TOWARDS UNDERSTANDING NURSING PROBLEMS IN CARE OF THE HOSPITALIZED ELDERLY

THELMA WELLS
Assistant Professor, School of Nursing
University of Rochester

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In September 1972 a three year nursing research project began in the Department of Geriatric Medicine at the University of Manchester, England. The study explored geriatric nursing by describing current nursing practice in the care of old people, documenting its constraints, and seeking relevant concepts for the development of a potential model for geriatric nursing. The process of nursing the elderly in one large hospital in northern England was studied to gather data from which implications for improving care to the hospitalized elderly arose. The research progressed through a series of questions:

What constraints to geriatric nursing practice exist within the hospital setting?

What do nurses know about care of the elderly?

How do nurses in geriatric wards describe the hospitalized elderly?

What do nurses in geriatric wards feel toward old people?

What is the work of nurses in geriatric wards? and,

What verbal communication occurs between nurses and patients on these wards?

The total research consisted of eight systematic, progressive, and interrelated studies of nursing experience.

The first study dealt with the utilization of space in geriatric wards, because it seemed logical that nurses' work and general attitudes would be influenced by the enclosed space that surrounds them. Some aspects of space influencing work would seem apparent, such as the effect of long, narrow wards on nursing practice. In such settings nurses would have long distances to travel, but a limited area in which to work. Walking time and crowded space could foster task assignment and a fixed ward routine rather than individual patient care.

There would probably be other subtle influences on practice, for example, if patient toilets were at a distance from the main care area. It has been estimated that elderly, continent, ambulant people can travel only 40 feet between the time of urge to void and voiding. Nurses on wards with distant toilets might first attempt to take patients to the toilet only to discover that the patients were frequently incontinent on the way or fell. The nurses might then discourage toilet visiting even for those patients who were closer and could get there safely. Worse still, they might not provide a suitable alternative. Distant toilets could breed a custodial atmosphere. The message to the nurse would be that it was impossible for the patient to get to the toilet, therefore, it was impossible for him to do anything else. While these examples may not fit the space problems in all settings, they serve to illustrate that space can shape nurse work patterns and subtly influence judgments.

In the wards studied there were serious space utilization problems. All the wards had critical shortages in toilets, bath and dayroom areas, as well as severe limitations in storage and nurse work space. One building, housing 80 patients, was unacceptable for patient care.

These findings meant that nursing care was taking place in trying or impossible environments. For example, it did not seem likely that patients' right to privacy would be supported when there was a general lack of single rooms and even individual bed curtaining! Further, renovation schemes appeared to address only the most primitive and visible of problems. Gross errors in planning and ignorance of space use with the aged were repeated and repeated.

Yet no ward sister/charge nurse actually knew the dimensions of her ward areas or how her ward stood in relation to the minimum standards operating for hospital space use in England. None of them had documented patient difficulties related to structural problems. They knew the general inadequacies but lacked the knowledge and will to address the space use issue. It was as if they felt that the nurses' role was to bend or force care of the elderly into the setting provided rather than to alter the setting, even in a marginal way, to facilitate such care.

Further to studying the environment in which nursing care of the elderly took place, the quantity and quality of furniture and equipment in geriatric wards was surveyed. Equipment and furniture needs for the elderly are complex. Nursing education does not include explicit instruction on these matters. This lack is displayed in nursing equipment vocabulary which indicates a generalizing rather

than specifying pattern. For example, the word "bedpan" is used frequently as if there were only one, yet most hospitals have a range of four to five quite different bedpans. Since nursing vocabulary does not distinguish them, it seems likely that neither does nursing practice.

In the wards studied, furniture and equipment for the elderly were usually insufficient, inadequate and substandard. Poor equipment meant that nurses could not utilize it as an aid to nursing. Instead, care took place in spite of poor furnishings. Because nurses have not been taught about equipment and may often work with poor examples, they often are unaware of how appropriate eqjuipment can help. It would appear that nurses do not know how to really use the good tools for care that they have or how to explain accurately what is wrong with the poor tools with which they struggle.

Another issue in care of the elderly in England is personalized clothing for elderly patients, an example of a progressive change imposed upon nursing. Formerly institutions provided wards with standard issue nightwear and, depending on the type of institution, standard issue daywear also. Clothing was easily recognized as the hospital's and frequently had visible markings declaring such ownership. Patients' garments were not selected necessarily for appropriate size or particular needs and when soiled were returned to the main supply for cleaning and re-issue probably to another patient. The new, "personalized" approach meant that garments should be issued individually by size, need and patient preference. They should be marked with the patient's name, be stored near him, and be worn only by him. Emphasis should be on normality and individual choice.

The concept of personalized clothing for the institutionalized elderly in Britain is generally well-accepted and various hospital clothing programs exist. One was said to exist in the setting studied. However, it was an informal and unplanned program. While patients appeared to be suitably clothed, closer inspection revealed that this was mostly decorative and sometimes not even rational. As examples, few patients wore underpants; their preference in clothing was not paramount; they were usually dressed by attendants; they frequently wore day clothes over night clothes. The use of clothing for therapeutic aims, such as relearning dressing skills or encouraging normality, was not evident.

A subtle assumption had been made that nurses would know how to use clothing in the care of old people, and that they would have

time to do so. Yet nowhere did the nurse receive education in techniques for dressing the handicapped or for teaching such skills to the elderly.

A basic question within the first year of study was: "What do nurses know about care of the elderly?" An open-ended questionnaire about nursing problems in geriatrics was developed and administered to a small, self-selected sample of trained staff and a small, stratified sample of untrained staff.

The untrained staff, the most numerous care givers for the hospitalized old, had little or no idea of the cause and care of common problems in the elderly.. For example, when asked to give reasons as to the cause of a patient problem there was a tendency to resort to a description of the problem, e.g., the cause of bowel problems was "constipation". Other comments were vague, such as giving "old thinking" as a reason for confusion. Social-psychological causes sometimes suggested judgments, or a failure to appreciate the emotional aspects of aging. For example, "laziness" and being "childlike" were noted in answers about about both urinary incontinence and eating difficulties.

The knowledge of trained staff tended to be global, vague, inadequate and confused. It was rare to find any accurate mention of the normal aging process. Commonly, answers which mentioned age were simple, imprecise statements such as for bowel problems, "body gets slow with age" and for confusion, "increasing with an aged body." While the range of responses under physical care was usually broad, they did not always include the most helpful techniques. No one noted the well-publicized English pressure sore assessment chart developed by Norton and colleagues 10 years before this study. Further, some suggestions for helping with patient problems caused concern. For example, restricting fluids before bedtime to reduce incontinence in the elderly is a debateable practice. The hospitalized old commonly are put to bed at 5 p.m. and may not receive an adequate fluid intake during the time they have free access to fluids.

The knowledge of nursing staff about specific care problems becomes extremely important when that same staff are asked to describe their patient population. In the geriatric wards as a whole, the nurses described the greatest patient need as putting on and taking off clothing; 50 per cent of the patients needed total dressing. The next extensive problem was incontinence, with 76 per cent of all patients described as having some degree of urine control difficulty. Almost a quarter of those were said to be always doubly incontinent.

Third in significance was activity. Only 21 per cent of the patients were described as ambulant; the majority were in chairs. Further, 20 per cent of the patients could not feed themselves and almost a quarter were always mentally confused.

The nurses' attitudes toward old people were explored in a small trained staff sample, using open-ended questions and the Kogan Old People Scale. These nurses held mostly positive attitudes towards old people and demonstrated such themes as desire to be depended on, altruism, and martyrdom as the reasons for choosing to work with this age group. The nursing sample crystallized their difficulties as "shortage of staff" and expressed frustration and anger over what appeared to them to be overwhelming problems in nursing care.

With all this background, what do nurses do in geriatric wards? Using an activity sampling method, nursing staff on four specially selected geriatric wards were studied. The greatest amount of nursing work observed was direct patient care, such as feeding patients and making them comfortable. However, the single most frequent activity of the 130 observed was Personal Time. This was a global classification for a number of relaxing or personal behaviors, such as reading a newspaper or going to the toilet. It was used only if a nurse behavior was unquestionably personal. When this activity was combined with other rest and relaxation aspects the percentage exceeded the suggested norm, which was 12.5 per cent of nurse time.

Considering this category more closely, Personal Time was more frequent and occupied more of the nurses' time in the hourly "worst" staffed wards. That is, nurses were more likely to engage in relaxing behavior such as having a social conversation with a colleague or an unofficial cup of tea when the ward was poorly staffed. Although this is an interpretation based on a retrospective view of a small sample, it would seem that the greater the pressure or stress of work, the greater the need for Personal Time behaviour.

The data from the nursing work study revealed that while nursing tasks randomly varied, the bulk of activity seemed to follow regular routines. The work routines were based on minimal universal needs such as meals, "getting up" and "putting to bed". Work was not organized, in the sense that it was not assigned by individual patient or specific task, except in obvious trained/untrained distinctions such as medicine administration and certain ward management work. However, during evening and night shifts even these few distinctions were not evident. Work progressed by area of the ward and time

of day. That is, nurses accomplished the routine demanded by the time of day, e.g., "getting up", from one end of the ward to the other.

The impression was of frantic, intense activity by nurses working in pairs or groups of three to complete the routine as quickly as possible. Individual patient preference or even necessary variation in care appeared to be obstructive to the goal, which was completion of the routine. These frantic, intensive periods of activity with patients were followed by slower paced work away from patients, such as making unoccupied beds or making sandwiches for patient meals.

The nurse work routines might originally have been designed to complete large amounts of work with inadequate staff numbers. However, these nursing routines appeared to have become irrational expenditures of enormous amounts of energy. For example, what did the rapid undressing of all the patients and putting them to bed before 5 p.m. have to do with patient care? Might it have been more sensible, and surely no greater effort, to base patients' "going to bed" time on their individual needs, preference and abilities? Yet there was an unwritten ethic that "day work" had to be completed before night staff came on duty, although this study discovered that night nurse work was minimal.

It certainly did seem as if nurse work was not sensibly organized, that nurses made work for themselves, undid each other's work, and worked against effective, or even logical, nursing care.

The most worrying of all the aspects of nursing observed was the nurse-patient verbal interaction which had been overheard. Nurse communication to patients appeared to consist of either a directive, a joking remark, or a playful session of questionable purpose. Since subjective and selective listening could have created a false impression, it became vitally important to correct or verify these impressions. Further, nurse-patient verbal communication is a visible sign of the nurse-patient relationship, the dynamics of which are thought to be fundamental to the delivery of nursing care. Thus, the final research year was spent in studying nurse-patient sustained verbal communication in a positive but average setting with a cross-section of nurses and with patients who were likely to exchange verbal communication.

Sustained verbal communication was defined as a verbal interchange between nurse and patient which lasted 25 seconds or longer with less than a minute break in transmission. On this basis it was found that nurses infrequently talked to patients and that, when they did talk to patients, they were more concerned about tasks and things

than they were about the patient as a person with feelings and thoughts. If nurse-patient verbal communication reflects the nurse-patient relationship then this was probably as limited as the conversations heard and not very meaningful.

After this three year study of geriatric nursing, what could the researcher conclude? Nurses in geriatric wards worked very hard and were well meaning. However, they worked very hard at and were well meaning about the wrong things. These nurses were products of a training system that taught them a series of tasks and neglected to provide adequate information about caring for the elderly. The central problem in geriatric nursing is the central problem in all nursing: nurses do not know why they do what they do. It is not helpful to anyone if nurses base their work on principles of trial and error, custom, and habit. Training has encouraged nurses to form ritualistic routines without thinking of the effect of such routines on patient care.

Effective and meaningful nursing care of the elderly is most likely to rest on a solid knowledge of the normal aging processes, on dynamic nurse-patient relationships, and on problem solving and research skills focused on outcomes to patient care. Perhaps more important than changes in curriculum for nurse learners are changes in knowledge states for nurse educators.

REFERENCES

Kogan, N. Attitudes toward old people: the development of a scale and an examination of correlates. *Journal of Abnormal and Social Psychology* 62:44-54, 1961.

Norton,D.; McLaren, R.; and Exton-Smith, A. N. *An Investigation of Geriatric Nursing Problems in Hospital.* London: National Corporation for the Care of Old People, 1962.

Scottish Home and Health Department. *Geriatric Accommodation Report.* Edinburgh, 1970.

Wells, T. J. Toward understanding nurses' problems in care of the hospitalized elderly. Doctoral dissertation, University of Manchester, England, 1975.