Oath was secularised from ‘primum non nocere’ (‘first do no harm’) to include the ethical requirement of promoting the welfare of the patient according to the ‘criterion of beneficence’. Thus, the utmost respect for human life from its beginning to the end stage was advocated. Nevertheless, the original paternalistic concept, where clinicians determined what therapies and interventions were in the patients’ best interests, persisted in many hospitals in spite of these changes (Colombo, Moja, Gonzalez-Lorenzo, Liberati, & Mosconi, 2012). However, with the rise of consumerism, during the 1960s, individuals began to take some degree of a role in the decision-making process. In 1964, the theories of Balint began to emerge, where illness was considered a psychosocial phenomenon, as well as a biological one (Kitwood & Bredin, 1992). In 1967, Rogers asserted that empathy, congruence, and an unconditional positive regard were all necessary to effect therapeutic change in patients (Kitwood & Bredin, 1992). A decade later, Bryne and Long (as cited in Kaba & Sooriakumaran, 2006) advocated that patient-centred consultations should recognise patients’ needs and

preferences. This concept of PCC has become embedded in New Zealand policy initiatives such as the Health of Older People Strategy (Ministry of Health, 2002), the New Zealand Disability Strategy (Ministry of Health, 2001), and within Health and Disability Standards (Standards New Zealand, 2008).

The term PCC does not lend itself to a concise definition, and has been used under different guises. Consequently, a proliferation of terms has emerged such as Patient-Centre Care, Client/Individual-Centred Care, Woman-Centred Care, Family-Centred Care (FCC) and Relationship-Centred Care (RCC). The first three terms imply that clinical care should embrace individual perspectives and preferences to foster a common understanding of illness and its management. On the other hand, FCC and RCC shift the care to others involved in the care process; for example, FCC develops the care around the whole family and not just the individual child/adult. Furthermore, the terms person, patient, client, individual/centred, focused, or directed care have also been used interchangeably (Leplege, 2007; Slater, 2006), even though they can have different meanings and applications. In this dissertation, the term “Person-Centred Care” will include all these terminologies.

#### **4.3. Person-Centred Care**

Person-Centred Care is a multifaceted concept. Carl Rogers initially coined the term in the 1940s to describe counselling techniques that recognized the individual’s unique values, personal history, and personality (Leplege et al., 2007). Kitwood (1997), who applied Rogers’ model to caring for people with dementia, insisted on a personal approach rather than a solely medical approach to care. He maintained that depersonalisation can occur in care environments that focus on the biomedical aspects of dementia and can compromise a person’s psychological health and well-being. In addition, his focus was mainly on the therapeutic interaction between clients and carers. He further identified personhood as, “A standing or status that is bestowed upon one human being by others, in the context of relationship and social being” (Kitwood, 1997, p. 8). The main features of PCC are derived from this concept of personhood. The goal of a PCC approach to care should be to respect the patient’s personhood (McCormack, 2003; Skaalvik, Normann, & Henriksen, 2010), where their individuality is valued and recognised.

#### **4.3.1. Personhood.**

McCormack (2004) argues that the concept of ‘the person’ is complex. He extracted four key concepts from Kitwood (1997) perspectives of personhood underlying person-centred nursing. They include: ‘being with self’ which relates to feeling recognised, respected, and trusted; ‘being in a social world’ through the recognition of biography and socio-cultural aspects of the person; ‘being in place’ by taking into account the surrounding environment (physical, social, and organisational) and its influences on the person; and ‘being in relation’- which refers to the relationally of the person and their development of social relationships.

Within this paradigm, there is an understanding of the older adult as a human being whose sense of self, dignity, pride, and ability to understand the meaning of situations and to act meaningfully remain intact, even during the acute phase of an illness. This understanding enables health professionals to think outside the concepts of cure, based solely on scientific facts and technical competency, and to adopt a more holistic approach (McCormack et al., 2002). A personhood approach acknowledges that the significance of illness can be bound up with the person’s goals, aims, and aspirations; illness can prevent the person from engaging in acts which they view as central to their life. In caring for an older adult, it is extremely important to gain some insight into his/her perspective of the illness and relevant symptoms. This enables PCC to be applied to practice when making clinical decisions about care.

The integration of the older adult’s social world, through a biographical and individual approach, can enable nurses to not only understand and offer coping strategies, but also to use this as motivation to maximise the patient’s potential. Likewise, a patient’s life-span, their perceptions, values, and needs can be used as personal resources and guidelines for practice, where age and illness became irrelevant as predictors of recovery. In acute settings, older adults can be overshadowed by the hectic efficiency of modern-day nursing care (Koskenniemi et al., 2013), but the establishment of effective, nurturing relationships can lead to better health outcomes and help to sustain a connectedness between the person and his/her social world (McCormack, 2004). The following section will discuss how an appreciation of ‘being in relation’ is relevant to PCC nursing care.

‘Being in relation’ is an interdependent relationship that entails being interconnected with other human beings. Nurses can encourage the inclusion of personhood in the care



of older adults through valuing interdependence. McCormack (2001) contends that the values that both patient and nurse bring to the care and nurturing of this relationship component of personhood may also provide and maintain the connection between health professional and patient. Although this view has merit, it is open to criticism as it tends to somewhat exclude family and other multilevel influences on the interaction between nurse and patient. The latter is supported by Clark (2002) who argues that we can only fully understand an individual by placing him/her within a matrix of relationships and social-cultural beliefs. The care of older adults in acute settings will include multi-professional members, as well as non-regulated members (healthcare assistants), and is embedded in a cultural and political context. Nurses' interactions are not only influenced by their relationships with their immediate surroundings but also by the structural environment such as policies, protocols, and regulations which may be beyond the role of some individual nurses.

According to the earlier social ecology model of Bronfenbrenner (1977), individuals exist within multiple environments and are influenced by factors within different levels of each one. Moreover, individuals are influenced by factors in an environment which exist in other 'outside' contexts (Bronfenbrenner, 1977). Regulations around the efficient management of the healthcare facility that exist outside specific healthcare settings can influence experiences within these environments by dictating certain choices and actions. An example of this occurs in the New Zealand DHB within which I work, where recent targets for medical wards around length of stay is restricted to three to five days, rather than allocating the length of stay according to the needs of the patients. Thus, the maintenance of personhood for an older adult in an acute setting is founded on the perspectives and the interactions with health professionals in that setting. Therefore, personhood can be compromised both intentionally and unintentionally by the action of nurses, who may not provide individualised care to meet the specific needs of the patient.

#### **4.3.2. Individualism.**

Edvardsson, Koch and Nay (2009) believe that individualising care demonstrates an appreciation of the person's unique histories and personalities, so that this care can be tailored to meet the person's specific needs. PCC assumes that each patient's reaction to

illness is unique, as opposed to assuming that all people with the same condition will have similar needs and, thereby, benefit from the same care.

If nurses do not show a commitment to the delivery of individualised care, they can tend to adopt a homogenous approach (Wilson, 2008). Conversely, an approach to care based on the individuality and understanding of each unique individual can combat the negative aspects of the traditional medical model approach. Therefore, the care delivery is only individualised if tailored to the needs of the individual as opposed to being routine and standard.

The social support offered to a patient illustrates the importance of individualising care. It may be appropriate to discharge a rest-home resident within days of undergoing an eye cataract surgery, as his/her personal social support is relatively high. By contrast, an older adult patient with similar surgery, but who is the main caregiver for his demented wife, is most likely to have complicated social circumstances which require further investigation. Individualised care means that care should first and foremost acknowledge that individuals are the experts about their own situation and that a care plan should include input from both the patient and healthcare professionals. This idea is shared by Suhonen, Leino-Kilpi and Välimäki (2005) when they define individualised care as a type of nursing care that promotes patient participation in the decision making where the patient's personal characteristics, clinical condition, personal life situation, and preferences are taken into consideration. That means patients should be active participants in their care as opposed to being merely passive recipients of that care. From this perspective, the older adult should not be left in ignorance or with a sense of powerlessness. For the older adult to actively participate in their care, they ought to be fully informed about their conditions and the alternative treatments/therapies available, as well as being given the opportunity to optimise their abilities.

However, the individuality concept embraces far-reaching changes of the working routines that influence nurses daily. In an acute setting, where resources are scarce, services delivered to one patient can alter their availability to another patient. Nolan, Keady, and Aveyard (2001) argue that individuality should not be ignored, but rather than investing in developing PCC as the watchword of quality, it would be better to develop the various dimensions of RCC.

At this point, it appears relevant to discuss autonomy from a PCC perspective. Autonomy is widely discussed in healthcare literature in such a way that implies a common understanding of the concept as 'individualism'.

#### **4.3.3. Autonomy.**

Autonomy, an ambiguous and often ill-defined concept, is one of the central principles of practice when caring for older people (McCormack, 2001). The liberal view of autonomy, based on independence and self-determination from an individual perspective, has been critiqued by Agich (2003). He suggested that, in the context of long-term care, it is preferable to work with a concept of 'actual autonomy'. This includes the lived experience of autonomy in circumstances where interdependence, rather than independence, takes place. Atkins (2006) agrees when he states a conception of autonomy focused on freedom of the will alone is not adequate. Possibly, the most important work enabling an understanding of autonomy in relation to older people was presented by McCormack (2001). McCormack (2001) confirmed that autonomy from an individual perspective is frequently untenable in the context of healthcare for older adult. McCormack (2001) suggests that, for hospitalised older adults, the capacity to undertake full autonomy at a time when they are at their most vulnerable can be limited. In present day healthcare systems, older adults can be expected to make decisions which could negatively influence their desire for independence and self-determination. Such a demand can be an unrealistic ideal and one that often results in a form of paternalistic or proxy practice (McCormack, 2001). McCormack (2001) maintains that autonomy should be based on interconnectedness and partnership, so as to emphasize both the uniqueness and interdependence of individuals. With any supported or substitute decision making, such as proxy care by family or healthcare professionals, caution should be exercised to balance rights and risks. Moreover, Atkins (2006) concludes that enabling patients to be autonomous will make higher demands on nurses who will need specific training in counselling-type communication skills. Such skills require special training and expertise as autonomy can be fragile. As noted in chapter 3, older people themselves will need emotional, linguistic, cognitive, and communicative competencies, which may not be available to them when acutely unwell.

Davies, Ellis, and Laker (2000) suggest that autonomy may be affected by the nurse's ability to negotiate care, provide information to patients, and acknowledge and

recognise personhood and individuality. Advancing similar arguments, Epstein, Fiscella, Lesser, and Stange (2010) assert autonomy is often achieved through caring partnerships among health professionals and patients, where patients are supported to consider all their options and actively participate on their own care. Without healing relationships, patients can be left to make decisions on their own in a fragmented healthcare system. Moreover, many internal and external constraints, as previously mentioned, may prevent an individual from exercising full autonomy (McCormack & McCance, 2010).

In 2001, McCormack conducted a qualitative study using 14 case studies of nurse-patient interactions. Through his in-depth, qualitative research, he identified a range of issues considered to be constraints to the older adult's autonomy. These included the dynamics of power and control, patient's access to information, the impact of professional authority, the restrictive nature of institutions, and the influence of family and carers in the decision making process. McCormack (2003) suggests the need for a conceptual framework for PCC for older people and an "authentic consciousness" which is a clarification of values to maximize potential for growth and development.

According to McCormack (2003), there are five enabling factors which assist nurses to facilitate autonomy and implement PCC into practice. They include 'informed flexibility' defined as the facilitation of decision-making through information sharing; 'sympathetic presence' defined as an engagement that recognises the uniqueness and value of the individual; 'negotiation' defined as patient participation through a culture of care that values the views of the patient as a genuine participant in the decision-making process; 'mutuality' defined as the recognition of the others' values as being of equal importance in decision-making; and 'transparency' defined as making explicit intentions and motivations for action as well as the boundaries within which care decisions are set.

Authentic consciousness emphasises interpersonal skills, direct negotiation, and partnership with older adults (McCormack, 2003). It focuses on their value and life stories rather than the mere clinical and technical skills necessary to retain autonomy. As seen in chapter 3, control and autonomy were viewed by the patient as an important factor in their experience of care. The transparency factor urges nurses to reflect on their own values and attitudes towards ageing in order to have successful negotiation. However, in modern society where ageism is rife, nurses could find this a real challenge

and a more in-depth discussion on ageism will be presented in chapter 5 of this dissertation.

If PCC is to be effectively practiced in the care of older adults in acute settings, there is a need for measurement and evaluation; especially the measuring of patients' experience of PCC, and the impact of interventions designed to improve it. As noted in chapter three, the experience of older adults is increasingly being regarded as an indicator of quality of care in healthcare systems. However, the measuring of PCC for older adults, particularly in acute settings, is underdeveloped. In the next section, I will review the literature on evaluation and measurement of PCC in an acute setting for older adults. I will first introduce some measuring tools which aim to quantify PCC, but since the scope of this dissertation is limited, the details of these tools will not be explored. Secondly, I will review three articles that evaluated and measured PCC in the context of acute care settings.

#### **4.3.4. Evaluation and measurement of PCC.**

The evaluation and measurement of PCC is particularly significant for health organisations and policy makers so that progress can be monitored and a more effective PCC health system can be created. Whilst there is an emphasis on providing PCC in care delivery, putting it into practice and achieving quality outcomes present a challenge. Outcomes can be varied according to whom is involved (namely the organisation, the patient, or the nurse). Nursing outcomes describe changes in a patient's state of health for which nurses are responsible (Müller-Staub, Lavin, Needham, & van Achterberg, 2006). Administrators are typically interested in quality outcome indicators such as length of stay, cost effectiveness, the number or type of infections, falls, or readmissions. However, hospital administrators have recently expanded their focus to include patient satisfaction with the care experience as an important outcome. In the long term, PCC ought to be judged by the quality of patients' perceptions and experiences of care and the quality of their interaction with health professionals (Epstein et al., 2010). Hence, in order to effectively evaluate and measure PCC in practice, different measures from each of the different sources are required. The current challenge is to identify reliable procedures that can systematically measure and develop PCC (Woolley, Young, Green, & Brooker, 2008). These evaluations and

measurements include patient surveys, direct observation, and both qualitative and quantitative methodologies.

Patient satisfaction surveys have been used as an integral part of evaluating health services in the United Kingdom since 2001, as well as in New Zealand (Aharony & Strasser, 1993; New Zealand Health Quality and Safety Commission, 2013b; Zwier, 2009). Even though patient surveys can prove helpful in assessing quality, they are required to be paired with other data sources due to their inherent limitations. For example, patient ratings can provide false results if they only experienced suboptimal care (Saba et al., 2006). Another area of potential bias in patient satisfaction surveys/interviews lies in the collation of data. Only patients who are physically and cognitively well enough to participate are included. Thus, those patients who are too ill, and may not be receiving PCC, are unable to be interviewed. In such cases, family members may have to be included in the collation of data (Mansell & Beadle-Brown, 2005).

Consequent to the limitations of patient satisfaction surveys, several other measuring tools to quantify the outcomes of implementing PCC have been developed. Some evaluate PCC by measuring caring as an outcome, as in the study by McCance, Slater, and McCormack (2009), who used a Person-Centred Nursing Index (PCNI) to measure the caring dimension as an indicator of PCC. The PCNI developed by Slater (as cited in McCance et al., 2009) is a combination of a Caring Dimensions Inventory (CDI) and a Nursing Dimension Inventory (NDI). This index was used to measure both the nurses' and patients' perceptions of care in the McCance et al. (2009) study which included 122 nurses, and 107 patients /family. Use of this tool revealed an incongruence between the nurses' and patients' perceptions of care. These findings encourage nurses to be cautious when making assumptions about what is important for patients in their experiences of care. As discussed in chapter 3, relational care is an important aspect of the patient's experience and nurses need to determine what the patient considers as caring and use this to effect changes in practice, if they are to deliver PCC.

Other measurement tools developed by Edvardsson et al. (2009, 2010) measure the extent the psychosocial environment of healthcare settings is perceived as PCC. These tools include the Person-Centred Climate Questionnaire (PCQ) for staff (Edvardsson, Koch, & Nay, 2010) and the PCQ for patients (Edvardsson et al., 2009). However, the responses around care practices can be restricted to categories in the questionnaires and

care should be exercised with the wording of questionnaires as it can manipulate responses and skew findings. Moreover, they can provide no real insight or understanding into the meaning and experience of the concept of PCC. In addition, there is little research about the feasibility of PCC in acute settings for older adults.

#### **4.3.5. Clinical evidence for effective PCC evaluation.**

In the ensuing discussion, I will review three studies which aim to evaluate PCC using the different tools of quantitative, qualitative and observational methods in acute settings (Wolf et al., 2008; Bolster & Manias, 2010; Alharbi, Carlström, Ekman, Jarneborn & Olsson, 2014). None of the studies focused primarily on older adults, but were chosen according to context, and environment. With some fine tuning or adaptation, the outcomes from these studies could be potentially transferred and used in acute settings for older adults.

A randomised, single-blind (patients), controlled trial by D. Wolf et al. (2008), used the Baker and Taylor Measurement Scale (BTMS) (Baker & Taylor, 1997) and the Schmidt Perception of Nursing Care Survey (SPNCS) to assess the individualisation of treatment planning on patient satisfaction, quality of care, and patient perception of nursing care on patient satisfaction. In this study, 116 patients (mean age 46.0 years) scheduled for bariatric bypass surgery were randomised to treatment with PCC (n=58) or standard usual care (n=58). Nurses (n=11) trained in providing PCC telephoned patients in the PCC group (n=58) 24 to 48 hours preadmission and explored the patients' goals, concerns, expectations, and fears around their hospitalisation. Patients were asked to select a partner from family or friends to include in planning the care during hospitalisation. Prior to admission, the information was then tailored to the care plan. The control group (n=58) received the usual care according to existing guidelines, policies, and procedures by non PCC trained nurses. Both groups completed two questionnaires at discharge and were contacted 24 to 48 hours post discharge to complete a structured interview.

D. Wolf et al. (2008) concluded that PCC did not significantly affect outcomes. There were no differences detected between the two treatment groups for length of stay, falls, postoperative infections or other complications, or perceptions of nursing care. Statistically, there were no significant multivariate differences between the two groups

when measuring patient satisfaction (BTMS,) or satisfaction with nursing care (SPNCS).

The qualitative findings in the D. Wolf et al. (2008) study revealed that most patients (>80%) in the PCC group had no pre-operative concerns. The remaining (20%) of patients reported general anxiety around surgery, pain management, and management of existing comorbidities. Ninety-six percent of patients requested that their care partner be included in the planning and of the 4% who declined the involvement of a care partner, most lived alone. Post-discharge interview data (>80%) reported positive themes such as very 'satisfied', 'nice', 'good', and 'excellent care' for both groups. Likewise, negative themes such as delays, medical management issues, need for individualised information/education and concerns with the hospital environment were distributed equally between both groups. However, the interview data indicated that nurses delivering PCC had a positive impact on the manner in which patients were prepared prior to surgery.

The major limitations of the D. Wolf et al. (2008) study were that the tools were not specific to the respondents and may not have been sufficiently sensitive to detect changes from the interventions and could account for a ceiling effect (D. Wolf et al., 2008). A post hoc power analysis disclosed that to achieve a power of .80 with a p-value of .05 would require an approximate sample size of 1,500 per group, which would have been difficult to achieve whilst still maintaining accuracy of the interventions (D. Wolf et al., 2008). Another reason for changes remaining undetected could have been that the nurses in the control group already had a high standard of PCC. However, comparison was not an option as the baseline characteristics of the PCC trained nurses was not obtained. As previously mentioned, the D. Wolf et al. (2008) study did not focus on older adults but the findings have the potential to be transferred to older adults. Any research with regard to older adults in acute settings necessitates specific tools and obtaining basic characteristics of nurses if comparisons are to be drawn.

Another observational study conducted by Bolster and Manias (2010) involving 11 nurses and 25 patients in an acute ward in an Australian hospital, whose vision and philosophy was PCC based, identified various challenges in relation to medication activities. This study employed a semi-structured interview using a thematic analysis approach, with eleven nurses but only 16 of the 25 patients post-observationally. The findings revealed that some nurses provided a flexible approach to meet the needs of



individual patients, such as the timing, crushing or halving of tablets for ease of swallowing. However, medication administration largely followed routine medication times and processes and interactions and decision-making were often nurse-imposed. Nurses frequently missed opportunities to actively engage patients in their medication activities. Although nurses reported that they wished they had more time to spend with patients during medication administering, this was not observed even during the less busy periods. In fact, nurses were usually located in the nurses' station either reading or documenting clinical notes. Thus, two themes of 'time constraints' and 'team communication' emerged from the Bolster and Manias study (2010). These contextual barriers to implementing PCC could be used to inform and challenge nursing practice.

Furthermore, according to Bolster and Manias (2010), there was a discrepancy between how the nurses perceived and reported the delivery of PCC and its actual application and it was often according to the nurses' perceptions. This finding is significant when related to older adults especially during acute illness when autonomy can be threatened (McCormack, 2001) and, as noted previously in chapter 3, some nurses may take over and not involve patients in their care. Although, it is possible that the behaviour of the practitioners changed as a direct result of being observed or the observational method could have caused discomfort to the participants, it does have the advantage of overcoming the discrepancy between what participants say and what they actually do. By using an interview technique, Bolster and Manias (2010) provide valuable insights not only into the contextual barriers but also into the experience of patients and the beliefs and behaviour of nurses.

Similar findings emerged from the recent Alharbi et al. (2014) study which used patient experience to evaluate PCC practice. This study investigated the implementation of PCC from a patient's perspective, in two medical wards at a Swedish hospital, where PCC had been implemented at least a year earlier. Sixteen patients, aged 22 to 91 years, who had been hospitalised previously, were interviewed after receiving care for at least two days. It was found that, although PCC had clearly occurred and gained momentum in the wards, implementation was fragmented and not fully achieved. Patients too had different perceptions of how individual nurses interacted with them.

Furthermore, patients responded differently to the PCC approach (Alharbi et al., 2014). Some felt included and could participate in their care and were enthusiastic about it. Conversely, others felt excluded but were not really expecting to be treated differently.

The latter, did not seem to mind and preferred to leave the decision making to nurses, who they perceived as the experts. In contrast, other patients did not perceive nurses as experts and wanted to participate actively in their care. Several patients reported non-PCC activities such as staff talking to each other over their heads or ignoring them or talking to relatives which made them feel 'excluded'. Even if the patients did not want to participate in their care, they were not invited or encouraged to do so. The findings from this study are very relevant to older adults in acute settings who often feel marginalised and are not encouraged or supported to be involved in their care as reported in the literature reviewed in relation to patient experiences (chapter 3).

The limited literature review in this dissertation confirmed that the implementation and evaluation of PCC in acute care varies widely and is never reliable. Patients respond differently to PCC, which may potentially be a reflection of how the nurses implemented and applied PCC. The main limitation of this review is that I was unable to include, or only partially include findings from the above three studies directly relating to older adults in acute settings (Alharbi et al., 2014; Bolster & Manias, 2010; D. Wolf et al., 2008). Moreover, the views of family and carers were not included in any of these studies.

Although the randomised study by Wolf et al. (2010) indicated that no long-term improvement in clinical outcomes were achieved, the other two studies did find positive relationships between PCC practice and patient satisfaction. There are other dimensions of PCC and multi-dimensional interventions which can influence clinical outcomes that were not captured in the above three studies (Alharbi et al., 2014; Bolster & Manias, 2010; D. Wolf et al., 2008). One limitation of these studies is that they were not isolated to older adults' population although they did include older adults.

#### **4.3.6. Limitations of Person-Centred Care.**

The limitations to PCC have been documented and a major criticism is that the concept is poorly defined in healthcare settings (McCormack & McCance, 2006). The concept of PCC is multi-dimensional, and, as previously discussed, any tool used to evaluate its effectiveness needs to be multidimensional. In line with the heterogeneity of the interventions, a variety of outcomes should be measured, including those of patients, staff, and service/providers. With regard to service outcomes, the impact of PCC was not often clear.

McCormack's authentic framework does have the potential to implement PCC, but it also has certain limitations in its application and requires further research (McCormack, 2001). This framework appears to have limited applicability to acute settings for older adults as it tends to underestimate the challenges nurses encounter in practicing in such an area. The framework demands an advanced level of skill, expertise, and knowledge of the older adult which poses a challenge for newly graduated registered nurses and enrolled nurses, whose education is less detailed. Imperfect duties cannot always be applied in the same way to each individual patient and context as they can sometimes compete with each other in the ethical decision making (McCormack, 2001). For a busy nurse, it can sometimes be tempting to apply standardised procedures to all patients. Routines can provide predictability and assist in the smooth functioning of complex workplaces. Moreover, it is possible to be efficient, professional, and diligent whilst also being sensitive, humane and caring.

One could argue that a framework resulting from research on such a small scale in one country (UK) with limited information around cultural sensitivity may not generalised to other countries such as New Zealand with its high ethnic diversity. Another limitation identified by Nolan, Davies, Brown, Keady, and Nolan (2004) is that PCC tends to exclude the multilevel influences on the interactions of nurses and patients as previously discussed.

In light of the above PCC framework limitations, I was led to approach the issues of care of older adults in acute settings from a different lens. I evaluated strategies such as those supporting and valuing those involved in the care (such as family/ whanau, health professionals and community) to work effectively together. An examination of the RCC approach to care could potentially improve the care of older adults (Tresolini et al., 1994) . In the following section, I will examine the use of the RCC framework as a foundation for the nursing care of older adults in acute settings. However, I first will provide an overview of the history of RCC's development, its dimensions and the Senses Framework by Nolen et al. (2004).

#### **4.4. Relationship-Centred Care**

The term Relationship-Centred Care was first introduced in a report by the Pew Fetzter Task Force on Health Professions Education (Tresolini et al., 1994) in the USA, after an extensive review of the failure of contemporary healthcare systems to respond to the

challenges posed by patients presenting with chronic conditions. The Task Force report suggested that an individual, disease-orientated approach would not in any way address the social, economic, environmental, cultural, and political contexts of healthcare. Instead, it produced a form of healthcare that was, at best, fragmented, episodic, and unsatisfactory for patients and health professionals alike. Tresolini et al. (1994) concluded that the interactions among health professionals, patients, families, and the wider community are at the foundation of any therapeutic or healing activity. From this synthesis of ideas emerged the concept of RCC.

The Pew Fetzner Task Force identified the following core features of effective RCC in healthcare settings: promoting and accepting the emotions of others; sharing knowledge as a basis for interactions; effective conflict management; a willingness to negotiate and compromise; and acknowledging what people do well (Tresolini et al., 1994). This relational practice necessitates developing and sustaining interpersonal relationships among everyone involved in care and requires emotional connection and collaboration. Parker (2002) defines relational practices as those activities necessary to develop and sustain interpersonal relationships within a specific context and sees emotional connection and collaboration as essential characteristics.

According to Nolan et al. (2004), RCC includes all those involved in caring for the older adult such as family, healthcare professionals, paid or voluntary carers, and those involved at the organisational level, such as managers and administrators. The authors agree with Kitwood's definition of personhood, as the standing or status bestowed upon one human being by others in the context of a relationship (Kitwood, 1997). In other words, the personhood of those involved in the care is equally important as those who receive care. Relationship-Centred Care promotes a culture where 'everyone matters' which concurs with one of the core values of the DHB where I work.

Moreover, RCC goes beyond the traditional level of the patient-nurse relationship: it also includes the relationship of nurse with other nurses, and those of the professionals and the nurse with the community by incorporating interdependencies and reciprocities of interactions. Reciprocal refers to the mutual simultaneous influence that the interacting elements exercise on each other. For example, if health professionals demonstrate negative attitudes towards older adults, they may, in turn, become negative and passive towards treatment/therapy. Likewise, physiologic measures confirm that patients and clinicians strongly react to each other in any clinical encounter (Fonagy as

cited in Dill & Gumpert, 2012). The developments of such a relationship should encourage instead the transformation of hierarchical patterns into a partnership in the context of any healthcare setting. Such relationships should attempt to strike a balance between the needs of all those involved in the care of acutely ill older adults as it involves multiple stakeholders and services.

Suchman (2006) states that the most basic tenets of RCC include the ability of everyone working in a partnership to achieve outcomes that are greater than the sum of individual efforts. Safran, Miller, and Beckman (2006) identified a link between effective team work and team functioning and a range of clinical outcomes such as reduced mortality, improved functional outcomes, shortened length of stay, improved workforce morale, and decreased staff turnover.

Effective relationships and team work result in improved team functioning (Safran et al., 2006). Clinicians from different disciplines need to collaborate in recognizing and responding to the patient's informational, relational, and emotional needs to ensure that the patients' needs are met. Therefore, relational effectiveness among services and stakeholders can be more important than clinical effectiveness. RCC promotes such relationships by minimising the disruption of healing relationships, enabling health professionals to bridge differences, listen and respect colleagues, and appreciate the contributions they bring from other disciplines (Beach & Inui, 2006). Such emotionally connected and partnered clinical relationships, advocated by Tresolini et al. (1994), acknowledges reciprocity, responsibility, and power sharing. However, without the requisite range of knowledge, skills, values and support, achieving such relationships can be doubtful.

#### **4.5. The Senses Framework**

Nolan (2001) also stressed relational care and captured it in the 'Senses Framework'. He saw the latter as being six interconnected senses, all of which needed to be felt by those both giving and receiving care, if high quality care is to be achieved. The Senses Framework, originally proposed in 1997, suggested that it could provide a greater sense of therapeutic direction for staff working within healthcare settings (Nolan et al., 2001). Nolan developed the Senses Framework after an initial overview of some 22,000 references. The majority of these items were academic papers in peer reviewed journals, with books and reports contributing approximately 5% of the total (Nolan et al., 2004).

The abstract for each item was scrutinised and key themes and concepts identified. After a more detailed reading of approximately 2,000, Nolan presented a summary of the 'senses' (Nolan et al. 2004).

The Senses Framework was first utilised in the Advancing Gerontological Education in Nursing (AGEIN) project in which 718 student nurses and 1,500 registered nurses participated (Nolan, Davies, Brown, Keady, & Nolan, 2002). Data were collated from questionnaires, focus groups, and observations and terms of impoverished and enriched environments of care. The framework also was tested by Faulkner, Davies, Nolan, and Brown-Wilson (2006) in residential environments and by Davies, Brown, Wilson, and Nolan (2000) in an acute setting for older adults. The findings from the research in this setting provided strong empirical support for the main framework and highlighted the parameters of good quality care.

The Senses Framework comprises of six senses, summarised as follows: a sense of security (to feel safe within relationships); belonging (to feel part of things); continuity (to experience links and consistency); purpose (to have a personally valuable goal/s); achievement (to make progress towards a desired goals); and significance (to feel that the individual matters). They are seen as prerequisites for good relationships within the context of care and service delivery. Nolan et al. (2004) maintain that the Senses Framework can more fully articulate the conditions necessary to create and sustain enriched environments of care in a wider context than PCC combined with RCC. The fundamental premise of the vision of Nolan et al. (2004) of RCC is that good care can only be delivered when the 'senses' are experienced by all the groups involved.

The Senses Framework promotes a way of understanding the prerequisites for creating positive relationships and defines the structures and interactions that maintain these relationships. It incorporates the concept of interdependent relationships required to create and sustain an enriched environment of care where the needs of participants are recognised and addressed. Nolan et al. (2006) explained that fulfilling the Senses Framework in an acute environment not only demands competent technical care, but must also acknowledge the importance of fundamental personal care that promotes dignity and makes skilled assessments of the patient's needs.

Insights gained in relation to the Senses Framework, when used in conjunction with RCC, may create an improved and more responsive delivery of care and have implications and relevance for older adults in acute setting. The construct of RCC seems

to hold some promise of contributing to improving healthcare quality but further investigation is needed. For instance, creating and sustaining such positive relationships according to Beach and Inui (2006) requires a resourcefulness and resilience on the part of the staff. Given the frenzied pace of the medical ward, as well as the objectivist, positivist concept that permeates contemporary scientific culture, where the emphasis is on a rational and linear thinking approach to problem solving, it may be difficult to find and sustain the time and will for reflection on self and well-being. A standardised, prescriptive manner has insidiously become the driving force behind nursing practice (Jonsdottir, Litchfield, & Pharris, 2004) and has encouraged a tendency to technical mastery, as opposed to humanism.

The Senses Framework has potential for a direct practical application and could include many of the complex factors which have been absent from the delivery of optimum care for older adults in acute settings. Indeed, older adults themselves have identified that the relational aspect is often absent from their care (chapter 3). The challenge to optimum care for older adults comes from the enormous diversity of factors in acute settings, including the diversity of nursing staff and health professional and their characteristics, their relationships, role expectations, the nature of the services delivered, the diversity of older people themselves in terms of their impairment severities, types of behavioural and psychological symptoms, physical health, social and cultural, as well as the physical structure of the ward. Other factors include inadequate staff numbers, knowledge, compassion and characteristics of the service itself, and activities that promote personal growth, lifelong learning, and ongoing support. All these influential factors need to be addressed before the six senses of the framework can be experienced by older adults and all those involved in their care.

In NZ, there is a model of care which anticipated many of the aspects of the Senses Framework, PCC and RCC. This is known as *te whare tapa whā*/ the four cornerstones (or sides) of Māori health and, in the following section, I will provide a brief overview of this Maori health model and briefly mention other Maori health models recognised by the NZ Ministry of Health (Ministry of Health, n.d.).

#### **4.6. Māori Health Model – *te whare tapa whā***

According to Durie (1984), *te whare tapa whā* model of care perceives health as a *wharenui*/house with four cornerstones (or sides). With its strong foundations and four

equal sides, the symbol of the wharenui illustrates the four dimensions of well-being. The first is taha tinana (physical health), where the physical ‘being’ supports our essence and shelters us from the external environment. Secondly, taha wairua (spiritual health), which determines individuals as a collective, who and what they are, where they have come from and where they are going. Then, taha whānau (family health), where the whanau provides the individual with the strength to be who they are. The taha whānau also provides an important link to their ancestors, their ties with the past, the present, and the future. Finally, taha hinengaro (mental health), which is how individuals perceive themselves in this universe, their interaction with that which is uniquely Māori, and how others perceive them (Durie, 1984).

The physical dimension/body cannot be separated from the aspect of mind, spirit/wairua, and family/whanau (Coyle & Williams, 2001). Should one of the four dimensions be absent or damaged in some way, the person or collective may become ‘unbalanced’ and subsequently unwell. This bears a remarkable connectivity to the principles of PCC (seeing the person in the patient).

Other models of Maori Health acknowledged by the NZ Ministry of Health include that based on “Te Wheke”, the octopus. and the eight tentacles that collectively contribute to waiora (total wellbeing) and a more recent model “Te Pae Mahutonga” (Southern Cross Star Constellation) which brings together elements of modern health promotion (Ministry of Health, n.d.). In these models of Maori health, understanding the importance of whanau (family) and how whānau can contribute to illness as well as assist in curing illness is fundamental. The Maori health models include a patient’s capacity to communicate, to think, and to feel, where mind and body are inseparable. This holistic approach reflects the collective nature of Maori and their spiritual view/wairua and is inherently related to health. These are important constituents for Maori health and are required to be included in any plans and interventions. Furthermore, the focus should be on the relationships among the different elements of health which influence well-being.

The Maori models of health anticipated PCC in many aspects as they all adopt a holistic approach to deliver care to address the diverse needs of Maori and whanau. PCC can empower Maori patients by enabling them to express their feelings about their healthcare during interaction with nurses and take that care beyond the medical model of symptoms and treatments/therapy (Boulton, Simonsen, Walker, Cumming, &



Cunningham, 2004). Physical vulnerability could be seen as the manifestation of social and psychological vulnerability (Scanlon & Lee, 2007). Interactions between Maori older adult patients and nurses are critical to addressing the physical comfort, emotional needs, spiritual, and cultural requirements as demonstrated in the Maori models of health. The latter also recognises the interdependence of people, that health and wellbeing are influenced and affected by the 'collective' as well as the individual in their social contexts. Maloney-Moni (2006) maintain that engagement must be with the whānau in dealing with health issues and that failing to do so will not result in better health outcomes. Thus, nurses practising PCC can use the partnership approach to ensure that plans and interventions are culturally embedded and decision-making is in the context of relationships within the social environment/context. In New Zealand, the bicultural Treaty of Waitangi obligates the government to be involved in the health of Māori. Initiatives to address Māori health have been based on the three key principles articulated in the Treaty of Waitangi – partnership, participation, and protection (Ministry of Health, 2015).

#### **4.7. The Magnet Model**

Adapting the models mentioned above to the needs of the acute hospital is challenging, and needs organisational changes. Another model relevant to the discussion of PCC and the older adult in the acute setting is the Magnet Model, which exemplifies the recognition of PCC and directs attention towards creating a healthy work environment, including at the organisational level.

Magnet designation is awarded to hospitals that have demonstrated possession of certain key elements such as creating an environment in which nurses are afforded professional autonomy, shared decision making, effective leadership, and professional development opportunities (Grant, Colello, Riehle, & Dende, 2010). Investing in nurse staffing, improving practice environments with high ratios of qualified to unqualified nursing staff as well as high educational levels among nurses, are equated with high levels of patient satisfaction (Aiken 2002). The view that if staff are not valued they cannot deliver PCC is supported by Armstrong and Laschinger (2006) when they state that nurses, who feel supported, valued and empowered, demonstrate more commitment to their workplace and deliver higher quality care. In the following section, I will provide a review of the literature relevant to the Magnet framework.

The Magnet Recognition Program was developed by the American Nurses Credentialing Centre (ANCC) in response to the 1980s nursing shortage in the USA (Grant et al., 2010). In order to gain Magnet accreditation, hospitals are required to demonstrate quality improvements across a number of components which are outlined below.

The first component involves transformational leadership which is a style of leadership where the leader identifies an organization's vision and communicates this vision effectively to employees in such a way that they are motivated to become involved in the decision making around their work practices (Grant et al., 2010). Individuals also require a certain set of needs to be met in order to be productive. This theory encompasses Maslow's higher level of needs which include: achievement, confidence, respect, problem solving, creativity, and acceptance to elevate self-esteem and promote self-actualization. Transformational leadership incorporates the same principles of shared governance to restructure the delivery of patient care (K. Johnson et al., 2012). These strategies can empower nurses to become an integral part of the healthcare delivery team.

The second component, structural empowerment, enables a flexible and decentralized organisational structure. This structure facilitates shared decision making among staff, as well as shared governance among leaders and staff (Grant et al., 2010). Shared governance involves partnership, equity, accountability, and ownership at the unit level where the care is provided (Porter-O'Grady cited in Barden, Griffin, Donahue, & Fitzpatrick, 2011). For example, nurses are able to review existing practices and incorporate evidence-based nursing into their current practice so that they became the champions of innovative practices.

The third component, known as exemplary professional practice, ensures autonomy and accountability for the care they provide (Grant et al., 2010). This entails evaluation and modification of the practice by the professional. Nurses also closely monitor patient satisfaction and nurse-sensitive indicators and incorporate practices to engage and empower both patient and family in care delivery. Since nurses are the experts in patient care, they share information and decision-making with patient such as face to face bedside handover, as opposed to a taped handover or one in the nurses station removed from the patient.

The fourth component includes new knowledge, innovation, and improvements through evidence-based nursing practices and continuous quality improvement (Grant et al., 2010). These four organizational components interact to create a positive work environment, resulting in better empirical outcomes which is the fifth component of the Magnet model (American Nurses Credentialing Center, 2013). The primary outcome of the Magnet model is associated with improvements for nurses which address high staff-turnover, retention, and satisfaction.

Furthermore, Magnet-accredited hospitals which fulfil criteria such as adequate staffing levels with a high percentage of Registered Nurses (RNs) do not always have better patient outcomes that are so called 'sensitive' to bed-side nursing care or fewer avoidable patients complications. The result of some studies such as that of Mills and Gillespie (2013) provide no conclusive evidence for improved risk-adjusted rates for pressure ulcer and failure to rescue ( $p > .05$ ) between Magnet ( $n=80$ ) and non-Magnet hospitals ( $n=80$ ). However, the study had some limitation as it used secondary data and did not include other essential conditions such as nurse staffing and education levels. Moreover, there was some concern that the clinical data recorded in patients discharge abstracts, such as failure to rescue, were adequately and consistently recorded and coded across hospitals.

Therefore, research should continue to investigate whether Magnet status impacts on clinical indicators of patient safety and quality nursing care. In addition, Magnet accreditation is a rigorous, lengthy, and costly process which involves the lodging of application, submission of written documentation, evaluation, and an on-site inspection with all costs borne by the healthcare facility (Middleton, Griffiths, Fernandez, & Smith, 2008). Russel (2010) states that a hospital takes an average of 4.25 years to complete the Magnet Recognition Program process at a cost of between \$US100,000 to \$US600,000 annually. This level of expenditure requires a careful analysis of the benefits of obtaining Magnet Recognition. Therefore, it is important to ensure that limited resources are being directed in the most efficient and effective manner.

In order to obtain a baseline measure of organisational structure and to identify areas of low performance, a useful exercise would be to undertake a survey and compare it against the Magnet standard prior to applying for Magnet accreditation. In a study by Middleton et al. (2008), the nursing practice environment was assessed according to a Practice Environment Scale (PES), especially adapted to the Australian context. Nurses

(n=67) from four wards at a 400 bed acute general hospital completed a self-administered questionnaire about their practice environment. The data were compared with the published norms from Magnet and non-Magnet hospitals in the US. The areas of difference were identified (the mean score for Staffing and Resource Adequacy was 2.07, which was significantly lower than the mean scores for both Magnet and non-Magnet hospitals,  $p < .0001$  each). A similar practice environment baseline (subject to its validity and reliability to context) measure before application for accreditation could prove useful for targeting of identified service gaps and areas for improvement. Therefore, hospitals, which do not have the financial means to pursue Magnet recognition, may still benefit from implementing changes to help create positive nurse practice environments based on this model.

However, there could be a tendency to utilise the Magnet model as a managerial tool to secure best outcomes based on risk management to the detriment of the less visible aspect of caring such as meaningful interaction with patient and family. Another problematic aspect of this model, is that it can be difficult to effectively measure invisible care and quantify it. Furthermore, there is the potential for complacency or regression to earlier systems, once accreditation has been granted rather than actively continuing to progress, develop, and improve.

#### **4.8. Releasing Time to Care – Productive Ward Programme**

In 2005 and 2006, the National Health Services (NHS) in the UK developed the Releasing Time to Care (RTC) and implemented in the following year. RTC is based on the principles of Toyota Productive System, known as Lean (Hamilton et al., 2014; NHS Institute for Innovation and Improvement, 2009). Lean's main philosophy is a patient-focused approach to identify and eliminate activities or processes that do not add value to patient perspective and to increase nurses' autonomy over improvement of their patient care work (Hamilton et al., 2014). The prime objective of the programme is to increase direct contact time between nurses and patients. It is designed to effect changes in the ward environment to improve efficiency by increasing nurses' autonomy with continuous improvement of their patient care. Rutherford and colleagues (2009) maintain that RTC is transformative for patient and their families as well as creating an improved work environment for nurses.

Releasing Time to Care is a self-directed tool kit comprising three foundational modules and eight process modules (Wright & McSherry, 2013). The three foundation modules are 'Knowing How We Are Doing', 'Well Organised Ward' and 'Patient Status at a Glance'. The eight process modules focus on fundamental aspects of nursing practice such as Medication and Patient Hygiene (NHS Institute for Innovation and Improvement, 2013) and was launched in several DHBs in New Zealand such as WDHB. Furthermore, there have been studies to evaluate the effectiveness of the programme.

From 2005 to June 2011, Wright and McSherry (2013) provided an overview of the literature published on RTC and the productive ward. They identified 18 empirical publications and categorised them according to seven themes which included patient and staff experience, direct care time, patient safety, financial impact, embedding and sustainability, executive support and leadership, as well as common barriers and determinants of success. Nine of the studies reported an increase in direct patient care time that ranged from 8% to 59%. Activity flow charts, a resource provided by the NHSI, were used to identify how much time was spent on activities which added no value to the patient. Activity flow charts were also employed to record and calculate the number and type of interruptions such as relatives, patient, patient status, advice, location of equipment, or information. However, these studies did not indicate whether the increase in time spent in direct patient care was quality time, which would improve clinical outcomes and patient experience. There was a lack of evidence from the patient's perspective and also how any increase in direct care time affected patient outcomes and the experience of feeling cared for. The outcomes of this review again reflect that importance of considering the patient's experience when seeking to make improvements to the delivery of care, as discussed in chapter 3.

Wright (2013) maintains that the length of time that staff spend with patients does not really indicate the quality of the interaction. In their double-blind study, 22 patients and 18 members of staff were observed over a period of an hour on five wards. Staff were observed interacting with participants for a total of two hours and 25 minutes and the length of interaction per ward ranged from 12 minutes to an hour and five minutes. In terms of demarcation of duties, nurses spent 26 minutes on procedures, 12 minutes on medications, 8 minutes on hygiene, 12 minutes on toileting and only seven minutes on patient communication. They concluded that nurses do not always take the opportunity to interact with patients in a meaningful way. However, the activity follow charts that

they used did not reflect the quality of care provided by the nurses. The amount of time spent with individual patient is related to the area of practice and patient acuity. For example, older adults can take longer to complete the basic tasks and nurses often spend more time with them. However, nurses could use the opportunity to provide meaningful interaction while performing these basic tasks. In the following chapter, I will discuss acute nurses' attitudes towards older adults which may consequently affect the care that they provide this group of patients.

#### **4.9. Summary**

In this section, the theme of “models of care” in providing care for older adults in the acute setting was explored. Focusing on the PCC model of care in the older adult, the literature review identified three subthemes: personhood, individualism, and autonomy that were considered important when caring for the older adult. The literature review also indicated that the evaluation and measurement of PCC in the acute care setting is limited and further research with well-defined and evidence-based measurement tools is required. Nevertheless, examination of the available literature indicated that providing PCC in acute healthcare is challenging for nurses practising in this environment and an alternative approach may be needed. Therefore, the RCC approach to care was examined. RCC requires that all the people involved in care feel the six senses of security, belonging, continuity, purpose, achievement, and significance (i.e. the Senses Framework). In particular, there is a need for a model of RCC that fits into the New Zealand cultural context. With this in mind, this chapter examined the Maori models of healthcare. The Maori model presents a holistic approach to healthcare, where body, mind and spirit are seen as being important not only to the individual, but also the wider whanau. Due to organisational constraints that can be seen as preventing the implementation of PCC and/or RCC, it was important to briefly review some of the organisational models of care (e.g. RTC and the Magnet Model) to explore if their implementation might improve the quality of care in the healthcare setting.

Having explored different models of care, it is apparent that some elements of each model could be used as guidelines to facilitate improved care in the acute setting. In the following sections, I will explore some of important issues facing older adults in acute setting, including ageism and attitudes of nurses that may affect the provision of care for older adults in acute healthcare settings.

## CHAPTER 5. Ageism and Attitudes

The attitudes that nurses bring to the healthcare environment have the potential to markedly influence their delivery of care, including the older adult in the acute setting. In this setting and with this group of patients, ageism needs to be addressed before optimal care can be delivered. In the following section, I will provide a background to ageism, stereotyping, and its connection to nurses' attitudes, as well as critiquing one qualitative and five quantitative articles regarding nurses' attitudes towards older adults in acute settings. In particular, I will deal with the subthemes of non-educational factors and educational factors influencing the care of the older adult in the acute setting (see Table 3).

**Table 3**

*Subthemes Relating to Ageism and Attitudes Experienced by Older Adults in the Acute Healthcare Setting*

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Theme 3: Ageism and Attitudes

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Subtheme 1: Non-educational factors

Cultural, ethnic background of nurses

Work load or difficulty in caring for the older adult

Older adult behavioral challenges

Subtheme 2: Educational factors relating to nurses

Knowledge deficits in the normal processes of ageing

Ill-informed about the attributes and capabilities of older (e.g. focus on disability rather than the potential resourcefulness)

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### 5.1. Background

Ageism, a term coined by Butler in the 1960s, refers to the discrimination exhibited towards people purely because of their chronological age, i.e. purely because they are 'old' (Butler, 1969). Ageism is a complex phenomenon, often firmly embedded in Western society (Phelan, 2011), and it is also a prominent issue in gerontological nursing (Corner, Brittain, & Bond, 2006).

According to E. Clark and McCann (2004), some older adults' social status has already been reduced in relationship to loss of employment and reduction in income, as well as a lack, or loss of, family support and social networks. Many adults will retire at 65 years and become eligible for superannuation, but others will want to continue in full or part-time employment. Political concerns are often raised in the media about the increasing

number of older adults 65 years and over, who are frequently portrayed as a ‘burden’ on the health services and the economy in general. Western society, which is predominantly youth orientated, tends to reinforce the concept of ageing as the antithesis of beauty and health (Robinson & Cubit, 2005). The ageism that is found within society is often mirrored in the workforce, and the health workforce is no exception.

In addition, the medical model of health with its focus on the reductionist approach, from a physiological and pathological perspective (Phelan, 2011), tends to dwell on the body’s deterioration and perceptions of incurability (Robinson & Cubit, 2005). This focus also perpetuates a negative stereotype of the ageing process and the older adult. Furthermore, the frenetic pace of many medical wards can lead snap judgements that place a patient in an accepted category of ‘old’. Such judgements can determine nurses’ interactions with patients according to Nelson (2002), thereby, cementing the common stereotypes of older adults, as well as reinforcing the attendant notions of vulnerability, dependency, and disempowerment.

Negative attitudes by nurses towards older adults, can feature throughout the healthcare system (Holroyd, Dahlke, Fehr, Jung, & Hunter, 2009). Attitudes can influence individuals’ behaviour (Wesley, 2005) and profoundly impact the older adult population, especially when combined with physical frailty and reduced adaptive reserve. This not only raises communication barriers between the young and the old (Park & Song, 2005), but can also lead to discrimination through the withholding of opportunities and resources (M. L. Johnson, Bengtson, Coleman, & Kirkwood, 2005). When nurses normalise negative stereotypes and discriminate against those who experience social marginalisation, there is a risk of not identifying older adults’ specific needs and realities. Therefore, failure to recognise, and acknowledge the negative attitudes and address factors affecting them can lead to nurses practising in such a way that they are unable to assist older adults to achieve their potential as a “person”. Furthermore, older adults can be positioned as passive (V. Williams, 2003), which diminishes their self-esteem (L. Miller, 2002) and engenders a passivity that often leads to premature institutionalisation and dependency. As noted in chapter 3, the building of a respectful relationships between nurse and the older adult is vital to prevent both the older adult and their families becoming disempowered within the acute setting,



Knowledge gaps have a negative effect on nurses' attitudes towards older adult patients and consequently on their practice. Getting et al. (2002) maintain that nurses, who are ill informed about the attributes and capabilities of older adults, are unlikely to identify factors affecting well-being, which could be addressed through appropriate and timely interventions and support. Without focused gerontological knowledge and expertise, nurses struggle to develop appropriate care plans and some nurses can be reluctant to care for dependent older adults as they can be perceived as cantankerous, demanding, and challenging (Gallagher, Bennett, & Halford, 2006). Thus, a nurse's knowledge of the ageing process can influence patient care.

It is particularly important, in the context of nursing, to identify nurses' attitudes and to understand what positively and negatively influences their attitudes towards older adults and what the implications are for nursing education and for the delivery of a high quality of care. In the following section, I will undertake a critical review of current literature to identify nurses' attitudes towards older adults and then explore the factors influencing these attitudes.

## **5.2. Attitude of the Nurse Towards Older Adults and Factors Affecting Nurses' Attitude in Acute Care Settings**

Outcomes from six studies (see Table 4) that investigated the overall attitudes of nurses towards older adults in acute settings are conflicting. In regards to the nurses in the acute setting, some researchers reported negative attitudes towards older adults (Gallagher et al., 2006; Higgins, Van Der Riet, Slater, & Peek, 2007; Modupe, Olufisayo, & Ojewale, 2013), while other researchers reported positive attitudes (Adibelli & Kılıç, 2013; Mellor, Chew, & Greenhill, 2007; Topaz & Doron, 2013).

For example, a qualitative study by Higgins et al. (2007) conducted in-depth interviews with nine nurses in medical and surgical wards in Australia. The researchers found that the negative attitudes displayed by the nurses were influenced by the pressure of physical work required to care for some older adults in the acute setting. The researchers identified 'marginalization' and 'stereotyping' as the main two themes that captured the perception of nurses. Furthermore, they cited high stress levels, due to inadequate resources, as preventing nurses from providing the time, support and level of care necessary for older adults and thereby, contributing to negative attitudes. The findings also suggest that nurses felt pressured into meeting targets for diagnostic

procedures and surgery as well as being compelled to function within an inflexible framework of routines and task completion. By adopting a model of care more suited to the pressures of their setting, as well as the needs of the older adult, many of these constraints might be minimised (see chapter 4 for further discussion) A nurse reported that time constraints resulted in older adults being left in bed instead of being encouraged to mobilize or given a bed bath instead of being assisted to take a shower. Healthcare planners and managers share some of the responsibility for this marginalization by not providing the necessary resources for optimum care. As identified in chapter four, a model of care (e.g. Magnet model or RTC) that takes into account the wider organisational structure of care, and thus the provision of adequate resources, can significantly benefit the care that the individual patient receives. Higgins et al. (2007) also found that older adults were confronted with a variety of stereotypes where the perception of some nurses towards older adults was that of 'burdens', 'heavy' to care for or 'a waste of time'. At handovers, the language was often redolent with stereotyping which, in itself, is cause for concern as this behaviour could be role modelled by junior staff. This tendency to stereotype or label the older adult demonstrates that the focus of nurses is on the disability rather than the potential resourcefulness and ability and not on the whole person. It appears that stereotyping is more likely to be related to the work environment, which, in turn, can generate negative attitudes.

Similar outcomes were reported in a study by Modupe et al. (2013). In this descriptive survey of 130 RNs/midwives, randomly selected from two hospitals in Nigeria, nurses showed negative attitudes towards the care of older adults even though they displayed a good knowledge of the ageing process. Of the participants, 73% agreed that the care of older adult was difficult and 80% agreed that the provision of optimum care required special education. The fact that 90% of the respondents maintained that older adults should be placed in a separate ward could engender negative attitudes. Other factors responsible for such attitudes included poor staffing, difficulty in caring for the older adult and older adult behavioural challenges. A limitation of the study was that the nurse responses may have been influenced by multiple internal and external factors such as the social environment, work or personal stressors and testing conditions. Another limitation was the lack of contextual clarity and that it was not limited to medical nurses alone (given that this dissertation is looking at the medical setting alone). Furthermore, different results could reflect instrument differences and, with self-report mechanisms,

there is the potential for self-selection bias which will be discussed towards the end of this chapter.

**Table 4**

*Summary of Reviewed Studies Related to Overall Attitudes of Nurses (Regardless of Their Years of Clinical Experience) Towards Older Adults in Acute Settings*

| Reference/Country                   | Sample size/ Design of study   | Tool                                    | Raw scores  | Findings and overall attitude  |
|-------------------------------------|--|---|---|--|
| Gallagher et al. (2006)/<br>UK      | 99 RN, 73 HCA and 15 porters recruited from two hospitals for acute and long-term settings<br>Cross-sectional survey               | KOP                                     | RN in acute-care:<br>+ KOP = 41.95,<br>-KOP = 68.13;<br>RN in long term setting:<br>+KOP = 40.37,<br>-KOP = 66.34<br>Possible range:<br>17–85,<br>mid-score 51,<br>high = –ve in<br>+ KOP, reverse in<br>–KOP | RNs exhibited more positive attitudes towards older adults than HCA and porters            |
| Mellor et al. (2007)/<br>Australia  | 31 RN and EN from a multipurpose health centre<br>Descriptive, non-experimental<br>quantitative research<br>Cross-sectional survey | KOP<br>PFAQ &<br>NKEPQ,                 | RN and EN: KOP = $173.4 \pm 19.18$<br>Possible range:<br>34–238,<br>mid-score 136,<br>high= +ve   | Positive attitudes.<br>Knowledge deficits in gerontic nursing and socio-economic knowledge |
| Modupe et al. (2013)/<br>Nigeria    | 130 RNs/midwives from two hospitals<br>Descriptive study<br>Cross-sectional survey   | A 30 item questionnaire                 | 73.0% of RNs thought older adults were difficult to care for (no p-value)   | Negative attitudes   |
| Topaz and Doran (2013)/<br>Israel   | 171 RN, 63% of whom worked in internal medicine units<br>Descriptive, correlational study  | KOP<br>PFAQ                             | KOP* = 3.32 out of 5, SD = .33;<br>PFAQ* = 12.77 out of 25, SD = 2.9  | Moderately positive attitude   |
| Slater et al. (2007)/<br>Australia  | 9 RN from both acute medical and surgical wards.<br>Qualitative, descriptive study   | In depth interviews from a larger study |   | Negative stereotyping by nurses in acute setting and negative attitudes                    |
| Adibelli & Kılıç (2013) /<br>Turkey | 282 RN, from the clinics of public hospitals mostly accommodating older adult patients<br>Qualitative descriptive study            | KOP (Turkish version)<br>design         | KOP = $98.83 \pm 11.19$   | Positive attitudes   |

\* = mean value; EN = enrolled nurses; HCA = health care assistants; KOP = Kogan's attitudes towards Older People scale (a Likert-type scale); NKEPQ = Nurses Knowledge of Elderly Patients Quiz; RN = registered nurses; PFAQ = Palmore's Facts of Ageing Quiz.

In contrast, other studies have shown that nurses are capable of positive attitudes towards the older adult such as in the descriptive research design study by Adibelli and Kılıç (2013) of 282 nurses working in a public hospital in Turkey. In this study, nurses completed questionnaires regarding the type of difficulties they experienced in older patient care, and completed the Turkish version of Kogan's Old People (KOP) scale (Kogan, 1961). This study found that some nurses (35.5%) demonstrating insufficient knowledge, skills, and experience. Other nurses experienced difficulties in caring for older adults due to inadequate physical work conditions and technical equipment and problems due to patient physical restrictions (55.6% - 50% respectively). Relational issues such as difficulty in communicating with patients/ family /caregivers (41.8%) and communicating with the staff in the health team (17%), as well as and not being appreciated for the care given to patients (9.9%), were also reported. Such outcomes adding weight to the discussion previously presented in chapter 3.

Despite the difficulties nurses experienced in older adult care, the nurses in this Turkish study nurses demonstrated positive attitudes toward older patients (KOP,  $98.83 \pm 11.19$ ). Moreover, there was no statistically significant difference in the attitudes of nurses toward older people according to their descriptive characteristics ( $p > .05$ ). These findings could be due to the nature of Turkish culture, where respecting and caring for older adults are traditional and embedded in the cultural heritage which may influence nurses' attitudes in a positive way. Nevertheless, these findings should be treated with caution as they may not be transferable to Western societies such as New Zealand.

Other studies have investigated the factors that have predicted negative or less positive attitudes towards the older adult by nurses in the acute setting. Education was one such predictor in a descriptive, non-experimental, quantitative study by Mellor et al. (2007). This study recorded acute care nurses' views (22 RNs, 8 enrolled nurses, 1 neither RN nor enrolled nurse,) as well as their knowledge of the ageing process and understanding of geriatric care in a multi-purpose health service in Australia. The self-report survey, which used KOP, indicated a positive attitude towards older adults ( $p < .001$ ) by RNs rather than Enrolled Nurses (ENs). The fact that RNs indicated a much more positive attitude to older people than ENs suggests that education is a predictor of attitude. This finding indicates that improving the skill mix and recognising skills could be a way of addressing the needs and attitudes towards older people in care settings. However, the

authors mentioned that KOP scale was not designed for nurses from the multi-purpose health service setting nor was it fully validated.

Other findings by Mellor et al. (2007) were that nurses, in the sample, demonstrated knowledge deficits in key clinical areas (fundamental nursing knowledge) with regard to changes in senses, lung capacity, learning as well as in the socio-economics of ageing with an average of 68.7% (SD=4.25) in accuracy using Palmore's Facts of Ageing Quiz (PFAQ). A significant correlation between the attitudes of the nurses and PFAQ scores ( $r=.596$ ;  $p<.001$ ) revealed the higher the score on PFAQ, the more positive the attitude. The authors also demonstrated fundamental knowledge deficits in the normal processes of ageing, common diseases, altered symptom presentation and adverse drug reactions. The latter were confirmed by another questionnaire known as the "Nurses' knowledge of the Elderly Patient Quiz" (NKEPQ) which recorded 68.2% correct responses (a mean score of 9.10, SD = 3.25). There were limitations to Mellor's study where certain factors might have skewed the results. For example; a small sample size and tools not designed for multipurpose units. A questionnaire based survey can have certain limitations such as the potential for self-selection bias as the respondents may be inclined towards more socially acceptable answers and thus not truly reflect their views. In spite these limitations, the study identified deficits in knowledge about the ageing process which could impede timely intervention.

Similar results, with a larger sample size, were reported in a study by Gallagher et al. (2006) where higher education levels predicted lower negative attitude scores and vice versa. The results of this cross-sectional survey compared 99 employees in acute settings (+ KOP = 41.95, -KOP = 68.13) with 87 long-term hospital employees (+ KOP = 40.37, -KOP = 66.34) in the United Kingdom (UK). Assistant personnel ( $59.15 \pm 9.88$  &  $68.3 \pm 6.54$  respectively) in both acute settings and long-term settings, showed significant negative attitudes ( $p < .001$ ) compared to 55 acute setting nurses and 45 long-term nurses. Using a multiple regression analysis, authors found level of education was a significant predictor of health-care personnel's negative attitude score ( $\beta = .464$ ;  $p<.001$ ), In fact, a total of 21.6% (adjusted 21.1%) of the variability in negative attitudes was predicted by health-care personnel's level of education.

On the other hand, a descriptive, correlational study by Topaz and Doron (2013) found that a lack of gerontological knowledge was not necessarily related to negative attitudes. They included a larger sample size of 171 nurses, 63% of whom worked in internal

medicine in Israeli units. The authors used the KOP and the FAQ1, with an internal consistency reliability of .75 and .72 respectively, to confirm deficits in knowledge. They reported moderately positive attitudes towards older adults but a relatively poor level of knowledge of the ageing process. Furthermore, in the regression model, the level of knowledge of the ageing process ( $b=.042$ ,  $p=.01$ ) was associated with attitudes towards older adults and the nurses' ethnic backgrounds ( $p=.01$ ). In fact, ethnic background was closely related to attitudes towards older adults. Jewish nurses scored significantly higher than their Arab colleagues, possibly due to their greater exposure to older adults. Only 3% of Arabs are over 65 years, compared to 12% of the Jewish population.

This study also has some limitations in that the convenience sample of 170 nurses was relatively young compared to the general nursing population and the participants were drawn from only one hospital. Moreover, as in previous studies, any self-reporting questionnaire always runs the risk of a social desirability bias which could skew the results. Religion wise, Israel is a homogenous society so that the level of the nurses' religiosity could well have influenced attitudes towards the older adult. Thus, a more useful study would include data not only on the levels of religiosity but also on secular levels, which would more easily facilitate its transferability to a New Zealand acute setting.

### **5.3. Summary**

The findings from the above studies of nurses' attitudes in acute care settings for older adults revealed that negative attitudes exist among nurses in acute settings. However, data from the various studies relating these negative attitudes to knowledge deficits in the nursing staff are equivocal, with some, but not all studies, indicating that higher educational levels were associated with fewer negative attitudes.

The use of questionnaires in the majority of the above studies may have contributed to the difficulty of being able to draw definite conclusions. The KOP and FAQ are widely employed instruments for measuring attitudes towards older adults but Tierney, Lewis, and Vallis (1998) caution against the continued use of these instruments as they may not give an accurate measure of present day society. R. B. Miller and Dodder (1980) objected to Palmore (1977) using the word "most" in FAQ, as well as the use of double-barrelled items in the questionnaire. Slevin (1991) states that this absence of the caring

dimension inherent in the KOP questionnaire makes it difficult to apply it in any context. However, Kogen (1961) asserts that although this questionnaire was designed to evaluate society's attitudes towards older adults, that it could well be an appropriate instrument for nursing settings. Nevertheless, this tool may not be appropriate for hospitalised older adults in acute settings.

Another reason for the inconclusive and conflicting results could be due to the self-reporting approach of the studies. The participants in the interviews or the questionnaires can simultaneously express conflicting ideas and beliefs (Marton & Pong, 2005) leading to apparently contradictory or inconsistent responses. The respondents may intentionally or unwittingly report inaccurate information due to external influences, time constraints, fatigue, or simply poor or incomplete recall of events (Brewer, Hallman, Fiedler, & Kipen, 2004).

However, in spite of limitations of both methods, these tools are important for obtaining information from the respondents around their understandings, beliefs and attitudes. Questionnaires, if well designed, provide evidence of patterns in large populations, whilst qualitative data from interviews afford greater insights on respondents attitudes, thoughts, and actions (Kendall, 2008). Focus group interviews with nurses could provide a greater insight and accuracy into the tensions, barriers and constraints that often prevent nurses from delivering even an adequate level of care for older adults (Stokoe et al., 2015). Therefore, further well designed studies are required to clearly and unequivocally establish a relationship between knowledge and attitudes. Such will need to use appropriate tools to obtain unbiased information from the respondents. Nevertheless, in spite of the limitations and equivocal nature of the reviewed studies, there are no grounds for not continuing to educate the nursing staff in the care of the older adult.

In chapter three, the care experience of older adults in acute settings was found to be mainly negative, with the quality of care for individual patients and family being defined by the nurse's ability to take a relationship approach. In chapter four, I reviewed various models of care, including PCC, RCC and various organizational models, as a result identified elements that are important to consider when caring for older adults. Chapter four explored the impact of the nurses' attitudes, with a focus on ageism, on the quality of care that the older adults receives. In the following chapter, I intend to

identify challenges nurses face when caring for older adults in the context of the acute healthcare setting in order to identify the barriers and enablers involved.



## **CHAPTER 6. Challenges for Nurses in Acute Care Settings**

In chapter three, I identified the experiences of both older adults and their families with quality care through relational practice. Bridges et al. (2010) support the view that relational care is of primary importance. Although the older adult's perspective of a good nurse is important, it would seem prudent also to include the perception of the nurses. A registered nurse's viewpoint provides unique insights into the other dimensions involved in the nursing care of older adults in the context of acute settings. Nurses frequently reported that they were not spending adequate time with patients and their families (Carthon, Margo, Lasater, Sloane, & Kutney-Lee, 2015; Kalisch, 2006; Schubert et al., 2008), thus affecting patient-nurse relationships. If relational practice is key to ensuring quality care for older adults, then staff need to be adequately supported to provide the kind of thorough engagement necessary for the relational care of older adults.

A summary of the theme and subthemes developed in this chapter is provided in table 5. I will provide a brief theoretical background to the influence of multiple physical environmental factors on nurses' perceptions and performances of their work. I will then explore the influence of the work environment on nurses' perceptions and attitudes toward providing quality care for older adults within acute settings. Ways that the organisational environment can affect the level of care will then be discussed, looking in particular at such factors as resourcing, collaborative working relationships, leadership, and organisational support. From the challenges that nurses are facing, I have chosen some examples to illustrate the various subthemes. Although the number of challenges is limited by the available space in this dissertation, they relate to my own experience, and their relevance to relational aspect of caring for older adults in an acute setting.

### **6.1. Theoretical Background**

The work environment of acute settings may have a substantial impact on the care that nurses provide for older adult. Positive perceptions of the work environment can lead to an increased commitment and performance among employees (Aryee, Budhwar, & Chen, 2002). Social exchange theory suggests that when an organisation values and supports its employees, the employees feel obligated to reciprocate through feelings of commitment to the organisation (Blau cited in Dawley, Andrews, & Bucklew, 2008). Armstrong and Laschinger (2006) support this view, stating that nurses, who feel

supported, valued, and empowered, demonstrate more commitment to their workplace and deliver higher quality care.

Data from clinical studies support the theories relating to the impact that the nurses' work environment has on the quality of care that patients receive. A cross-sectional study by McHugh, Kutney-Lee, Cimiotti, Sloane, and Aiken (2011) to determine the work experiences of registered nurses (n=95,499) was carried out in 428 hospitals. The researchers found that when nurses were dissatisfied with their work environment, then patients experienced a significantly lower quality of care. Similarly, Kutney-Lee et al. (2009) evaluated the relationship between the nurses' (n=20,984) work environment and patient satisfaction across 430 hospitals. This study indicated that an improved nurses' work environment resulted in improved patient experiences.

Given the demographic changes that affect social welfare and health, older adults tend to have multiple disorders or illnesses, which result in the need for a more complex approach to care-giving and an increased nursing workload (Fried, Ferrucci, Darer, Williamson, & Anderson, 2004). There is an increased need for well-trained nurses who are capable of creating a safe and patient-centred environment. It is important and relevant to understand from the perspective of nurses, how the nursing work environment relates to quality care for older adults and positive patient experiences.

With this in mind, the outcomes from studies (see table 6), that investigated the quality of care of the older adult in acute settings were evaluated. Data from these qualitative studies will be used to illustrate how various aspects of the physical and organisation environment influence the care that patients receive.

**Table 5**

*Subthemes Relating to Challenges for Nurses Caring for the Older Adults in the Acute Setting*

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Theme 2: Challenges for Nurses Caring for the Older Adults

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Subtheme 1: Physical environment features influencing care

- Physical organisation of the room e.g carpeted and uncluttered ward
- Social organisation of the room e.g. lack of privacy, noisy
- Emotional and physical safety of the room

Subtheme 2: Organisational environment affecting care

- Resources (time constraints and staff shortages)
  - Collaborative working relationship
  - Leadership support
  - Organisational support
  - Nurses characteristics
-

**Table 6**

*Studies that Investigated the Response of Nurses to the Care of the Older Adults in an Acute Setting*

| <b>Study<br/>[Location]</b>   | <b>Study design<br/>[Intervention]</b>                              | <b>Sample<br/>size</b>   | <b>Results</b>   | <b>Conclusion</b>   |
|---|---|--|--|---|
| Cioffi and Fergusson (2009)<br>[acute hospitals (n=3) in Australia]   | Qualitative with an exploratory descriptive approach [teamwork]     | Registered nurses (n=13)<br>Enrolled nurses (n=2)                                | The team nursing, team approach, and team effectiveness, increased responsibility, availability of support and engagement  | Team nursing proved effective   |
| Kalish (2006)<br>[medical-surgical wards in the USA]  | Qualitative with focus group interviews [nursing care]              | Nurses (n=107),<br>Licensed practical nurses (n=15)<br>Nursing assistants (n=51) | Nine elements of regularly missed nursing care (ambulation, turning, delayed or missed feedings, patient teaching, discharge planning, emotional support, hygiene, intake and output documentation, and surveillance)<br>Seven themes relative to the reasons for missing care were reported                       | Nursing staff and managers need to employ various measures to decrease the problem of missed nursing care |
| Milton-Widley and O'Brien (2010)<br>[acute medical-surgical wards (n=5) in public hospitals (n=2) in Australia] | Qualitative study with constructive inquiry approach [nursing care] | Registered nurses (n=27)   | Three themes were identified:<br>• being informed about care;<br>• limiting care<br>• rationalising actions.<br>Nurses understood quality care was important, but care was limited and interventions prioritised.<br>Lack of care was blamed on health services, lack of clinical leadership, patients, and nurses | There is a need for good clinical leadership aligned with empowerment                                     |
| Tadd et al. (2011)<br>[wards (n=16) in acute hospitals (n=4) in the UK]   | Qualitative with ethnologic methodology [dignified care]            | 40 older adults<br>25 relatives<br>79 front-line staff<br>32 senior managers     | Wards were poorly-designed, confusing and inaccessible for the older adult<br>Older adult were bored due lack of communal spaces and activities staff were demoralised and ill-equipped with skills and knowledge Variations in quality of care received.  | Dignified care was not provided due to lack of systemic and organisational factors                        |

## 6.2. Physical Environment Features Influencing Care

The physical environment influences the quality of care that nurses are able to provide patients. The physical environment includes the quality and safety of workspaces and patient areas (Janakiraman, Parish, & Berry, 2011). Older adults require a therapeutic environment to aid their physical and psychological recovery.

The physical environment of the acute wards may not be appropriate for the older adult. As demonstrated in the qualitative study in the UK by Tadd et al. (2011) (see table 6), the physical organisation of the room environment of an acute ward was often complex, busy, noisy, sterile, and lacked privacy. A staff member commented that, “There is nowhere for people [older adults] to walk to, socialise or watch TV... they must either be in the bed or sitting beside it, ... [staring] at the walls for hours on end” (Tadd et al., 2011b, p. 38). Moreover, as part of a fall prevention programme patient’s lockers were removed so that older adults risked losing hearing aids by either putting them on the crowded table, or in a cupboard that was not easy to reach (Tadd et al., 2011b). In addition, many older adults experienced isolation when they were sent into side rooms.

Although the study by Tadd et al. (2011b) demonstrated that a poor physical environment contributed to a lack of care, other randomised trials have shown that when the physical environment is specifically designed for the needs of the older adult, then a significant improvement in outcomes for both the patient and carer occur. For example, in one study involving 1,531 hospitalised older patients, the older adults were randomised to a multicomponent intervention or standard care (Counsell et al., 2000). Those randomised to the intervention that included a specifically designed environment (e.g. carpeting and uncluttered hallways) and PCC had significantly improved outcomes. There was a lower rate of decline from baseline in the Activity of Daily Life (ADL) in the intervention group at discharge (34% vs 40%;  $p=.027$ ) and during the year following hospitalisation ( $p=.01$ ). Satisfaction with care was greater for the intervention group than the standard care group among patients, caregivers, physicians, and nurses ( $p<.05$ ). Similarly, improved physical conditions were part of the care received by older Norwegian patients with hip fractures randomised to comprehensive geriatric care ( $n=198$ ), but not those randomised to orthopaedic care ( $n=199$ ) (Prestmo et al., 2015). Those receiving specialised geriatric care had their own room within a 15-bed ward, while those randomised to orthopaedic care may have been sharing their room with up to four others. Although an improvement in the physical environment was only part of the improved quality of care for those in the specialised geriatric care group, mobility after 4 months was significantly better for those in this group (Short Physical Performance Battery score  $5.12$  vs  $4.38$ ;  $p=.010$ ) (Prestmo et al., 2015).

### **6.3. Organisational Environment Affecting Care**

#### **6.3.1. Resources.**

Care environments that lack sufficient resources such as staffing, appropriate skills, or time may potentially cause nurses to withhold or fail their obligations to carry out necessary interventions for patients (Schubert et al., 2008). Time constraints due to staff shortages and the higher acuity of older adults are the main reasons that nurses omit or delay care for older adults. Nurses caring for older adults with a high degree of physical and medical needs felt pressured to avoid time consuming interventions.

In the qualitative study by Kalisch (2006) in surgical-medical wards in the US [see table 6], multiple competing demands on the nursing staff were identified. These multiple demands, especially when nurses were short-staffed, resulted in staff not attending to essential nursing care. Nurses reported that they often missed interventions that took a long time, such as ambulation, hygiene, teaching, discharge planning, and bathing. Nurses also commented that supporting the emotional needs of older adults can be a lengthy process, and that they were reluctant to engage in this way for fear of falling behind with other tasks (Kalisch, 2006). Similarly, as reported in chapter 2, the older adult reported that when nurses did not relate to them or try to get to know, then the quality of care that the older adult received was lessened. Impedances to safe care were also explored in a study conducted by Higgins et al. (2007) that found caring for older adults was not a priority when staff experienced time pressure. One nurse commented that when demands were high, the care of older adults was often left until last:

If the ward is incredibly busy and we've got lots of pre-ops and post-ops in admissions and discharges', usually the oldies [sic] in the corner just have basic care - they get left behind and you might leave them to last and you realise that you haven't got much time to do anything with them, so you give them a quick wash and turn them over and that's it. (Higgins et al., 2007, pp. 231-232)

Similarly, nurses in this study would use pads or bed pans instead of mobilising older adults to the toilet to save time to attend to other duties such as medication.

These findings echo the observational and interview-based study of Maben, Adams, Peccei, Murrells, and Robert (2012) which reported that nurses under time pressure lean towards attending to other technical tasks, rather than meeting the time-consuming functional needs of older adults. When nurses become task-oriented there is less time

for holistic care (Hart, 2003). Furthermore, an inability to engage with patients in a meaningful way can dehumanise the nurses themselves (Austin, 2011).

However, increasing staffing may not necessarily improve the quality of care for older adults. Whilst some studies, such as that by Rothberg, Abraham, Lindenauer, and Rose (2005), revealed improved outcomes with increasing staff levels, other studies, such as that by Needleman, Buerhaus, Mattke, Stewart, and Zelevinsky (2002), showed improvement across 799 hospitals in the US with increased RN numbers for some of the outcomes that were measured (e.g. lower rates of pneumonia [ $p=.001$ ], shock or cardiac arrest [ $p=.007$ ], and "failure to rescue" which was defined as death from pneumonia, shock or cardiac arrest, upper gastrointestinal bleeding, sepsis, or deep venous thrombosis [ $p=.05$ ]); however, the rate of in-hospital death was not altered by increasing the number of RNs. As Schreuders, Bremner, Geelhoed, and Finn (2015, p. 800) noted in their retrospective, longitudinal study involving 256,984 hospitalisations across 58 inpatient units, "our results suggest that adding more nurses is not a panacea for reducing inpatient complications to zero". Other factors in the work environment, such as effective collaboration and communication between team members and management support, may be needed if there is to be an effective level of care.

### **6.3.2. Collaborative working relationships.**

The development and maintenance of collaborative working relationships with all involved in care are essential for quality care. Teamwork, both within nursing teams and in collaboration with multidisciplinary teams, may be crucial for producing better quality care (Rathert & Fleming, 2008). Kalisch and Lee (2010) linked effective nursing teamwork with increased productivity, quality patient care, satisfaction, fewer errors, increased nurse retention, and decreased stress. Nurses identified that by interacting and discussing issues with other healthcare professionals problems would be solved sooner, with ideas and thoughts being exchanged in a complementary manner and with mutual respect (Kieft, de Brouwer, Francke, & Delnoij, 2014).

Nurses have noted the importance of an effective, collaborative team. In a descriptive, exploratory study, nurses ( $n=15$ ) working in three acute wards in Australia described their relationship within a multidisciplinary team (Cioffi & Ferguson, 2009). Cioffi and Ferguson (2009, p. 9) noted that "Allied health will come, nurses will come, and then the doctors will come and talk about what is going to happen to the patient...we can say

what our issues are.” The availability of both internal support (nurses within the nursing team) and external support (educators, charge nurses, and managers) was also observed in the team approach.

Lack of effective communication within a nursing team has been found to be particularly problematic, and the importance of team work has been underestimated. In the study in an acute ward by Kalisch (2006), both RNs and the nurse assistants highlighted that nursing care was missed when members of the team did not effectively pass on patient information at report time and work as a team. In instances where the exchange of patient details did occur, there was an absence of collaborative planning for the care of the patient. Additionally, NAs would not inform the RNs about the care they had completed or had not completed. In another prospective, observational (109.8 hours) study of two wards in Australia, nurses (n=57) did not increase their level of engagement with other professionals over a 2-year period (Westbrook, Duffield, Li, & Creswick, 2011). Nurses experienced a dramatic increase in time spent completing tasks alone (from 28% per shift at baseline to 39% per shift by the end of a 2-year period). However, during this time, there was a significant decline in the nurses’ time spent with other nurses (from 54% to 41%). The amount of time they worked collaboratively with other nurses declined from 80.6 seconds to 53.9 seconds. There was little change in collaboration or communication with other health professionals which remained at very low levels. Similarly, an observational study (98 hours) of medical-surgical nurses (n=27) on two wards reported the interactions between nurses and non-nursing colleagues was only 2.8% (Cornell et al., 2010). These examples illustrate that the importance of teamwork was not considered in those settings. In order to improve teamwork and solve issues, effective leadership and specific communication skills may be needed.

### **6.3.3. Leadership support.**

Effective leadership can positively impact the working environment of the nurse. The team leader can support staff development and encourage team members to develop clinical leadership skills (Ferguson & Cioffi, 2011). Nursing leaders should be provided with the knowledge, skills, and support to create excellent clinical environments (O'Connor, 2015). Nursing leaders must be passionate and committed to nursing,

articulate, have consistent professional standards, have management knowledge and skills, negotiating/mediation skills, and the ability to set goals and to listen.

Importantly, effective leadership is significantly correlated with higher employee perceptions of productivity and morale (Rouse, 2009). A review of 15 studies found that managerial support had a strongly positive influence on the well-being and ability of the nurses to cope and thrive in the workplace (Shirey, 2004). In particular, nurses in an acute care setting with greater levels of perceived support from their supervisors experienced less occupational stress (Hall, 2007). In the study of Cioffi and Ferguson (2009, p. 8) nurses reported positively about the leadership and noted that, “You’ve got your team leader, your CNM, your educators. If there is a problem, there is always someone you can go to.”

Conversely, the lack of effective leadership can negatively affect the working environment of the nurse. In the study by Milton-Wildey and O'Brien (2010) , the absence of engagement and clinical leadership of the charge nurse managers (CNM) resulted in the nursing team viewing them as a separate group who were not aware of the problems ‘on the floor’. Similarly, a study by Cathcart et al. (2004) found that the increased span of control for the CNM directly correlated with a decrease in nurses-employee engagement. The CNM was too involved in administering and managerial roles to spend enough time engaging with the nurses in patient care and solving clinical problems on the floor. The researchers of this study commented that the use of nurse managers/supervisors for administrative duties and management of physical resources may have overlooked the crucial activities of coaching, praising, counselling, and leading people.

The absence of clinical leadership may also lead nurses to feel that there is nothing they can do to change the situation. In the qualitative study by Kieft et al. (2014) , nurses highlighted that management was tied to a system that was dominated by controlling costs. According to participant nurses, they wanted to provide a patient with a specific form of care, while management limited care to maximize numbers based on budgetary considerations (Kieft et al., 2014). The sense of disempowerment experienced by the nurses may result in displays of specific behaviours such as socialisation with colleagues around the nurses’ station, as observed in the study by Milton-Wildey and O'Brien (2010) or become emotionally divested, as noted in the Kalisch (2006) study. If nurses are to flourish and provide PCC for older adults, then leadership and



management need to be supportive, paying careful attention to the morale and unity of the team.

Effective leadership of a nursing team also has a significant impact on the quality of care the patients receive. Schreuders et al. (2015) discovered that the availability of a charge nurse manager and educator promoted patient safety and quality of care. In this study, nursing unit managers were frequently involved in team meetings to discuss and address specific issues. This led to nurses in the team gaining an increased understanding of developments in best practice.

#### **6.3.4. Organisational support.**

Support of the organisation can be an important determining factor that influences the capacity of nurses to deliver quality care for older adults. Organisational support refers to the general belief by an employee that support will be readily available from the organization when stressful situations arise and urgent needs are addressed (Laschinger, Purdy, Cho, & Almost, 2006). Organisational support also includes factors such as the leadership and unfair work conditions (Al-Hussami, 2009). According to Al-Hussami (2009), the more committed nurses are to their organisations as a result of perceived organisational support, the more they will be productive in their organisations. These same individuals are also more likely to tolerate major organisational change (Ingersoll, Kirsch, Merk, & Lightfoot, 2000).

The current emphasis on higher productivity for example, to meet budgetary target set by Government policy tends to diminish the importance of relational work. As O'Connor (2015) noted, the nursing values of participation and collaboration are not valued in the current environment. There is ongoing staffing and cost pressures which are creating an increasingly hostile and stressed environment within which nurse's work. The team becomes focused almost exclusively on 'pace', with the sole function of their efforts ensuring that the 'patient' is moved through the system as quickly as possible (Kieft et al., 2014). All other considerations were secondary and, indeed, likely to be seen as an impediment to the ultimate goal. As one nurse in the study by Tadd et al. (2011b) explained "No matter how hard you try it's just numbers in beds and get them out, get them out, get the next one in, get the next one in, get them out, get them out. There's no... nothing" (Tadd et al., 2011b, p. 36). In the study by Kalisch (2006), some nurses talked about detaching themselves emotionally from their patients, "We

don't let ourselves think about it (missing nursing care). It is the way we cope. Underneath we don't feel good about it" (p. 310).

Working continuously in such situations can reduce organisational commitment in nurses, and ultimately reduce the quality of care of the older adults. A study conducted by Redfern, Hannan, Norman, and Martin (2002) in a rest home in UK with a sample of healthcare staff (n=44 staff, n=18 residents) revealed a close correlation between job satisfaction and organisational commitment ( $r=.60$ ,  $p<.001$ ). Similarly, a larger survey of RNs (n=1,853) in the USA reported a strong positive relationship between job satisfaction and organisational commitment ( $r = .63$ ,  $p < .001$ ) (Ingersoll, Olsan, Drew-Cates, DeVinney, & Davies, 2002). Therefore, healthcare administrators are urged to promote and develop organisational commitment among nurses. Al-Hussami (2009) suggests that issues related to job satisfaction and organisational support, such as unfair work conditions, salary inequities, lack of employee support, should be addressed promptly and justly.

#### **6.3.5. Nurses characteristics.**

Nurses in acute settings exhibit a number of characteristics. In the study by Cioffi and Ferguson (2009), some nurses exhibited accountability for their actions, a commitment to the nursing team, an enthusiastic and motivating attitude, and remained informed. These nurses worked as a team and supported each other, leadership, and educators. Despite these positive attitudes, a number of nurses in this group acknowledged the difficulty of trying to ensure quality care when patient acuity was high and the skill mix in the team was inadequate. Alternatively other studies indicated that there were other nurses who highlighted/displayed routine seeker behaviour, were under informed, had a short-term focus, reacted emotionally, blamed others (system or older adults) for the limited care, and were not engaged or caring (Kalisch, 2006; Tadd et al., 2011b). Such positive and negative nursing characteristics can be reflected in the patient's experience of their care (see chapter 3) and ultimately impact patient outcomes.

The education level of the nurse may also have an impact on patient outcomes. A higher level of education of the nurse has been associated with better patient outcomes such as lower mortality and failure-to-rescue. (Aiken et al., 2014; Kutney-Lee, Sloane, & Aiken, 2013; Van den Heede et al., 2009). In one longitudinal study involving 42,000 nurses (at baseline in 1999) in 134 hospitals in USA, a ten-point increase in the

percentage of nurses with a baccalaureate degree was associated with an average reduction of 2.12 deaths for every 1,000 patients ( $p<0.01$ ) (Kutney-Lee et al., 2013). This study would suggest that obtaining a higher level of education is an essential “next step” in the progression toward a more educated nursing workforce committed to lifelong learning.

Improved outcomes may result if nurses are specifically educated in the needs of the older adults. Edvardsson and Nay (2009) in a discussion paper explained that the acute hospital organisation into ‘specialities’ such as neurology and orthopaedics meant that staff knowledge often lie within these specialities, something that can work against a holistic approach and quality outcome for older people. Although acute hospitals are excellent for single diagnoses, rapid treatments, and short stays, when older people end up in this setting they suffer from the consequences such visits are known to induce. If registered nurses were able to achieve higher levels of education in gerontology, they would be better able to address the needs of older adults who are the main users of this “specialised” healthcare system.

#### **6.4. Summary**

In this chapter, I obtained insights into the challenges facing nurses working in acute settings. Nurses identified a range of elements that both facilitated and inhibited them from providing optimal care for older adults. The elements were physical features of the wards, resources, collaborative relationships, leadership and management support, and the characteristics of the nurses themselves. The current emphasis on higher productivity may be reflected in lower staff levels, with the result that nurses prioritise care of the older adults to be task oriented, rather than seeking a holistic approach. This pressure, combined with not having suitable physical features in the acute setting, presents a challenge for nurses to provide appropriate care for the older adults. If older adults’ care needs is a priority, then the organisation should be structured in such a way that it creates a healthy work environment for nurses, who in turn can facilitate a high standard care for their older adult patients. Nurses must also take responsibility for changing their practice environments, empowering themselves and the others in their team. Empowerment can come from seeking knowledge and professional development. An educated nurse is perfectly positioned to assume a leadership role in

healthcare reform. It is up to nursing leaders to raise the standards of nursing education so that this vision can become a reality.

## **CHAPTER 7. Discussion and Recommendations**

Providing an environment with a model of care delivery that encourages PCC and facilitates the formation of relationships between all involved in care has the potential for effectively responding to older adult needs in acute settings. I investigated the delivery of PCC to older adults in acute settings. This literature was critically reviewed for themes, associated constructs, and the relationships between the themes in order to answer the research question “What are the barriers and enablers to PCC for older adults in acute care settings?”

Because of the increase in life and health expectancy of individuals, in coming years an increasing number of older adults are likely to present to acute care settings (Covinsky et al., 2003). An older adult with an acute illness can have nonspecific symptoms which require skilled nurses capable of thinking laterally (Edvardsson & Nay, 2009). For example, an older adult’s ability to express needs may be reduced due to the acute illness, and any cognitive impairment exaggerated by their environment. Other problems such as falls, delirium, dehydration, constipation, and functional deficit may develop or worsen during the acute illness period (Inouye et al., 1999; Mecocci et al., 2005; Siddiqi et al., 2006). The acute care environment is constantly changing and the over-reaching aim is to treat acute ailments as quickly as possible. This creates unique stressors such as an undignified environment which is difficult for an older adult to cope with. In light of this reality, various approaches to improving the care of older adults such as PCC, RCC have been suggested in the literature and are summarised in chapter four.

Chapter three analysed pertinent research on “the experiences of older adults in acute care settings”, with the key themes that were identified being physical care and relational care. Findings from the literature presented in chapter three depicted the care experience of older adults in acute settings, demonstrating positive experiences, as well as others that were negative. These provide both barriers and facilitators to PCC. For example, not getting attention when asked, or not meeting an obvious need, with the lack of communication also being highlighted as barriers to PCC, and the cause of the reduced quality of care provided by nurses. For the older adult, the development and sustaining of interpersonal relationships are important, and the essential characteristics of emotional connection and collaboration can be facilitated if PCC is provided with a relational approach. The review of literature in chapter three suggested that elevating

the importance of relational care through interpersonal relationships and attention to the needs and expectations of older adults and their families may afford them a more positive experience of care. Inclusion of the families' views is important as these allow the older adults and their families to be considered as a unit and act as facilitators.

Having explored the meaning of PCC in hospital in relation to the theoretical framework, findings about how PCC can be undermined in hospital were next presented. Having critically reviewed various models of care in chapter four, the question of whether the terms "person-centred care" should be used to reflect the realities of working with older adults within acute healthcare settings was debated. PCC aims to provide care that meets all the physical, psychological, spiritual, and social needs of the patient, focusing on abilities and strengths, rather than disabilities and weaknesses (Hebblethwaite, 2013; Kitwood & Bredin, 1992). Providing PCC requires the nurse to include an older adult's life-span, their perceptions, and values. The establishment of effective and nurturing relationships is often difficult in acute care settings. Despite the advantages of PCC, the present review has highlighted the difficulties of applying PCC in acute settings. Mansell and Beadle-Brown (2005, p. 23) suggested that PCC is "scarcer in reality than it is in rhetoric".

Evaluations of PCC in clinical settings indicated that older adults do not consistently receive PCC. The most prominent barrier to providing PCC for older adults which emerged from the evaluation of PCC (4.3.4.) was the lack of consistency, compounded by a lack of knowledge about PCC. A lack of clarity and transparency in practice, particularly related to the complexity of the framework was also identified. Hospital systems and staff workload and work patterns were also identified as threatening PCC. Hebblethwaite (2013) noted that when nurses in acute setting developed care plans and goals, their priorities were often addressing their organisation's plans, not the older adult's ' plans. Care pathways and performance targets for waiting times were either irrelevant or actively obstructive to high-quality care for patients with complex conditions. Nurses in acute settings were not grasping all the opportunities to make their care person-centred (Edvardsson & Nay, 2009; McBrien, 2009). Some nurses mistakenly believe that the task-based practice that they were doing was PCC (Bolster & Manias, 2010). Person-centred care seems to be practiced by some individual nurses rather than being comprehensive and consistent across services. Other studies such as Skaalvik et al. (2010) supported this outcome. It could be suggested that nurses do not practice PCC due to lack of knowledge or not having a role model on the ward. In this

case even if nurses wanted to provide PCC they are unable to. Therefore, it is important that PCC is taught both at university and as part of professional development. This is particularly important since there is a wide range of interpretations of person-centred care across the professions.

In light of the literature review presented in chapter three, PCC appears to underestimate the relational processes of care that older adults wanted and PCC is limited in its inclusion of all the various people involved in care. MacDonald (2002) asserts healthcare professionals should subscribe to a relational view of the concept of PCC, conceiving of human beings as belonging to a network of social relationships within which they are deeply interconnected and interdependent. McCormack (2001) advocated a similar stance, suggesting an individualistic view of autonomy be replaced with one based on interconnectedness and partnership, emphasizing both uniqueness and interdependence among individuals. Older adult's autonomy often is threatened during acute illnesses and it is often a time when they need to rely on family or staff to assist them in the decision making process or make decision on their behalf. To enable this process to occur nurses must consider a relational approach to care that encourages the older adults to be involved in their care and/or to include the family in the decision making. Nolan et al. (2004) asserts a relational approach to care espouses that relationships exist at many levels, including among patients, their families, staff from all disciplines, and the wider community. Therefore, PCC is limited if it does not consider relational approach to care.

In light of the limitations of the PCC approach, the Pew Fetzner Task Force (Tresolini et al., 1994) proposed a new model for healthcare delivery known as RCC that reflects the existence of multiple environments of care and the importance of interactions among and between differing disciplines involved in care as the foundation of care (Tresolini et al., 1994) . The RCC model can address or explain how a challenging nursing environment may result in adapting behaviours that affect nursing practice.

Moreover, this holistic approach to care has been reflected in the collective nature of Maori models of care such as te whare tapa whā and te wheke. The Maori models of healthcare anticipated PCC in many aspects, adopting a holistic approach to deliver care to meet the diverse needs of Maori and whanau. PCC can empower Maori patients by enabling them to express their feelings about their healthcare during their interaction

with nurses and take that care beyond the medical model of symptoms and treatments/therapy (Boulton et al. 2004).

Based on a critical review of the literature (see chapter three), in general, RCC appears to deliver PCC more effectively by providing a vehicle to more comprehensively assess and maximise the potential for the nurse/older adult patient relationship by empowering all those involved in the care. Furthermore, the review of the two organisational model of care known as 'Magnet model' and 'releasing time to care' (in chapter three) demonstrate the acknowledgement/recognition of an organisational movement towards better supporting front line staff to provide quality care for patients. However, often the nurse's time for providing direct care is restricted due to the increased amount of paper work required for compliance with regulations and providing written evidence. The New Zealand MOH has been enthusiastic about promoting Magnet features in health organisations (MOH, 2005). The purpose and direction of leadership in high performance organisations such as Magnet hospitals are linked to cultures that place high value on all key stakeholders, not just on service users and leadership.

Nurse's attitudes are important barriers to providing relational care for older adults. Consequently, a combination of lack of knowledge along with attitudes related to ageing may prevent nurses from making optimal care decision. In the literature review of the attitudes of acute care nurses towards older adults (see chapter five), negative attitudes towards older adults were reported by several researchers (Gallagher et al., 2006; Higgins et al., 2007; Modupe et al., 2013). Such attitudes can greatly influence the care older adults receive. Some studies revealed that nurses were in danger of emotionally rejecting and stereotyping older adults due to being exposed to very ill and complex older adult patients or they were too busy to attend to the specific needs of older adults (Higgins et al., 2007; Modupe et al., 2013).

A critical review of the literature (see chapter five) also demonstrated that insufficient education of nurses was associated with the delivery of a lower quality of care of the older adult care (Gallagher et al., 2006; Mellor et al., 2007). The nurses' knowledge about age-related changes was not consistently evident. Nurses in acute settings require an understanding of multiple pathologies and their impact on older adults' quality of life and how to respond to the older adult needs. Because of the requirement for nurses to possess a high level of knowledge and understanding, a bachelor's degree is now the entry qualification for nursing in New Zealand. In 2007, the nursing entry to practice



programme was introduced in New Zealand which provides a 10-12 month support programme for new graduate nurses and provides clinical preceptorship to them (MOH, 2005). For those nurses who were trained before the establishment of the degree, education in the art and science of nursing has been available through the provision of a graduate certificate or diploma. Although, since 2007, District Health Boards (DHBs) have funded and supported nurses to undertake postgraduate education (Barnhill, McKillop, & Aspinall, 2012; Pearson, 2003), access to post-graduate education can still be limited. Furthermore, a lack of consensus about the translation of learning from postgraduate education into actual practise at the ward level exists. Studies reported a lack of managers' support, time constraints, staff shortage and colleagues negative attitudes as barriers for implementation of new knowledge and skills into the clinical area (Barnhill et al., 2012; Gijbels, O'Connell, Dalton-O'Connor, & O'Donovan, 2010). Never-the-less, in hospital, the majority of staff providing the physical and emotional care for older adults are untrained care assistants who have very few qualifications, and are on low pay.

Education may be a way of increasing nurse's awareness and reflection and it is by these strategies that there may be a reduction in the prevailing negative attitudes and stereotypes regarding the older adults. However, addressing stigmatising attitudes held by health professionals may not be as simple as increasing exposure or education. Further research is required to determine the origins of such attitudes, with qualitative research designs being used to investigate whether these attitudes are the result of actual negative experiences, predisposed prejudices or cultural influences and values (Fernando, Deane, & McLeod, 2010).

In New Zealand, there have been significant efforts to improve the gerontological curriculum for undergraduate nurses over the past decades. However, the average age of nurses currently practising is 46.7 years old so they would have graduated from programmes where formal gerontological education was not a significant part of the curriculum. Therefore, an effective continuing educational programme around gerontology may mitigate ageism to some degree. However, the inclusion of any intervention including education requires careful consideration of how it may impact on clinical practice.

Furthermore, there is continued debate around the most appropriate level of education nurses require for optimum practice. In the literature review by Cotterill-Walker (2012),

it is reported that an advanced level of education is related to professional and personal growth which may positively influence patient care. However, nurses report barriers to the implementation of new knowledge and skills at the ward level. These barriers include lack of management support, time restrictions, staff shortages, and negative attitudes of other staff (Spencer, 2006); this aspect of the organisational structure was discussed in more depth in chapter six. Other non-educational factors such as ethnic background, gender, the level of participants' religiosity can have mixed effects on the attitude on nurses towards older individuals. Furthermore, most barriers are interconnected, for example, the difficulties experienced by nurses generate negative attitudes which are often related to the structural and contextual aspects of healthcare organizations.

A review of the literature presented in chapter six indicated that nurses are able to identify a range of obstacles and achievements in providing PCC for older adults. Nurses' work-related environment with respect to the organization is one of the important obstacles in providing relational care for older adults. These include: the physical environment (Schubert et al., 2008) resources, the workload and lack of staff (Slater et al., 2007), organisational support (Kieft et al., 2014), collaborative team (Kieft et al., 2014), effective communication within a nursing team (Kalisch, 2006), effective leadership (Ferguson & Cioffi, 2011; Kieft et al., 2014), and the characteristics of the nurses themselves. Moreover, insitutional constraints such as the current emphasis on higher productivity may be reflected in lower staff levels, with the result that nurses prioritise care of the older adults to be task oriented, rather than seeking a holistic approach. To improve care, there is a need to develop clinical champions, those who recognize institutional problems related to the care of older adults, and who can apply institutional resources.

What has become clear from this review is that models alone will not ensure older adult's needs are met. One cannot expect nurses to successfully implement PCC if they do not feel supported by the organisational system within the hospital. Solutions to this situation must focus on factors which motivate and support nurses to provide PCC. Moving towards implementation of PCC requires a significant overhaul of systems within an organisation. Unless an organisation changes its systems (structures, processes and patterns of behaviour), frontline staff will not be able to fully incorporate PCC into their daily routine of caring for older adults. This view is supported by Plsek cited in Manley, O'Keefe, Jackson, Pearce, and Smith (2014) who notes that person-

centred, safe and effective care and cultures need to be supported by whole systems approaches, through integration and interaction to embed shared values and purposes in structures, processes and patterns of behaviour.

Organisational factors can inhibit nurses delivering PCC in acute settings. The quality of interactions and relationships between older adults and nurses is shaped by the team and the organisational climate of care. Having effective managers and staff working in a supportive organisational context could remedy many of the problems encountered by older adults and their nurses in a hospital. Supportive and informative work environments that recognise the complexity of patients are also required to assist health professionals to provide holistic care (Goldberg et al., 2012; Plant & White, 2013; Shafiei, Gaynor, & Farrell, 2011). This view is supported by Mountford and Webb (2009) who suggested that to achieve the best and most sustainable quality of care, a commitment to building high-performing organisations is required. In New Zealand, the Ministerial Review Group (2009) suggested changes to healthcare systems and emphasised the need to incorporate frontline clinicians in the decision making process to ensure that the delivery of care is PCC.

The importance of the core values and principles, as well as the organisational culture, in delivering PCC is well established and understood. McCormack, Manley, and Garbett (2004) introduced Practice Development (PD) in nursing which requires clinicians and the organisation to review and align policies and care models in an effort to embed the philosophy of transformational culture and leadership at the front line. There is a need for leadership to be competent in enabling power to be vested in staff who are interacting with patients. Valuing everyone's contribution by providing opportunities through formal participation is an example of transformational leadership. This motivates staff to take responsibility for the quality of service they provide. However, major cultural change is not a one-off event and takes years to become integrated and sustainable. The evidence for the effectiveness of developing nursing leadership skills is limited, and suffers from a lack of consensus around what constitutes effective leadership in nursing (Watts & Gordon, 2012). The robust and routine evaluation of the quality of the leadership is required and the modification or change of the management model to support practice development may be necessary.

Recognising and developing expertise in the work place is an important step in practice development. The erosion of nursing skill and position should be carefully investigated

and addressed. Organisations can create and foster a stronger bank of role models and also spark a sense of possibility (Mountford & Webb, 2009). Professional mentorship is important in fostering professional growth in knowledge, skills, attributes, and practice (Nettleton & Bray, 2008). The mentors themselves can benefit from the mentoring role especially when mentoring is formally recognised and contributes to the mentors own professional development. However, poor mentorship can bring lasting consequences for those being mentored.

A limitation of this review is that the search strategy was limited to English language Publications. The broad topic like the provision of care for older adults is influenced by so many factors which need in-depth analysis; however, due to constraints of time and words I was not able to cover all the areas involved. The lack of current fiscal situation which all DHBs are experiencing and the limited research conducted within New Zealand on the topic of this dissertation are other major limitations of this literature review.

## **7.1. Conclusion**

As demonstrated in this review of the literature there are several barriers and enablers to the delivery of PCC to the older adults (65 and over) in an acute hospital setting.

Barriers to care included those that reflected the older adult's experience of physical care (e.g., lack of assistance with activities of daily living, lack of adequate pain management and age-unfriendly physical settings) and of relational care (e.g., poor verbal and non-verbal communication). Negative attitudes of nurses towards the older adults may also result in barriers to care and may be a reflection of the ethnic or cultural background of the nurse, or their lack of knowledge around caring for this patient group. Additionally, the increased challenges faced by nurses erect barriers to delivery of care such as a lack of time and resources, overwhelming patient loads, and lack of effective leadership, and organisational support.

In contrast, the enablers of delivering quality care that are relevant to the patient's experience included utilizing the client's own knowledge, building respectful and empathic interactions and relationships with patients and family by carefully listening and communicating. The provision of a secure and emotionally safe physical environment also enhances the patient's experience of care. Enablers that help to counteract negative attitudes of nurses include increased education around the needs of

the older adults. Enablers that minimise the challenges nurses face include providing an aged friendly environment, adequate resources, a collaborative working environment, appropriate leadership, and organisational support.

Although the delivery of PCC with a relational approach is what older adults in acute settings indicated as contributing to a higher level of satisfaction with care, this review highlighted the complexity and difficulty of providing the enablers or overcoming the barriers in the acute setting. Although the New Zealand healthcare system emphasises the need for PCC, but its implementation within the New Zealand context has not been fully examined. Therefore, further research to see if PCC or alternative more relational models of care are applicable in New Zealand will be useful. Educational institutions perhaps, should review the content of pre-registration nurse education to ensure that all new nurses have the skills to work with older people and should develop postgraduate training for nurses caring for older people with complex needs. Attention should be given to the New Zealand healthcare system, to ensure that staff are supported. Although the focus of this dissertation was only on nurses, the discussion and recommendations could equally apply to other allied health profession and members of the medical team.

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