 **A PERSONAL PHILOSOPHY OF GERONTOLOGICAL NURSING:**

**AN ETHNOGRAPHIC ADVENTURE**

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**ABSTRACT**

**Objectives:** To articulate my personal philosophy of gerontological nursing.

To identify why I professionally do what I do.

**Method**: Using auto-ethnography, I reflected upon my years of work in *Supportive Living* settings to identify:

(a) what tasks I enjoyed and why

(b) how I can best use my passion to honour our older adults and

(c) what about my practice was science, nursing, or anything but.

**Results**: This reflective exercise enabled me to articulate my perspective toward gerontological nursing, thereby helping me to discover that I do what I do in order to bring older adults joy and comfort, and to help maintain their integrity and dignity. If gerontological nursing is to be person-centred, then I will happily do whatever I can to achieve my nursing goals, regardless of whether or not the task is considered traditional nursing. In my professional career while caring for older adults, I have acted as an interior designer, an executive assistant, and a detective, among many other functions. My philosophy reflects that if we are to be truly person-centred, then it should not matter who does what.

**Implications**: To use a truly person-centered Gerontological Nursing model with our older population, the organizational silos must be eliminated. Gerontological nurses will be asked to willingly fill a variety of roles not considered typical nursing roles.

**Key Words**: person-centred nursing, older people, gerontological nursing

**Background**

As busy nurses, often overwhelmed by multi-tasking and bureaucracy, it is easy to forget why we became nurses, what we enjoy about our profession, and why we do what we do. I was, therefore, excited when I was given the opportunity to reflect upon my personal philosophy of nursing. My professional career has taken me to caring for older adults. It is my niche, where I am passionate, and it is where I will stay for the remainder of my career. In moving forward into the next phase of my career, this reflection was a timely affirmation of my passion and a verification of why I am engaged in gerontological nursing practice. Relatedly then, the objectives of this project are to articulate my personal philosophy of gerontological nursing, and to identify why I do what I do as a registered nurse.

**Methods**

Pringle (2003) has emphasized that it is the responsibility of nursing staff to ensure that quality of daily life is maximized among residents of long term care, particularly those living with cognitive impairment. I suggest that it is our responsibility to make every day the best possible day for all residents in the continuum of care, not only in long term care. There is joy to be had by all (care staff and residents) if we accept the responsibility to make the most out of every day. To assist with this process, it seems logical to ask myself what matters to me in my work life. How may I make every day the best possible day for me, thereby enabling me to make the best possible day for those for whom I am responsible?

Auto-ethnography was selected as the research method for this inquiry. Streubert (2011) cited Malinowski (1961) as describing ethnography as a method by which the “native’s point of view” (p. 168) is learned. Geertz (1973) added that doing ethnography is interpretive and results in a thick, rich description of the perspective studied. This approach was an appropriate selection because my objectives are asking for articulation of my perspective.

Inductive reflection upon my nursing practice was conducted in order to answer the following questions: (1) What professional activities and roles do I enjoy and why?; (2) How can I best honour or give tribute to older adults in my role as a gerontological nurse?; (3) Is my nursing practice an art, a science or some combination of both? Inductive reflection allowed me to reflect on specific experiences in order to reach a conclusion about my more general philosophy of gerontological nursing.

**Results and Discussion**

Through reflection on my professional practice, two discoveries were highlighted for me. First, I realized that caring for older adults is the centre of my nursing practice. This aspect affirmed my belief that I have found my niche in gerontology. Similarly, improving the daily quality of life of the residents I care for is my professional priority, which is in complete alignment with Pringle’s (2003) impassioned point of view discussed above. Second, I discovered that I have a willingness to share roles with other professionals, if doing so is in the best interests of older adults, and demonstrates honouring their personhood. I am more than happy to fill whatever role is needed if doing so would lead to any of my gerontological nursing goals. I am not willing to have my practice structured into stereotypical or traditional nursing roles. Nursing is often discussed philosophically as being an art or a science, neither, or both. Reflection has shown that as a gerontological nurse, I am simultaneously involved in the art and science of nursing, as well as a number of other atypical nursing roles.

Some of the roles that I have adopted are as follows:

♦ a detective, in assessing reasons for lack of bowel movements and for investigating the whereabouts of the television remote control for a resident whose dementia acts as paranoia and she hides the remote to keep it from being stolen.

♦ an interior designer, rearranging furniture to minimize fall risk on the way to the washroom while keeping the prized photos and doilies exactly in position.

♦ a chaplain with a resident contemplating his legacy as he faces his mortality.

♦ a teacher when instructing a resident how to use the telephone or how to navigate to the dining room.

♦ a creative artist while managing a chronic wound dressing with only a roll of gauze and paper tape.

♦ a negotiator with a resident who insists that care staff reuse an incontinent pad because she did not want to spend too much money.

♦ an interpreter for a resident who returns from a doctor appointment and has no comprehension of the medical jargon he used to explain test results.

♦ a clown, bringing laughter to the group eagerly waiting 45 minutes before the meal for the dining room doors to open.

♦ a secretary as I dial the phone for a resident whose arthritic finger no longer allows her to dial, or as I transcribe a note to be mailed to a grandchild.

Only a small portion of my professional practice is spent carrying out traditional nursing skills or assessments. I am alright with that. Much is being asked of registered nurses, and we must expand our idea of what constitutes nursing practice. To me, nursing is whatever leads to achievement of care goals the older adults, their families, and I have developed together. We nurses need to recognize that caring involves a range of interventions, including anxiety management by searching for a remote control, and subsequently creating calmness in an agitated resident. It would be uncaring to leave her in that state when there is something I can do to help.

Four goals of my nursing practice were identified as a result of my inductive reflection and adventure through auto-ethnography. I am more than happy to do whatever I can if it brings *integrity*, *dignity*, *joy* or *comfort* to the older adults for whom I care.

**Integrity**

Integrity versus despair is commonly known as Erikson’s last stage of psychosocial development. Erikson (1960) described this stage as reaching “…the end of life with a certain ego integrity – an acceptance of his own responsibility for what his life is and was, and its place in the flow of history” (p. 45) or of living in despair without having achieved this acceptance. Within the settings of continuing care, in which we encounter older adults, many to most are facing their own mortality – as friends and family die, as options for management of disease become limited, or as acute medical situations become more severe or more frequent. It is our responsibility as nurses to enable the older adults under our care to achieve integrity and peace with the lives they have lived. Facilitating conversations with family and friends, listening to their stories, giving gentle encouragement to resolve grudges and lost connections, recruiting assistance from chaplain services or social work if appropriate, or reminiscing with those able are examples of ways we may help them achieve integrity.

**Dignity**

In our current culture of frequent under-staffing, increased resident health acuity, and work demands, the dignity of the older adults we care for often falls by the wayside. It becomes easier and faster for staff to care for the residents in a systematic and routine manner, a manner that inhibits individualized care. This is not to say that the staff does not care, or that they are not aware that individualized person-centred care is best. They do care and they do know. The system, though, does not support them. Anderberg, Lepp, Berglund and Segesten (2007) suggested that “preserving dignity in older adults means to individualize their care by becoming aware of the person’s needs, wishes, and habits on a physical, mental, spiritual and social level. Considering an older adults’ life story, i.e. life experiences and views of the future, and subsequently adjusting the care, can result in the person feeling valued and accepting more easily their dependence on care” (pp. 639-640). They go on to provide tangible ways in which dignity of older adults can be preserved: individualize the care provided, restore whatever possible control to the resident, respect them, advocate for them, and listen sensitively to them. It is paramount to see the very unique lives led by our older adults, and to see how they are unique individuals, unlike anyone else. Anderberg et al. (2007) emphasized that the etiology of dignity is “…to be worthy” (p. 637). It is our professional responsibility as nurses to care for older adults in a manner that recognizes the worth of these individual and the full lives they have led.

**Joy**

One of the best things about attaining this nursing goal is its reciprocity! Bringing joy to the older adults I care for brings so much joy to me as well. Once, when doing my regular surveillance of residents, one person who had moderate dementia, asked while I was there (understanding that I was a nurse), if I would please take a look at her daughter. Her ‘daughter’ was a doll on the chair in the back of her dark closet. It took only a minute or so, and very little effort on my part, to ‘take her pulse’ and ‘listen to her heart.’ But the joy it brought this resident to hear from a nurse that her daughter was just fine and doing well was priceless.

Joy is closely tied to humour. In fact, “…humor…invites…joy…” (Herth, 1993, p. 151). Once we provide person-centred care and find the joy in our own work, we should easily see plenty of opportunity to introduce humour into the days of our older adults. Another resident with moderate dementia once raced up to me, and invading my personal space said, “I’m going to massacre you.” Given the fire in her eyes and the intensity of her speech, I believed her intentions. I replied, calmly, “I have a very busy weekend so could we do it next week.” Well, the open laughter that this elicited from her was great. And the agitation that brought that threat out of her in the first place was resolved. She went on to have a very light-hearted day. Herth (1993) defined joy as “…a feeling of delight, enjoyment, and pleasure” (p. 151). If we look and listen, there is ample opportunity for us to provide these types of experiences.

Herth (1993) suggested that “preferred sources of humor, those identified as most likely to enlist a humorous response, were comical everyday-life experiences…” (p. 149). I am sure most gerontological nurses have witnessed conversations among older adults about constipation and laxatives, sagging body parts, or cracking and popping sounds when they get out of bed. Although these everyday experiences are not necessarily funny by nature, older adults may find humour and comradery by sharing with others, and they may provide us opportunity for appropriate humour, and therefore some joy.

**Comfort**

To provide comfort is likely a reason why many of us pursued the nursing profession. Speaking for myself, providing comfort is somewhat hedonistic. I feel good helping others be and feel comfortable. A resident with moderate dementia once got lost during the night. She had been walking around, but evidently found herself in a dark room with an equally demented unit mate yelling at her. When we found her, she was visibly shaken up. I took her to the living room, got her a blanket and a cup of tea. I simply sat with my arm around her, reassuring her that she was now safe. She rested her head on my shoulder, looked at me with what I saw as gratitude (she no longer could express herself verbally), gradually settled down, and 30 minutes later was sound asleep. Seeing her in such distress earlier and helping to bring comfort and peace to her was so rewarding.

I realize that our older adults have contributed much to society, have taught the next generations, have fought for their countries, and have often lived very difficult and challenging lives. I feel it is our job to honour them and their lives by making their remaining years as comfortable as possible. There are the obvious comfort measures – physical comfort, pain management, etc. – but also considerations such as room temperature, compatible table mates or eating alone, having the doilies just so, having things around them that are familiar and comforting, preferred music and activity. Almost two decades ago, Le Navenec and VonHof (1996), following Kitwood’s (1996) model, emphasized what the provision of comfort actually entails in order to enhance personhood well-being of persons with dementia

Providing comfort in nursing is as old as the profession itself. Although Florence Nightingale (1860) did not address comfort specifically, the measures that she said nurses should take strongly imply that it is nurses’ job to provide comfort, to bring in fresh air, have patients in clean bedding, allow and encourage sleep, minimize noise, and speak to the patient where they can see you. Those types of actions seem to me to be “Comfort 101” actions. She notes that “if a patient is cold, if a patient is feverish…if he has a bed-sore, [in other words, if the patient is uncomfortable] it is generally not the fault of the disease, but of nursing” (p. ix).

**Implications**

Lessons that I learned from this adventure that I can apply to my personal practice have implications for broader nursing practice and to nursing practice in general; they are not restricted only to gerontology. A willingness to break down professional territories is required if person-centred care is to be provided to older adults. Territorial attitudes of “that’s not my job” are counterproductive to achieving the identified nursing goals and to providing individualized care. True person-centred care should foster genuine collaborations, and sharing of roles as needed. Respect the expertise of the various care partners, and consult them frequently, but share the responsibility of care provision.

In a previous work setting, the head of the nursing department communicated to all staff that the nursing staff was responsible for everything that came out of a human body. In the case of a stool incident in a resident’s washroom, for example, the nursing staff was responsible for cleaning up the bulk of the mess to the best of their ability. Housekeeping was then responsible for following up with the appropriate disinfecting. A resident’s garbage pail had fallen over and a tissue had rolled out onto the floor. The housekeeping staff felt it was nursing staff’s responsibility to pick up the tissue because it contained the contents of a resident’s runny nose, which came from the person’s body. This was simply a ridiculous situation, comical almost, if it had not had such damaging ramifications to nursing morale and to relationships between departments.

Getting stuck in thoughts of what traditional nursing is and is not will prevent genuine collaboration. It feels more natural to me to identify appropriate care goals, and then do whatever is required to achieve them. And if the goals are agreed upon by the entire team, then hopefully professional territories will be blended, all in the betterment of providing integrity, dignity, comfort and joy to our well-deserving older adults.

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