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UNIVERSITY OF ALBERTA

# NURSES' PERCEPTIONS OF CARING FOR LONG TERM CLIENTS AND HOW CARING MAKES A DIFFERENCE

BY

© PATRICIA A. JURGENS

A THESIS

SUBMITTED TO THE FACULTY OF GRADUATE STUDIES

AND RESEARCH IN PARTIAL FULFILMENT

OF THE REQUIREMENTS FOR THE

DEGREE OF MASTER OF NURSING

FACULTY OF NURSING

EDMONTON, ALBERTA

SPRING, 1995

ISBN 0-612-01568-8

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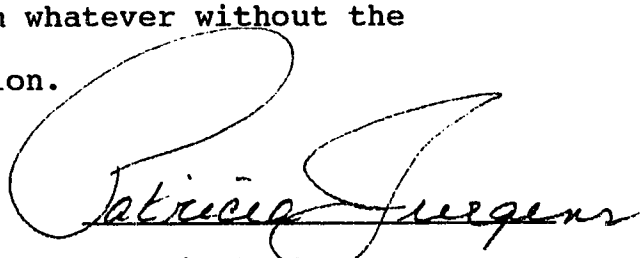

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Olive Yonge

Dr. Olive Yonge

Diane Buchanan

Dr. Diane Buchanan

Marion Allen

Dr. Marion Allen

L. Stewin

Dr. Len Stewin

DATE: January 31, 1995

# DEDICATION

Thank you to:

Roy - You live love when the going is rough

Jacqui - Your free spirit teaches me enough is enough

Jeff - You continue to excel because you're tough

It is a blessing to have all your love

To My Higher Being:

I have grown in immeasurable ways

My spirit has found freedom

My body has found wellness

My psychic has found self love

I am finally a whole being and

Today is the First Day of the Rest of my Life

ABSTRACT

Clients in long term care facilities rely on their caregivers to meet their total needs. Caregivers depend on their knowledge base, values and physical stamina to meet these needs. These attributes should be empowering to the long term care nurse; however, these nurses frequently feel undervalued and misunderstood.

The essential research question for this study is, "What are the nurses' perception of the process of caring for long term clients?" Four other questions stem from the initial question: How do long term care nurses describe caring; does caring make a difference; is caring important to nurses; does caring influence the satisfaction that nurses feel toward their jobs.

Data was obtained from 12 registered nurses working in the long term care area. They were interviewed one or two times. The data is described and validated by recent literature.

The long term care nurses interviewed in this study felt strongly about caring. These nurses believed that they delivered holistic care but the individual aspects of care were dealt with in a separate fashion. They described their care as being unique and different from long term care. In their narratives, these nurses felt that their families and friends often misunderstood their work. The nurses disclosed touching and personal accounts of memories and family events. They felt these events affected their style

of care. Each nurse respected and identified this individuality in their colleagues.

These findings have implications for long term nursing practice, administration and education, as well as for general nursing. This is a time of transition within the health care field and long term care nurses are being replaced by less trained caregivers. This study validates the importance of the art of caring combined with the science and knowledge of nursing. Long term care nurses believe that when caring is given a priority, they experience greater job satisfaction as well as provide higher quality service.

ACKNOWLEDGEMENTS

Exploring new concepts that open the mind to a higher plane, you realize quickly your limitations and the amount of help, support and energy you receive from others.

To Dr. Olive Yonge, my thesis supervisor and mentor over the past several years, thank you for support, enthusiasm and mentoring. Your wonderful blend of knowledge, caring and humour is irreplaceable. To Dr. Marion Allen, Dr. Diane Buchanan and Dr. Len Stewin, members of my thesis committee, your support, expertise and extra help are much appreciated.

To Dr. Shirley Stinson, thank you for your visionary mentoring and unconditional support as a professor, academic advisor and friend. My hope is that one day I can paint a picture that clearly identifies your significant role in my transcendence.

I wish to acknowledge the long term care facility which allowed me to conduct my study. To the individuals who participated in this study, thank you for your sharing, time, trust and stories.

To Roy, Jacqui and Jeff, thanks for putting up with a wife and mother who tried to balance many roles at one time. You have truly kept me grounded while I regained perspective through your day-to-day unconditional love.

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# CHAPTER I: Introduction

" . . . you have to do the physical things but it's the psychosocial things that are far more important, be it an arm around their shoulders, listening to their stories or sitting down with them". The informant from this study who shared the above quote validated that nursing is undergoing a transition to holistic care. The focus of nursing care has shifted from biological basic care to that which includes the special relationship between the patient and the nurse (Peplau, 1952).

If anyone needs a special relationship, the elders of our society do. Many elders do not have a support system and depend on nurses to meet their total needs in the emotional, physical, spiritual and social areas. In the past, elders were often cared for by their extended families, friends and neighbours as well as religious communities. Today due to a migratory society, dual working families, mo
.re broken families and less support from the religious communities, the workload for nurses and other health care professionals is increased in the care of elders.

There has been a steady increase in the aging population of Canada. Statistics supplied by the Senior Citizens Secretariat, 1989, showed there are 200,000 elders in Alberta. Elderly people are living longer and recuperating sooner and more easily from serious diseases.

Most elderly people choose to stay in their home as long as possible. This is often accomplished by using government or private home care in addition to family support if any is available. With this home support, the clients stay in their homes until they can no longer manage acts of daily living. By the time they are admitted into a long term care facility, they require a high level of care to meet all of their needs.

Nurses practising in the long term care field often feel misunderstood and undervalued. There appears to be an unwritten hierarchy of nursing jobs which are often rated or categorized by technology and the acuity of the illness. Technology appears to be equated to machines. This rating system puts long term care nursing at the bottom of the scale (Deckhard, Hicks & Rountree, 1986).

If long term care nurses have this "second class feeling", could this affect their care? Can they be truly present with a client when the system does not allow them to feel good about themselves? It is important that we understand how long term care nurses care for their clients and how this caring makes a difference. This understanding could help support the long term care nurse as well as improve the care provided to long term care clients. This may be the first step in understanding and empowering the long term care nurses.

This study investigated the nurses' perception of

caring for long term clients and how this caring makes a difference. This type of research is essential at this time because the number of elders is steadily increasing and it is imperative that we understand the role of the nurse in long term care. It is hoped that the information collected in this study will help empower the nurse, thus validating the care they give to clients in long term care. Administrators in long term care settings must know what type of professional nurse to hire and how to retain these caregivers. Educators also need to understand this special type of caring and assist student nurses in identifying and nurturing this feeling in their nursing duties.

Statement of Problem

Caring has always been identified as a direct action of nursing (Watson, 1988). There is very little research and documentation, however, in the area of long term care and about the process of caring and how caring makes a difference. In recent years, the focus of care has shifted from meeting the biological needs of the client to honouring the relationship shared between the nurse and the client. Nurses working in long term care feel devalued and misunderstood(Pfaff, 1987). They also believe their special type of caring is unique and demanding. At times, nurses accept positions in long term care as a temporary job in hopes of switching to acute care, while others seek out this specialty. Over time, these nurses have grown to love

their work and the relationships they share with their clients (Deckhard, Hicks & Rountree, 1986). They feel that their caring makes a difference which gives them a certain degree of job satisfaction. These nurses believe that caring and the art of nursing are most important yet undervalued. We know caring occurs within nursing; however, we do not understood how, why, when or where caring occurs in long term care nursing. There has been no study of or research project on how caring makes a difference from the nurses' viewpoint in long term care.

## CHAPTER II: Review of the Literature

There are many articles written about caring in general as well as caring in nursing. Few nursing studies look at caring for long term clients from a client's perspective. The literature review will focus on caring as a general concept in nursing, carework, role ambiguity in caring, caring in long term care, and trends in long term care.

### Caring

Morse, Solberg, Neander, Bottorff and Johnson (1990) examined caring as a concept. From their review of 35 authors who have written about caring, they identify five epistemological perspectives: caring as a human state, caring as a moral imperative or ideal, caring as an affect, caring as an interpersonal relationship and caring as a nursing intervention.

Further work needs to be done to examine the meaning of caring, how caring affects clients and what nursing would be without caring. Do only nurses care is a frequently asked question. It is assumed that parents, friends and spouses all care, yet they are not all nurses. Morse et al.(1990) describe caring as a human trait. Other authors feel that caring is a "fundamental value" and that it serves as the base of nursing care. Caring as an affect comes from being emotionally involved with a patient and it is this involvement that motivates the nurse. The authors who write about caring as an interpersonal relationship believe that

caring is the essence of nursing and that all other nursing duties stem from this hub. Caring as a therapeutic intervention is used when the nurse has assessed the situation and believes that caring would be the best intervention at the present time. It is seen as one of the many tools nurses have in practice. Morse et al. (1990) point out that we must continue to debate and query the concept of caring to assure the proper fit to the art and science of nursing.

Watson (1988) believes that "Caring is the essence of nursing" (p.33). She states that caring and having high reverence for the person and human life are congruent. Watson cites empirical research which substantiates the view that caring connotes personal responses such as concern, empathy and being treated as a person. She also cites cross-cultural data focusing on "nurse presence", a concept that includes touch and exchanged feelings such as love, sorrow, pain, giving and taking time. The concept of caring, according to Watson, is also postulated to be greater than categories of specific nursing actions, and includes an internalized value system, a caring ideal. Watson states, "The ideal and value of caring is clearly not a thing out there, but it is a starting point, a stance, an attitude which has to become a will, an intention, a commitment, a conscious judgement that manifests itself in concrete acts" (p.29). She also reflects on the

"transpersonal" aspects of caring. In this scenario, the nurse enters into the life space of another person and can detect the person's spirit in such a way that this person has a release of subjective feelings that were longing to be released. Watson also notes that the transpersonal approach brings the "self" to the nursing encounter, a view which may be in conflict with the traditional views of nurses, who are often instructed to keep personal and professional interests apart.

The role of caring in nursing was also considered by Greenleaf (1991). She believes that any caring act is influenced by the social context in which it happens. This influence is caused by the definite expectation that caring will occur and by the available resources to support caring. Greenleaf states that "nurses are ordered to care in a society that does not value caring" (p. 75).

Greenleaf (1991) explores the difficulty of ordering nurses to care through four potential scenarios. In the first scenario, caring is provided to those in need of care in a context that furnishes all necessary resources. She also noted, that in a "quality" health care institution, credit for quality is often given to physicians or administrators, and actual carework remains invisible. The second scenario involves a setting which is supportive of caring, but the worker does not provide care as expected (e.g. a night nurse who falls asleep on the job). Thirdly,

a careworker may attempt to care but the context is nonsupportive. There may be too many demands, too many patients, insufficient or faulty equipment, or lack of support staff for housekeeping. Harm may occur to those dependent on care. To the careworker in such a setting, the feeling is one of despair. The caring ideal is diminished, and the careworker may be placed in a personal bind of wanting to deliver a better quality of care but may not have sufficient resources. In addition, the careworker may be put in a personal bind such as not having staff to cover the next shift, and having to stay late. The fourth and last scenario is of the uncaring worker in a nonsupportive context.

The ambiguities inherent in the definition of care were also studied by Greenleaf (1991). She states, "care is different at home than at work. Caring relations in families are ongoing, in the work setting they are limited, more proscribed" (p.73). In establishing this difference, she noted that "there is a potential for estrangement from self that results when jobs demand emotional labour; acting as if one cares deeply for clients . . . as one would for family" (p.74). This described the bind often experienced by nurses. They are encouraged to care for their clients, yet they are discouraged from becoming too attached. Furthermore, Greenleaf (1991) discusses caring and payment as related and suggests that nurses care as a job related

duty, which is in contrast to Morse (1990) who sees caring as an essential human trait.

The concept of care is very complex according to Leininger (1970), who states " . . . the most unifying dominant and central intellectual and practice focus of nursing is care" (p.13). Universal and nonuniversal practice, caring conflicts, caring consequences, caring gaps, caring needs, caring processes and caring behaviours all account for the variations of care. She uses words like assistive, supportive and facilitative in her definition of care. To Leininger, skilful activities (direct or indirect), to assist people in a compassionate, empathetic and supportive manner, describe caring.

Human caring is a universal phenomenon (Leininger, 1984); however, the patterns of caring and expressions vary among cultures. Caring acts are essential for human bonding, development, growth, survival and a peaceful death. Leininger (1984) believes that curing cannot occur without caring but that caring can occur without curing. There also appears to be a direct relationship between caregiver and care receiver behaviours. As technology tries to take on the role of caring, human caring decreases and becomes more depersonalized. Politics, religious values and economics appear to be directly correlated with the quality of health care provided.

In Leininger's book (1978), she describes who clients

approach when they need caring services. She believes clients first approach local caring people like family and friends who are nonprofessional. If their condition does not improve, professional caregivers are approached. This supports the belief that caring is innate but that caring and knowledge are important to nursing.

Caring is a way of being and is an end in itself but not a means to an end. Noddings (1984) states that caring is based on receptivity. In the relationship between client and nurse, each " . . . feels with and receives the other" (p. 30). Noddings refers to caring as a process that is not cognitive but rather emotive. This process requires that the nurse and client be engrossed with each other.

Giordano (1994) spoke about the importance of caring at the "Celebrate Caring" conference she attended in New Orleans. At this conference for operating room nurses Giordano stated, "caring is an end in itself rather than a means to the end of curing" (1994, p. 1136). This statement strongly concurs with Leininger's work (1984). At the conference presenters discussed the need to pay tribute to caring nurses, as they are masters of the art of healing. The operating room is an area highly dependent on advanced technology. If this specialty acknowledges the value of caring, the long term care specialty with little technological support should also pay tribute to caring.

Carework

Carework according to Greenleaf (1991) is a type of work that is sanctioned by society and entailed in the realm of paid labour. She explains that carework in nursing involves many overlapping tasks. These tasks include attending to the needs of each person as well as responses to medications, medical and nursing treatments, disease processes and all other internal and external impositions on the person. In addition, Greenleaf (1991) notes that the careworker needs time to listen, focus and reflect on the assessment of the situation and the effectiveness of the activities, and time to teach. The notion of the complexity of carework is further compounded by the invisibility of the work and the workers. "An important characteristic of caring acts is that they are most noteworthy in their absence, when neglect, indifference, or even abuse, alert us that something is missing" (p.74). Results of neglect are more apt to be noticed than results of carework. Thus a problematic difficulty arises, not only because carework is taken for granted, but also because carework is what the careworker is being paid for, regardless of training or expertise. A second difficulty is that of measuring and quantifying carework. Administrators within an organization, who try to focus on behavioral tasks, duration of time and effort involved, and level of skills required, may miss the qualitative aspects of the essence of

attention, planning and evaluation, assessment and reflection that cannot be measured yet take time and energy. Greenleaf (1991) concludes that "such partial accounting of carework erodes the caring ideal of the worker, cheats the cared for, and subverts the intent of the social context" (p.75).

Many caregivers express the need to feel good about themselves in order to facilitate the caring of others. They discuss the fine line between caring for themselves and caring for others while achieving a state of well being. Giordano (1994) discusses the importance of taking care of ourselves as caregivers. When we practice self care and we increase all our lines of communication, our caring for others improves.

Role Ambiguity in Caring

Alexander (1984) suggests that nurses in the hospital setting experience conflict, low job satisfaction and high turnover, due in part to three disparate professional demands. First, as independent professionals, nurses are responsible for providing direct, professional care. Secondly, they are responsible for carrying out physicians' orders for treatment, and thirdly, must be involved with the day-to-day administration of the patient care unit. Such role strain can affect nursing practice and ultimately the implementation of caring. This concern was noted by Littlewood (1991) who discussed how one must manage

ambiguity as a central part of caring. Littlewood notes that the ambiguity of the caring role centres around two functions: on one hand the nurse is an advocate on behalf of patients in a primarily biomedical health system, where she/he mediates between lay and professional notions of distress and responsibility; and on the other hand she/he deals with the disruption of normative time and space caused by sickness.

Similarly, Samuelson (1991) comments on the duality of the nursing role. Nursing has been historically a female role and has developed qualities of caring in association with other professionals as well as in an autonomous fashion. Nursing, according to Samuelson (1991), also refers to carrying out physicians' orders. This validates the dual role in addition to increasing the complexity of caring.

Care in Long Term Care

In Koff's (1988) definition of long term care, terms like chronicity, and physical, social and psychological functioning are stressed. He believes that the ailments that affect most older people cannot be cured. He refers to the physical, social and psychological as being one, and argues they cannot be treated as separate entities. We must think of how the whole person functions when determining the services they require. This validation of client individuality is not achieved by diagnosis alone. Koff

notes the need for continuity of care throughout a chronic illness; the concept of care can be thought of as a continuum. Long term care shares the characteristics of chronic illnesses, which are long term by nature; require care on a sustained basis; have uncertain prognoses; include multiple diseases; are disproportionately intrusive on the lives of patients and families; may require a wide variety of service; and can be expensive.

Renz (1994) describes her experience as a float nurse in a heavy geriatric unit. Reassigned from an Intensive Care Unit, her initial attitude was negative. Renz was buddied with a geriatric nurse who modelled individualized, empathetic and interactive care, based on the knowledge that someday she too would be old. This role modelling changed the author's perception of caring for geriatric clients. She recognized the importance of knowing their name and a little about their history, likes, dislikes and culture. She also realized that this type of care demanded physical, emotional and spiritual hard work but gave back immeasurable satisfaction.

Trends in Long Term Care Nursing

[illegible] demographics, crises in the labour force, rising [illegible] and increasing consumer education will positiv[illegible]ape long term care (Griffin, Leftwich and Smith, 1989). Between 1984-1999, the number of people aged 75-84 is forecasted to rise by 58 percent, and the number of

those over 85 is projected to rise 132 percent from 2.2 million to 5.1 million (U.S. Census Bureau 1984, cited in Griffin, Leftwich & Smith, 1989). The authors note that nursing homes will need more than one million registered nurses by the year 2000, a 100 percent increase over those needed in 1990. They believe that because of increased consumer education and the recognition of choice for quality care, creating a supportive and humanistic environment for both employees and residents should aid in employee recruitment and retention, as well as in establishing a true partnership with long term care residents and their families.

Employment opportunities in long term care are reported to be increasing (Deckhard, Hicks & Rountree, 1986; Griffen, Leftwich & Smith, 1989). Results of previous studies have suggested that long term care nursing can be dull and unrewarding and that nursing homes rate at the bottom of the list because they are considered to give custodial care (Pfaff, 1987). In contrast, the results of a recent survey of 1,118 nursing staff members suggested that there was positive job satisfaction associated with long term care nursing (Deckhard et al., 1986).

Robertson and Cummings (1991) conducted a broad based magazine survey of 1200 nurses working in long term care. Five factors were identified as formative to nurses' attitudes about long term care: education (had a clinical

rotation or mentor in long term care); experience (previous work with older adults); work schedule (flexibility and choice of shift); relationships with patients; and patient care (challenge, autonomy, responsibility and judgement in performing patient care). However, salaries, staffing and supplies were also noted as areas of concern.

Nurses with positive job satisfaction, who remain in the nursing field in long term care, are receiving personal satisfaction from their work and feel that they are making a contribution (Robertson and Cummings, 1991). These authors quote a nurse:

> I came into long term care as a matter of convenience. I stay because I have grown to love the work, the long term relationships and the satisfaction I gain from the positive impact I can make of resident's lives. I have been satisfied with my work . . . because I felt I made a difference (p.45).

Over the past decade, gerontological nursing has become a speciality and has received much attention in the literature. This specialty brings many challenges and rewards but is still fraught with misconceptions according to O'Brien (1989). Jordan (1983) states, "Nurses who are dedicated to practice in long term care settings are often judged by unknowing colleagues as not practising in a real nursing position" (p. 171). A staff nurse in a nursing home

tends to have more hands-on care. O'Brien (1989) describes the qualities of understanding, empathy and patience as essential traits when providing geriatric care.

Koff's (1988) belief that most elderly cannot be cured stresses the importance of relationships, caring, comfort and dignity. Koff does not explain how caring is accomplished from individual nurses' perspectives, how nurses feel about caring when curing is not possible and how nurses believe they make a difference. This belief about caring and not curing also supports a less technological field, with fewer tasks and a focus on meeting clients' holistic needs.

The relationship between physical, social and psychological care is also stressed by Koff (1988). Although this emphasizes the importance of holistic care, the author does not explain how long term care nurses provide holistic care and how they feel about this challenge. With increasing numbers of long term clients, the integration of physical, emotional, social and spiritual care from a nurse's perspective must be explored. This will validate the nurse's role in long term care and facilitate the planning of human and financial resources for long term care.

Some authors did not differentiate between care and caring. Care is a way of being or respecting a person. Caring is the dynamic action of actualizing care. For the

purposes of this study no differentiation will be made between care and caring. If informants describe care then this will be considered in the same context as caring.

Summary

Caring requires a special regard for a person. It can benefit both the recipient and the caregiver. If caring comes from one's heart, we can question whether all nurses can or must care. Nurses receive payment for their caring and Greenleaf (1991) refers to this as "carework". We do not know if nurses care more because they receive a salary. Watson (1988) states caring, "is viewed as the moral ideal of nursing where there is the utmost concern for human dignity and preservation of humanity" (p.63). She also views caring as multidimensional and complex (1988). Several authors view caring as an innate value that is present deep inside each of us. This caring is actualized through client relationships, our work values and society's stereotype of the caregiver. The individuality of nurses' caring is not described. Koff (1988) identifies the need for the continuity of care throughout a chronic illness. This concept of care can be thought of as a continuum.

Research Questions

Caring is an important part of nursing, although Morse et al.(1990) alert us to the diverse roles of caring in nursing depending on the paradigm from which one is looking. The present study attempts to increase our understanding of

caring and long term care nursing. Individuality of caring is cited but not expanded upon. Descriptions of long term care nurses' perspectives of care cannot be found in the present literature.

The essential research question for this study is therefore, "What are the nurses' perceptions of the process of caring for long term clients?" Four additional questions stem from this main question: "How do long term care nurses describe caring, does caring make a difference, is caring important to nurses, does caring influence the satisfaction that nurses feel toward their jobs."

To answer these research questions, grounded theory methods were initially chosen. However, as the interviews and concurrent data analysis proceeded, it became apparent that no process was emerging. At this point the writer decided to use an exploratory descriptive design to present the final analysis of the data.

# CHAPTER III: Method

## Introduction

Haberman-Little (1991) describes how qualitative research approaches sensitize people to the diversity of response of humans to health and disease, by describing and uncovering meaning to events in their lives. Caring between the nurse and the long term client and how that caring makes a difference has not previously been described; therefore, qualitative methodology is most appropriate to answer the research questions (Chenitz & Swanson, 1986). The qualitative method used for this research project will help nurses and researchers understand the nature of the caring relationship and how it makes a difference.

## Descriptive Research Design

The purpose of this study is to describe the nurses' perceptions of the process of caring for long term clients and how caring makes a difference. A secondary purpose of this descriptive research is to accurately portray the characteristics of persons, situations or groups and the number of times a certain phenomenon happens (Polit and Hungler, 1983). Brink and Wood (1989) list implicit assumptions in the use of descriptive research: a single variable exists in the studied population; the research design is based on a detailed literature review; and basic criteria for external validity can be achieved through sample selection procedures when the population parameters

are known. The cause and effect relationship is not important within this type of design.

There was no conceptual framework about caring in long term care. Caring as a general concept was discussed at length in the literature but long term care specifically or the long term care nurses' perspectives of caring was not described. A descriptive research design attempts to paint a picture of a particular situation or phenomenon. It is hoped that this project might promote increased nursing knowledge and support for further work and research in the area of long term care.

Sample Selection

In qualitative research, a large number of individuals is not required because the researcher seeks common data which are indicative of a theory or phenomenon. This can be done through observations, interviews, documents, audio or video tapes or any combination of these, depending on what information is needed. The more data obtained, the stronger the research; thus the findings will have a wider applicability (Strauss and Corbin, 1990).

The informants for this study were registered nurses working full time or regular part time in a long term care facility. The informants were volunteers, spoke English and had a minimum of three years experience in a long term care facility. The first informant was selected by the researcher from a list of names obtained from the Director

of Nursing. A list containing the names of all the registered nurses employed full or part time was provided. The researcher then approached a nurse to explain the study and to obtain consent as well as to listen to feelings and concerns. The initial informant, after being interviewed, was asked to give the name of a colleague who would like to be interviewed. This is called snowball sampling.

In snowball sampling, the first priority is the establishment of a trust relationship with the informant (Field and Morse, 1985). This sampling method follows a social concept because it is assumed each nurse will refer a colleague he or she knows well and respects. Field and Morse (1985) state this method is helpful in a facility where the research project is regarded with distrust or suspicion.

Snowball sampling is a method of purposeful sampling which is used to obtain as much information as possible. Characteristics of purposeful sampling include: an emergent sampling design, serial selection of sample units, continuous adjustments or focusing as well as selection to the point of redundancy. In serial selection of sample units, it does not matter where you start as long as successive informants are selected to extend, test or fill in the data. These successive informants are most easily obtained by nominations. Twelve registered nurses were interviewed for this study. An increase in sample size or

reinterviewing was not required as the data became saturated.

This study took place in an Alberta city. The administrators of the long term care facility initially informed the nurses about this study and then the researcher was invited to explain the study to the nurses. It was anticipated that there would be difficulty attracting informants with a negative attitude towards caring. It was assumed that nurses who do not value caring would not volunteer for a study on caring. In this study, the nursing informants appeared to place a priority on caring.

After the registered nurse agreed to participate in this study, a convenient meeting place and time was established. The study was fully explained, consent signed and the informant received a copy of the consent (Appendix C).

Theoretical Sensitivity

Strauss & Corbin (1990) refer to the personal quality of the researcher as theoretical sensitivity. Theoretical sensitivity comes from a keen awareness of the literature, professional experience, personal experience and the analytic process. An extensive review of the literature helped this researcher become sensitized to the phenomenon being studied. Another source of sensitivity is professional experience. The researcher has varied experience in the health care field, including long term

care facilities, which hopefully allowed for more insight. This researcher recently helped her mother move into a long term facility. This personal experience allowed for a broader view of all the roles within a long term care facility as well as deeper understanding of caring. The researcher was careful not to assume that other families have had a similar experience. As the data was collected, the researcher became immersed in the data. This allowed for making comparisons, asking questions, thinking about all sorts of possibilities, making hypotheses and developing theories (Strauss & Corbin, 1990).

Data Collection

Data were collected using semistructured interviews lasting approximately one hour (see Appendix A) and guided by a set of open ended questions. During this exploration process, the questions were initially broad and became more focused as relationships within the data were found (Field & Morse, 1985). All interviews were conducted in person and each interview was audiotaped and transcribed. What the informants described as their view or experience was considered valid. Each informant was interviewed one or two times. Where data categories were not saturated, additional interviews were held or new informants sought. The researcher used fieldnotes to record observations and impressions during the interviews. These notes were written immediately following the interviews in a quiet place and

were used to aid in analysis of the data. The fieldnotes included a description of the physical setting, portraits of the informants, as well as emotions experienced by the researcher. Biographical data were collected on each informant (Appendix B) so as to provide a picture of the informant.

Data Analysis

An important part of data analysis is the process of recording and analysing interviews and fieldnotes (Field and Morse, 1985). There must be an orderly fashion to the process of data analysis. In this study, narrative transcriptions are voluminous. Coding the data is an attempt to recognize categories. This is followed by the establishment of flexible storage and filing systems.

Krippendorf (1980) and Wilson (1985) suggest narrative analysis by separating the answers to each question into similar categories. It is important to really understand the meaning behind each answer. This is accomplished by reading the answers several times. This allows the investigator to create subcategories. For each step, the reasons for division of categories is written down.

The interviews were transcribed word for word by a typist. The lines were numbered using the WordPerfect program to enhance the coding procedures. Wide margins were left as well as large spaces between the paragraphs to facilitate analysis of the data. Researcher fieldnotes and

memos were also reviewed after each interview and reviewed again prior to the next interview. A diary describing the researcher's reflections on the settings was also kept.

The researcher was continuously aware of and maintained an open attitude. Personal values were bracketed as much as possible within the transcriptions. Ambiguous words were clarified with the informants. Fieldnotes and memos were used in the data analysis in an attempt to provide the most true to life scenario and to avoid attempts to guess or judge.

Trustworthiness

Trustworthiness is an important aspect of qualitative research and is necessary to ensure rigour (Guba, 1981). Guba identified four aspects of trustworthiness: truth value, applicability, consistency and neutrality. Krefting (1991) described truth value as the researcher being confident in the truth of the findings. The discovery of human experiences as they are lived or perceived by the informants reveals the truth value. In other words, the findings become credible. If the findings can be applied to other settings or groups the study demonstrates applicability. Guba (1981) rephrased applicability to fittingness or transferability. The data should contain consistent thought. If one believes in multiple realities, consistency is not appropriate as one thought cannot be replaced or reproduced (Lincoln & Guba, 1985). Perhaps this

aspect is better described as dependability. The last criterion of trustworthiness is neutrality or freedom from bias.

Rosenbaum (1988) believes validity has limited appropriateness to qualitative research because validity pertains to measurement. In qualitative research, the researcher is the instrument. Lincoln and Guba (1985, p.193) describe characteristics of the human as an instrument: responsiveness, adaptability, holistic emphasis, knowledge based expansion, processual immediacy, abilities to clarify and summarize, and to explore atypical or idiosyncratic responses. Lincoln and Guba (1985) stress that the human instrument and the paper and pencil are fallible; therefore teams of human instruments would increase validity.

The importance of volunteering was respected by the researcher during the data collection. Only informants willing to participate and able to express their thoughts and feelings were selected. The informants were interviewed at a location convenient to them and were not expected to inconvenience themselves. Biographical information that describes and determines if there are differences in the nurses' backgrounds was obtained (Appendix B). Fieldnotes were kept from the beginning of the study in an attempt to control biases and assumptions. A diary containing personal reflections was also kept. Interviews were transcribed

verbatim. The transcribed interviews were checked with the audiotapes by the researcher prior to analysis. The informants reviewed the transcripts and they discussed the analysis of the data to verify accuracy of interpretation. Interviews, analysis and fieldnotes were discussed with the thesis supervisor regularly. A pilot interview was conducted and analyzed prior to this study to increase trustworthiness. The data obtained through this interview were not used in this project. The researcher had previous experience in interviewing and had reviewed the literature on caring, long term care and qualitative, descriptive research.

Serious errors in study design can come from lack of knowledge about the population; thus pretesting all tools is imperative. Two issues to keep in mind are acquiescent response set -- when respondents tend to agree with the interviewer -- and social desirability -- in which respondents answer with the perceived socially desired answer rather than the actual answer. To counteract a socially desired response the researcher began the interview with a statement such as, "We all have good days and bad days." As well interviews were conducted off site to promote a nonthreatening atmosphere. Coffee and tea were served to facilitate comfort and trust. The tape recorder was not in the informant's line of sight and the lighting was diminished to promote comfort. The interviewer

acknowledged that there were no right or wrong answers to allow for freedom of disclosure.

The use of repeated interviews with the same subject is a way of ensuring trustworthiness. Repeated interviews validate the informant's information. To ensure a correct data base from the written material, several readings of the data and a second person reviewing the material are essential.

Bias

The researcher has previously worked in the long term care field and has developed ideas and views of nursing in this setting. These personal values were bracketed and the researcher engaged in self-reflection by keeping a diary. The thesis advisor was actively involved throughout the research process and assisted in identifying and clarifying any bias the researcher may have had. The researcher attempted to focus on this research and not her nursing experience. All of these measures were undertaken to avoid bias entering the research.

Ethical Considerations

This proposal was approved by the Joint Faculty of Nursing and University of Alberta Hospitals Ethics Review Committee prior to implementation. Formal access to the long term care facility and to the informants was obtained. Following an explanation of the study, informed consents were obtained from the informants regarding participation in

this study (Appendix C). All the informants in the study were able to speak English to ensure understanding. Participation of the informants was voluntary and they could withdraw from this study at any time. If the informant became emotionally upset or if any unusual circumstances occurred during the interview, the informant was given the option of discontinuing the interview.

Confidentiality of the informants and confidentiality of the agency were maintained. The researcher was the only person to know the names, addresses and telephone numbers of the informants. This information was kept separate from the research data. To avoid any chance of identification, each informant was assigned a code number. Any information that could be used to identify the informants was erased from the tapes. All data from the interviews were kept in a locked metal cupboard in the researcher's home. Data will be retained for seven years according to research requirements at the University of Alberta. The transcriber of the audiotapes was required to sign an oath of confidentiality (Appendix D).

The risk to the informants was minimal. The researcher was sensitive to the informants' emotional states as well as being keenly aware of the changing health care situation due to financial restraint. The first nurse, identified by the Director of Nursing, was assured that any information shared would not be identified.

# CHAPTER IV: Findings

## Introduction

The results of the data analysis are presented in this chapter. The major categories are: nurses' perceptions of caring for long term clients, long term care nurses' descriptions of caring, caring makes a difference, caring is important to nurses, and caring influences the satisfaction that nurses feel toward their jobs. Nurses varied in the manner, ease, emotion and details disclosed as they discussed caring. Most gave emotional accounts about special clients or family members. Some shed tears as they remembered a special bonding with a client.

Twelve registered nurses were interviewed; several were interviewed twice. The highest level of nursing education was a diploma in nursing. One nurse had a nonrelated undergraduate degree. The average age of the twelve long term care nurses was 47 years. The average years of active nursing was 16 years, with an average of 6.5 years in long term care. Interviews yielded volumous data because the informants talked freely and easily about this subject.

Analysis showed that long term care nurses felt strongly about caring. These nurses felt their care was holistic in nature but that the individual aspects of care were dealt with in a separate fashion. For example, they would go apply a dressing to a client and consider this a physical task; at the same time, they would stop to talk to

the client, joke with the client and touch the client's hand or arm out of respect, which demonstrated holistic caring.

The long term care nurses strongly believed that their care was unique. They felt the uniqueness was built on their ability to have long term relationships with clients, which allowed them to build trust with and to learn the little idiosyncrasies of the clients. The informants frequently felt their work was misunderstood by their spouses, friends and family. They attributed this to our society's lack of respect for the elderly and our infatuation with technology.

These nurses believed that their personal life experiences affected the type of care they give as a nurse. Most of the informants related touching narratives about memories of grandparents or other family members. They felt there was a direct relationship between their personal experiences and values and the care they provided.

Nurses' Perceptions of the Process of Caring for Long Term Clients

Nurses found it difficult to describe caring for long term clients. All of the nurses interviewed quickly stated that they cared for clients every day but caring was difficult to describe. When asked about caring and how caring transcended from the beginning to the end of the relationship with clients, they all seemed unable to put their feelings into words. A lot of nurses found that

caring was discussed very little at team conferences or when documenting. They took for granted that all nurses cared for every client, but they cared for some clients more deeply or easily than others. The nurses commented that caring was taken for granted and not actively integrated into their training. Very little time was spent in training or in team conferences talking about the actual art of caring or how the caring took place. Most of the time was spent discussing tasks. The nurses seemed unable to join the caring needs of the clients to the tasks of the nurses.

Some informants believed that caring was innate, or that it increased with education, while still others felt it was a spiritual relationship with the clients. One nurse talked about caring and technology.

> . . . when I started I liked the way things were at that time. Technology was not as grossly exaggerated as it is today. Somehow with what's happening now technology is slowing down and that helps us. I think a lot of technology gets in the way of healing. It is such a facade. We use all our money to get every toy there is and we need it to help these patients but really what we want is research, research, research and we want to be God. Healing doesn't happen that way. I mean, if doctors ever think they're going to heal, if they're going to find a cure for cancer in a pure

> technological way, forget it because there's a whole person in there . . .

One of the nurses talked about the difficulty in describing a caring process. She understood the word process to be a method similar to how nurses were taught techniques like changing dressings. Procedures were taught in numerical order and everyone knew exactly how to do things right. She felt that caring was too emotional for this type of description.

> Oh, I'm not sure that it can be as technical as a process. To me caring is very much a personal thing, not that I let my feelings get involved or overly involved, but I really do see these people like maybe a grandmother, and I think their personal comfort and their emotional comfort is number one . . .

Another nurse saw the process of caring as being more important at certain times during the stay of a resident in a long term facility than at other times. This particular nurse saw the need to be caring as most important at the time of admission. She recognized that the residents were making great changes in their lifestyle and had many adaptations ahead of them.

It was this nurse's perception that caring was meeting all of the residents' spiritual, social, physical and emotional needs. She also saw the need of documenting the

assessment in good care plans. Caring was not just a relationship between the client and the nurse but was facilitated more through consistency by the whole team if a good care plan was documented and easily accessible.

> I think especially on admissions we really try to make them feel comfortable. We try to involve their families and show the empathy we have, how they will settle in. We try to construct good care plans to accommodate their needs and we don't look at just needs that might be dressing and eating, for example. We try to look at them holistically and give them, you know, our expertise in any area that we can especially nursing and then again we involve all our team members and we try to coordinate this all together so that they do get probably the best care they could according, especially with the care plans, trying to get everything, all their needs tended to.

Other nurses saw caring as key to how the nurse was feeling about the client and how the client was feeling about the nurse. They saw the caring as being a relationship and a friendship. Caring to these nurses had no beginning and no end. Every interaction should improve caring and the relationship between the resident and the nurse. They saw caring as making the client feel safe in

their new environment. They also recognized that caring was shared. The nurses were aware that 24 hour care must be shared in a manner that's noncompetitive and honest while allowing the individual nature of each nurse and each resident to come through.

Some of the nurses who talked in this fashion saw themselves caring more deeply for residents experiencing acute illnesses or increasing physical, emotional, social or spiritual needs. They found themselves caring for residents who had no families or were divorced and lonely. Some nurses felt they cared more deeply and easily for residents requiring increased physical care. One nurse talked about residents who had cardiovascular needs or those who were diabetic. She had a great empathy for and quickly warmed to these types of clients. Another nurse talked about having special relationships with clients who were palliative and especially those who were dying of cancer. She felt cancer was a loneliness that no one else could describe and that they needed all the caring she could give. Other nurses felt closer to residents who were cognitively impaired.

> Personally, I think I probably care more for a level three or level four alzheimer resident because they need more care to feel comfortable and to feel safe or secure.

Most of the nurses felt that trust and healing were part of a true caring relationship. Caring was built on a

trust between the resident and the nurse and consequently continued to grow as the relationship grew. They felt that physical, emotional, spiritual and social needs could all be better met if the trust was true and at a "soul level" between the resident and the nurse. One nurse eloquently described her feelings of trusting and how she facilitates trusting to the task of caring.

> I build trusting relationships with clients and patients and really bond with them and through that bonding there's a lot of healing that happens and while I do a bath or get a resident dressed, I'm throwing out caring questions. I'm interested in the person and I learn because they open up and share their deepest pain, their conflicts and all these things that come out while I'm working with them. It's pain that is transferred through the body either spiritually or psychologically. There are events in life that happen that leave a residue of pain and it's felt in the body and so with my counselling skills I reach out into those areas with them and have been told many times by residents or patients that real healing was happening and even some doctors have come and have asked me, 'What is it that you do because you're doing more for my patient than I am'. Sometimes, and if the doctor was really asking that question

> with real interest and with taking time, I would sit down and talk with him and share with him what I was doing. You know, I explain that to them and there have been occasions where patients have told me of criminal things that they had done and I had to tell them that had to be passed on and that it would be passed on in a caring way for them because it's not going to go away or heal within them if it's left where it is and is hidden and they usually cooperate. There's usually not an awful lot of resistance because they trust me, you know.

Some nurses perceived the purpose of caring as the nursing process. They saw that the first thing that you had to do was to assess the resident and the family as to how they are coping and their required needs. The nurses were very quick to cite the nursing process and consider it as a possible base for caring. Most of them stated that they had not been taught that the nursing process was to involve caring but rather the nursing process was to involve tasks. They further stated that with the experience that they had derived, especially in long term care, they quickly realized that the nursing process and caring could well be congruent.

> The first thing that's involved is assessing. We not only assess the resident but we assess the family and how they're coping as well. Through a

> process of elimination, we figure out the best plan of action that will work for that individual involving their medications, socialization, all the things that we identify that a resident needs in order to have a will to live basically.

Two nurses talked about the amount of physical care that is required in long term care, simply by the virtue of the life-span process. They recognized that it wasn't perhaps right that physical needs would be considered the most important. Because of the increasing acuity of residents and changing health care systems, as well as less trained staff, physical needs were now becoming the highest priority in the caring process.

Because of the high priority given to physical needs, these nurses felt that the most important skill they needed to have was a strong knowledge base. Their nursing knowledge enabled them to care more effectively for the resident with increased physical needs.

> I have to have knowledge of my nursing, physiology, drug interactions, all the medications they're on, that is what might be detrimental. To have this knowledge, also to remind the doctor because sometimes they're writing orders and they forget that they're still on such and such and there's like a bombardment of different drugs that they're on and no wonder they're falling.

One of the nurses who had diverse experience in both acute and long term care described caring as more involved at the personal and emotional levels in long term care. This could be because these residents are there for a long time and relationships can become deep and trusting. Long term clients have diverse needs and the facility is considered to be home; therefore, you become part of their extended family.

> . . . caring for a long term client is much more involved personally than caring for an acute care client in that you're dealing with their whole lives, not just the illness aspect of their lives. The quality of life becomes much more of an issue in the caring because if somebody's admitted to an acute care facility and certain aspects of their lives, certain needs are not met while they are there, then although that's unfortunate it still maybe, you know, won't cause any long term problems for the person, whereas in long term care all needs for that person have to be met because you're looking at a long term, ongoing, probably until death type of relationship between nurse and client.

Narratives About Caring for a Special Client

Every nurse interviewed had no trouble remembering a special resident or relationship. Some informants kept

memories vividly alive for years while others chose a recent resident interaction. Most of the informants shared their stories with teary eyes and strong emotions. At times the emotion was contagious and the researcher found herself sharing tears or laughter with the informants. It was easy to validate their sincerity and genuineness when caring for the residents. One nurse told a story in which advocacy was her primary role.

> Since I've been at this facility, there is one lady who was there when I first arrived. She had sort of a problem character in that nobody was ever able to control some of her bizarre behaviours. You know, she'd come out into the middle of the corridor stark naked and, you know, she'd probably do that for two or three days straight and then we wouldn't see the behaviour for months or a year again . . . You know, over a course of several months I developed a bit of a rapport with her and started to realize that if you talk to her adult to adult and sort of called her on some of this behaviour, you could stop it. Sometimes you'd see her in the hallway and she'd say, 'I'm going to fall.' You'd say, no, you're not. I'll walk with you down the hall. She would really want you to get a wheelchair, take her down and you would say, no. . . . She had one daughter

and one son in other provinces. One daughter here, who was the image of her physically, just younger, unfortunately got cancer, had chemotherapy, improved, got sick again and over the course of a few weeks it became apparent she was going to die. She was in the hospital and her mother (my patient) had succeeded in driving her son-in-law up the wall while trying to cope with his wife's illness. His mother-in-law was the last thing that he felt he could cope with at that time. . . . Her son-in-law had told the people at the hospital that he didn't want her to s[illegible] or upset his wife. So through a series of phone calls and consultations between myself, the other nursing staff, my patient, the people at the hospital, the husband, and the administration, we finally organized a couple of trips to see her daughter. . . . She died within a week of those trips. I was panicky that she get to visit her daughter before she died, because with her coping skills or lack of, any chance she was ever going to resolve this grief could only come if she saw that daughter before she died and she spoke about this. She was discharged later to be closer to family, but the day she was discharged she spoke about this and said how much it meant to her.

At times nurses seemed unable to let their memories diminish or die. One nurse felt her memories remained so vivid because the client reminded her of the special relationship she shared with her grandmother. Another nurse disclosed her fear of losing her own parents or not being able to care for them in a manner she felt they deserved. It appeared that all nurses remembered or easily retrieved accounts of special relationships because of personal memories or fears. One informant shared an incident so close to her heart that many years later, it continues to haunt her.

> I had one that sticks out in my mind like for years ever since I was just a new grad. That's how far back it goes and it's still in my mind. She was a medical patient. Her abdomen was very swollen. They thought she had ovarian cancer and she refused surgery and I would go in and she was on morphine and I'd give her morphine for pain and she would beg and beg me for more. There wasn't any change really and finally, I mean, I'd go in and, you know, it was getting to me. It was bothering me when I'd go home, how this woman was wanting me to give her an overdose and finally I asked . . .

After finding out her patient really wanted to die, this nurse sought outside advice.

> And finally I went to my supervisor and I said I can't take this any more. I said it's affecting me. I go in there and I come out and I go in the bathroom and cry because she's in such agony and the irony of it was, like she wouldn't have surgery. They took me off her case and she never had ovarian cancer. She died from a cyst. It was what they called a chocolate cyst, and here it had blown up so much that it had destroyed her organ, you know, just compressed her organs and after all that she never had cancer. They could have just taken that ovary out and that would have been it but she wouldn't let them. That's been on my mind for so long, like different aspects of that whole thing has affected me. It really bothered me. It was a relief, like a big burden was taken off me when I was taken off the case. It pops up in my dreams once in a while yet and that's 30 years ago.

How Do Our Nursing Peers Care?

The majority of informants believed their peers demonstrated care in a positive manner. Cited characteristics of care were: kind, warm, gentle, humorous, and flexible.

> I've seen some, you know, warm and caring nurses who are in there doing the same things I'm doing

> who believe in touch and who believe in things like this.

Some discussed harsh and negative client treatment that they had observed over their careers in various locations and specialities.

> I've seen some, let's say, rough care given, just treating the patient like an object rather than a person. I've seen nurses be really short with patients like they didn't have a right to say or comment or anything. I've seen nurses ignore patients . . .

Some nurses discussed how their training prepared them to become task and policy orientated. They acknowledged that this preparation allowed them to carry out their tasks more efficiently, but did not validate some of the emotion that came with the tasks. This nurse describes her peers as practising a strict, policy orientated approach and validates the importance of how certain tasks are performed.

> Some nurses are very much the letter of the law and to be a good nurse means that I am exact about all these things. These things are their nursing tools and functions and it's like the letter of the law rather than the spirit. I approach it from the spirit end of it and so I will do these things but it's not as important for me to be exact but to be caring . . .

As nurses evaluated the caring behaviours of their peers, they also appeared to look introspectively at their own behaviours. It was almost like a comparison between other methods of care and their own. Many informants shared their uncomfortable feelings in evaluating their peers, as they felt that evaluation was more of a management duty. Others possessed a strong allegiance to peers and disclosed that they were not always perfect in their own practice.

> I think it's fairly positive. You know I sometimes admire the patience that other nurses show towards people and the extra time they take and I see a lot of positive things happening.

Long Term Care Nurses' Description of Caring

Most nurses discussed care from a holistic perspective, recognizing psychical, social, spiritual and emotional needs. They attempted to meet the clients' total needs in the most dignified manner possible. Each nurse appeared to have an internalized priority of these needs. Most felt physical needs were superior to spiritual needs while a few felt spiritual needs topped the list.

All the informants believed that caring was an innate value but that the nursing knowledge increased the skill level to provide care. Most of the nurses shared childhood memories or value systems that affected their caring. Some nurses could imagine themselves as they aged and the type of care they would like.

> I like to look after their mouth. You know, mouth and teeth are very important things to me and I like to have mine clean. I can't imagine eating breakfast without your teeth clean and your mouth feeling fresh that you can taste your breakfast instead of, eeuuhh, yeah. I like their hair done. I like to see their hair combed and done, you know, if they've got enough hair to just style it in a way. If I ever had time during the day to just put a few rollers in or do something especially if their family are coming and they haven't gotten to the beauty parlour because families like to see their moms like done up nice. I know when I like to go visit my mom she does her own care mostly but I like to see her dressed up and not a stained shirt on. There are times that she neglects to change her shirt or something but I like to see them in clean clothes and buttons on their clothes and not have their nylons hanging down when they're walking down the hall or their diaper falling off . . .

Some nurses saw their roles of educator, role modeller, coordinator and facilitator as their prime way of caring. In this long term care facility, registered nurses worked as team facilitators. The teams included multidisciplinary professionals and nursing attendants. Nurses acknowledged

that the above roles were becoming increasingly important during the present health care reform due to untrained staffing. They also validated the importance of these roles in long term care nursing because they felt the residents were often unable to cite their needs.

Caring for Physical Needs

Most of the 12 informants felt that they lacked the time to do much hands-on care. They missed this relationship and the opportunity for further assessment. Some nurses felt their care improved when given the opportunity to have a client relationship over a period of time. They also based their assessments on resident habits and gut feelings. Nurses' perceptions about physical care varied. Some identified physical care to be basic tasks like bathing, mouth care and skin care.

> I like to give a resident, if they're washing up for the morning, nice warm water, new towels and cream.

Other nurses discussed physical care as an opportunity to touch and hug their clients. They felt that this touch could also be demonstrated through extraordinary physical care such as curling hair, painting nails, and shaving.

> Don't be afraid to touch and I think staff have seen me hug, kiss and touch and I've said to them, little things, just tiny things are important. We have a curling iron and that's a wonderful thing.

> They can sit down with somebody's hair that looks as though they came out backwards that morning and spend time and just sit and talk and curl hair. The resident ends up looking better but also there's that very important time, and touch . . .

Caring for Emotional Needs

Emotional needs and caring were acknowledged by all informants as each nurse identified and met these needs quite differently. This nurse recognized the importance of past experiences and heritage, as well as listening with interest and respect.

> I don't think enough people take time to listen to what they're saying is going on. You can ask them questions like what's happened before and was it a birthday or was it a wedding and then they kind of bring it all back because that's easy for them to bring back the past memories. When you ask to look at their photos they just beam. They just beam and they get the bottom drawer out and get their photos out and they sit on the bed and they'll name all these people because that's who they know. I think that helps them because I think past things are easier to remember even sometimes for us and that makes them feel good because they can remember. They don't get that scary feeling of losing that part that they can't

> remember. And they feel that somebody is interested in their family. They've lost everything. They're there with one bed, a dresser, a TV and one dinky little closet after 75 years bringing up and working on farms, feeding about 10 or 12 workmen and caring for the kids, having these 6, 8 kids, keeping papa happy and now they're down to a bed and a dresser. I find that so hard.

Many nurses believed that providing emotional care requires a strong client-nurse relationship. They felt this relationship was based on trust and compatibility. As they shared their feelings about providing emotional care, all the informants identified the necessity of time in establishing this trust relationship. It was expected that the client would treat the long term care facility as if it were their home. The opportunity to build a relationship and to recognize individual uniqueness was therefore enhanced. All of the nurses felt that time enabled them to know the real resident as opposed to knowing them only as a patient.

> . . . take time to care for emotional needs. The emotional needs are met through the vehicles of relationship, trust and building a rapport. I do a lot of sitting and talking and I sit on beds. I've sat on the floor and that's what a lot of

> them need. They just need to talk and I think it overlaps a lot but I think the families have an extraordinary number of emotional needs and that's something that I sort of pride myself on when I've got time.

Nurses identified the need to respect each client as an individual with special values, beliefs and histories. One informant compared this respect to being able to turn the other cheek or walking a mile in their shoes. Another informant felt she met the emotional needs of the residents by being nonjudgemental and by offering respect.

> The first thing is to respect their emotions, their feelings and just because they may not react to something the way you would like them to doesn't mean their feelings are not valid. I do believe in validating their feelings.

Although all nurses expressed a strong belief in the importance of emotional caring, some believed all basic tasks, especially physical needs, must be a priority. While discussing the necessity of emotional caring, nurses expressed their anxieties about not providing this care. They stated that the cutbacks and health care changes were forcing them to practice a strong prioritization model of care which often resulted in only required tasks being done. Emotional caring was often a luxury. The following quote illuminates one nurse's feelings about emotional needs

taking second place to physical tasks.

> Not as much as we should. I think we get caught up in the pace. We get caught up in making sure the job is done and the job means the physical or the mechanical tasks. Too often we walk by and I'm the first one to admit that. You get caught up in things but yet holding somebody's hand is more important than giving a bath.

Another informant believed that emotional care like hugs and touch could be given even with staff shortages and increasing acuity of residents. This nurse believed that it was not the quantity of touches and hugs but rather the quality. She believed that kindness, gentleness and individuality could be given in the same time that it takes to complete a given task. The emotional caring provided the residents with an outlet for stress and frustration according to this informant.

> Well, they say that a person needs eight hugs a day just for maintenance so I try to hug my residents. The hug, the touch, the closeness, the hand touching, pats on the back and the shoulder are important. I talk to them all the time. Some of them need to dump all their frustrations. I can deal with that because I realize when they come in there they have lost a lot. They have lost their homes one way or another. Their

families don't come and visit them as much. They're losing body function and mobility. They are s frustrated. They need that extra love.

Ca in r ocial Needs

Some nurses felt overwhelmed with residents' social needs and they relied on the recreation department, volunteers and families to meet these needs.

Well, socially like I encourage them to go to whatever programs are offered.

One nurse believed that some families let their loved ones down and she felt angry because this placed more expectations on her. Another nurse empathized with families, stating that today's world is hectic and demanding. Most nurses agreed that they would gladly attempt to meet the social needs of the residents but that lack of time created a problem. These same nurses often referred to the "good old days" when they went shopping, visiting, or walking with the resident. Again the individuality of caregivers was illuminated. One nurse believed that the residents' social needs were so important that friendships which developed inside facilities would likely not have occurred within communities.

One thing that we certainly need to respect is their need for friendship with each other. There are certainly friendships that crop up and develop within the population that might never ever have

> developed outside. People would be worlds apart either economically, culturally, socially or whatever, but within the institution sometimes two highly unlikely people will become buddies and that bond is very, very important to them.

Caring for Spiritual Needs

The perception of spiritual needs varied from respectful, peaceful and subconscious to highly religious. The ease with which the informants discussed this topic also varied greatly. Some nurses definitely related religion and spirituality while others saw no correlation.

> Well, I think most nurses equate spiritual with religion and they're two different things. On the spiritual level we are all one. On the religious level we're divided.

Most nurses relied on individual families, churches and the pastoral care department to help meet residents' spiritual needs. These nurses talked about the individuality of spiritual needs they saw in their patients and believed this should be honoured with respect and dignity.

> You let them (the residents) set the ground work quite often and take it from there but one of the biggest things I find is acceptance of who they are and what their beliefs are. If they don't believe that prayer or going inside a church is worth anything, then accept that. They still have spiritual needs and that

is really, really important.

Best Care Provided

Nurses felt that their best care should be given every day and they appeared scared to cite or isolate any occasion that did not meet the standard. Accomplishing expected tasks, meeting resident needs, supporting coworkers, and intervening appropriately in crisis were indicators of the perception of best care. Others felt they have never achieved the best care. One nurse described the feeling of completing her duties.

> It would have been on a busy night when I got everything done and still had time to give somebody Tylenol, to send someone to the hospital with chest pain or something like that. I got to them and I dealt with them effectively without them feeling like they were in my way. It is like dealing with that resident so that his or her needs were completely met and yet still getting to everybody else at the same time and having everybody feel that they're equal.

It appeared that many nurses had high expectations of themselves and the care they were able to provide. Some wondered if they would ever accomplish this type of care. Two nurses candidly pointed out that they were scared to identify their best care because it might deter them from trying harder.

> I haven't had the luxury of giving the ultimate care. I've just had to do what I've had to do.

Most nurses who were able to describe an account of their best care identified this care with a dying client. When asked why, they responded that dying with peace, dignity and respect was very important to them. They believed this value system was possibly the reason why they chose to work in long term care. One nurse remembered giving her best care to a dying client during her student days.

> Actually when I was in nurses' training I was looking after this gentleman who was terminal and I think he was in his 90's. I had to do a bed bath demonstration for my instructor and we looked after that man and he got the best bed bath that he'd probably ever had in his stay in the hospital. I felt such a connection with that man who I realized probably wasn't going to live that long so I just went out of my way to make sure everything was perfect for him that particular day. When I came back the next morning he had died.

Worst Care Provided

Nurses reflected on lack of time, increasing resident acuity, less staff, changes in health care trends and high professional expectations as boundaries to providing care.

All informants worried about not completing their duties and leaving more work for their peers. Many nurses related accounts of busy shifts and taking their concerns home with them.

> . . . I couldn't fall asleep because I was trying to figure out if I had done everything that's just physically expected of me in terms of meds, paperwork and staff. I had trouble in my own mind, I was concerned that even the basics weren't covered let alone the emotional . . .

These same nurses felt torn between their loyalties to clients and their allegiance to peers. They described scenarios of feeling good when meeting the client's total needs, but feeling down when their peers had increased amounts of work.

> Unfinished work. I feel that probably happens quite often because of priorities. Somebody was sicker than somebody else and so the next resident sort of got something left behind. Then the work is probably picked up on the next shift because I just didn't have time to deal with it.

None of the nurses believed there were reasons strong enough to validate residents' needs not being met. All decisions and actions were based on residents' wellbeing.

Caring Makes a Difference

All informants strongly believed that caring made a

dramatic difference in the residents' self-esteem, healing, and increased state of general health. The nurses easily related accounts of how care made a difference both to the client and to them personally and professionally.

> Some days when I'm really rushed and I don't have time to do normal things, I rush in and I say I'm sorry. I'm really in a rush this morning. I drop their pills on the table. I say you won't forget to take these, like the cognitively alert ones and I rush out again to continue on my work. The next day when I come back they'll go, 'Oh, you were really busy yesterday, huh?' and I said yes, I didn't have time to do much. To a lot of these residents, this is their home. You're invading their privacy. You're coming into their private and personal space and if you're just there to do their pills and leave again, it's like you're some stranger walking into their home . . .

Although the nurses believed that caring made a difference, they had great difficulty in stating the amount of difference it made. Most of them related narratives about relationships, trust, and sincerity and they felt that these qualities were immeasurable. They believed these qualities attributed to caring. All the informants agreed that the art of caring in combination with the science of nursing made a difference to the resident as well as to the

caregiver.

Beliefs and Values That Make a Difference in Caring

The individuality of each informant shone as they disclosed personal descriptions from past and present which they believed affected their style of care. All the nurses believed that their family values, and both positive and negative past experiences, and past relationships directly affected their caring. A nurse painted a loving, gentle and teary picture about her relationship with her grandpa and how she remembered him as she cared for her clients.

> I was 13 when my grandpa died. He was my best friend in the whole world. He took me to school and we went to picnics. We did everything together. We went fishing. We went trapping for gophers. We sat and watched 'The Price is Right' and argued about who was going to win. Until he died when I was 13 he was my very best friend. He had cancer. I knew I was going to be a nurse at that time. When I was a little tiny kid about six years old, grandpa would say, 'You be a good girl and you be a nurse for grandpa?' [crying] . . .

Most of the nurses believed that long term care nursing was not understood within their profession or within society in general. They talked about the little validation they experienced from family, friends and acquaintances. One nurse discussed her friends' perceptions of long term care

residents.

> . . . like some of the people I associate with, they say stuff like, 'Oooh, how can you work with old people all the time? They're drooling and gross and they shit in their diapers and they spit food everywhere.' I try to explain that we have to realize these people have had a life and they have families out there that love them. They have a different cultural background. They represent our history and one day we're going to be in their position and we have to respect them for where they've been and what they've done and we can't just look at them as having many problems. I'm not scared or disgusted by them because I know everybody's going to get old.

Some nurses revealed their inner feelings through a comparison between long term care and acute care. They identified that acute care has a romance and skill connected with it that degrades the supportive role of long term care. This nurse disclosed her internal, positive beliefs about individuals' rights as well as the negative picture society has about long term care.

> . . . a person is entitled to respect and acceptance and that no matter what our age we have emotional needs and the need for some sort of friendship. Even people who can hardly speak any

> more develop bonds with certain other people. There's always the need for socialization, for emotional support and a whole lot more. In a negative way, I find that long term care is a little bit negatively affected because it doesn't have the romance that acute care has. Society often sees long term care as depressing, as people who are just kind of hanging around waiting to die.

Other nurses expressed their belief in self love as a method of being able to love others. These nurses felt that it was healthy rather that narcissistic to care for oneself. They also confirmed that the profession and society in general did not affirm this value. This nurse expressed this belief eloquently.

> I think you have to be happy and well. If you're concerned about your wellness, then you'll be able to care for others. If you're a wreck in your own life and you're not coming to grips with things and you're tired and depressed or scattered all over the place, I don't think you make for a very good caregiver.

Factors that Interfere With Caring

All informants listed lack of time as the most interfering factor. Others listed increased paperwork, less professional staff and frequent meetings.

> There is so much expected paperwork that if I could give away all the paperwork and do a minimal amount, I could spend more time with the actual residents.

The nurses believed that the quality of client care is sacrificed as the workload increases. They tried to achieve all their real and perceived expectations but often they felt unfulfilled and dissatisfied. All the informants readily disclosed that their daily goals were made up of task orientated duties. Once these duties were achieved, their care could expand to include emotional, social and spiritual needs.

> I am trying to do so many things say on a given morning that I think in some cases it takes away from the care that we can give because we're spread too thin.

Caring is Important to Nurses

Most nurses talked about a reciprocal relationship between resident and caregiver and that caring created a win-win scenario for both parties. Caring was cited as going beyond meeting basic needs of the resident.

> I'm doing something for them but they really give me something. I get a lot, I mean, this is why I'm in nursing.

In discussing the reciprocity of caring, nurses referred to feelings of warmth, happiness, fulfilment and importance.

Some informants disclosed in great detail the feelings they experienced when they delivered high quality care.

> It just feels warm. You feel like you're walking about a foot off the ground, that's how much you've gotten from a certain person.

Nurses did not expect appreciation or improvement from the residents they cared for. Their empowerment came from the belief that they helped in some way.

> Just knowing that because you were there that day, someone else was a little happier or a little better off or when you left that you made a difference.

Some cited that the fulfilment they received from caring is the phenomenon that keeps them in nursing. They revealed that today's expectations are higher and more demanding than ever before. Many informants experienced a personal satisfaction after completing a busy shift successfully. It appeared to be important to most of the nurses that both the art and the science of nursing be carried out with skill and caring.

> I think it meets a lot of my needs in that I'm happiest when I'm involved with people on a personal basis rather than the hard core skills. . . . If you're going to call yourself a registered nurse then I think those (hard core) skills have got to be good. It's the softer

skills that make me the happiest and it always has been ever since I first started nursing.

How Has Caring Changed?

All the informants agreed that the concept of caring has not changed. However, the health care environment and expectations have changed drastically, thereby affecting care.

There's more distancing now because I'm not at the bedside as much. Sometimes I almost feel more like a technician than a bedside nurse, you know.

Most of the nurses felt that technology has affected the type of caring but not the quality of caring. Nurses who have been in the profession for many years identified similar caring techniques but increasing technical requirements. They believed that their nursing practice incorporated their individual caring methods.

I don't think caring has changed. My personal feeling is that nursing and my own practice hasn't changed.

Does Caring Influence the Satisfaction that Nurses Feel Toward Their Job?

All nurses strongly believed there was a direct correlation between caring and job satisfaction. They all stated that they would no longer be in this profession if they did not receive this personal satisfaction.

Caring and my type of caring enhances my job

satisfaction.

Most of the nurses realized that their skills and knowledge base could be incorporated into other jobs and professions. Some had experienced jobs both within and out of the nursing profession. These nurses recognized the physical and emotional expectations of long term nursing. Many cited accounts of friends and family in describing jobs that required less caring, but quickly recognized the satisfaction they received from clients.

> . . . I find that if I walk away without doing it (caring), I feel a little less happy with myself, a little less satisfied with my job.

Other nurses identified the win-win scenario that can be created through the art of caring.

> I feel extremely fulfilled in what I do and I feel that while I reach out to them, they are nurturing me in the way they respond and the way they are. It's the caring coming through that nurtures me, you see.

While most of the nurses recognized the fulfilment and satisfaction they experienced after caring for residents, some informants worried about burnout and lack of recognition. One nurse believed that long term care clients took more energy from the caregiver than the caregiver received from the clients. She believed that long term care nurses needed a strong support system to nourish them as

they tried to meet the heavy demands of these clients.

> You can give your all and meet the needs of a person but it drains you even when you feel good about your caring. . . . Sometimes you don't seem to be fulfilled. It doesn't balance out. That's the reality of it because there's more giving than anything else and unfortunately there aren't many pats on the back in the nursing profession . . .

What Gives the Most Satisfaction?

All nurses stated that the completion of tasks gave the most satisfaction. Others talked about using special nursing skills, working with a positive team, meeting a residents' unique needs and being somewhat in control of their shift.

> On a day I feel high, nobody got sicker. I didn't have to send anybody to the hospital. Some things happened that were very positive for the residents. I was able to do all the dressings and do all the charting and everything was under control. We were able to have lots of laughs about this or that or the next thing and the staff got along. Everything just sort of fit together.

Nurses stated that the changing health care scene forced them to be more task orientated. A few nurses expressed anxiety about the future and their role on the health care team. They felt a responsibility for the job satisfaction

of their nursing team peers. It appeared that the ultimate satisfaction came when clients and peers experienced positive affects.

> I'd go home knowing that I had done everything and had extra time to spend with people, but I think the other thing that really feels good to me is if I see my staff have the same happiness.

What Gives the Least Satisfaction?

All informants stated that not completing tasks, and leaving residents with unmet needs and coworkers with more work caused them to feel less satisfied as well as rushed and panicky. The nurses felt that external circumstances prevented them from delivering ideal care. This caused them much anxiety and distress.

> On the days I feel bad I sort of failed one of the residents in one way or another. I didn't have enough time to deal with a particular problem. This nags at me until I figure something out in order to help them.

Many nurses believed that completion of tasks identified them as expert nurses. They felt torn between client needs and facility expectations. The increasing number of unskilled workers added stressors to the professional long term care nurse. The informants felt expected to role model high quality, holistic care in an attempt to educate their team mates. At times the nurses

took responsibility for crises that were not related to their job performance.

> I didn't feel like I was ever going to get finished. Silly little things seemed to take more time than they ought to like dressing changes. Some residents had developed never-ending pressure sores that take forever and a day to heal.

Summary

All the nurses disclosed a positive perception towards caring for long term clients. Most of the informants experienced job satisfaction in knowing that they had made a difference in the residents' quality of life through their caring. Although all the nurses agreed with the positive concept of caring, their individuality was illuminated through their detailed descriptions of caring for long term clients.

# CHAPTER V: Discussion

This chapter consists of six sections. The model of holistic care which arose from the analysis of the nurses' perceptions of long t rm care is discussed first. Then factors to be conside ed in this study are discussed, including the limitat ns. Next, the findings and the relevant literature are brought together to assess similarities and differences. Lastly the implications to nursing, personal reflections and conclusions are discussed.

## Model of Holistic Care

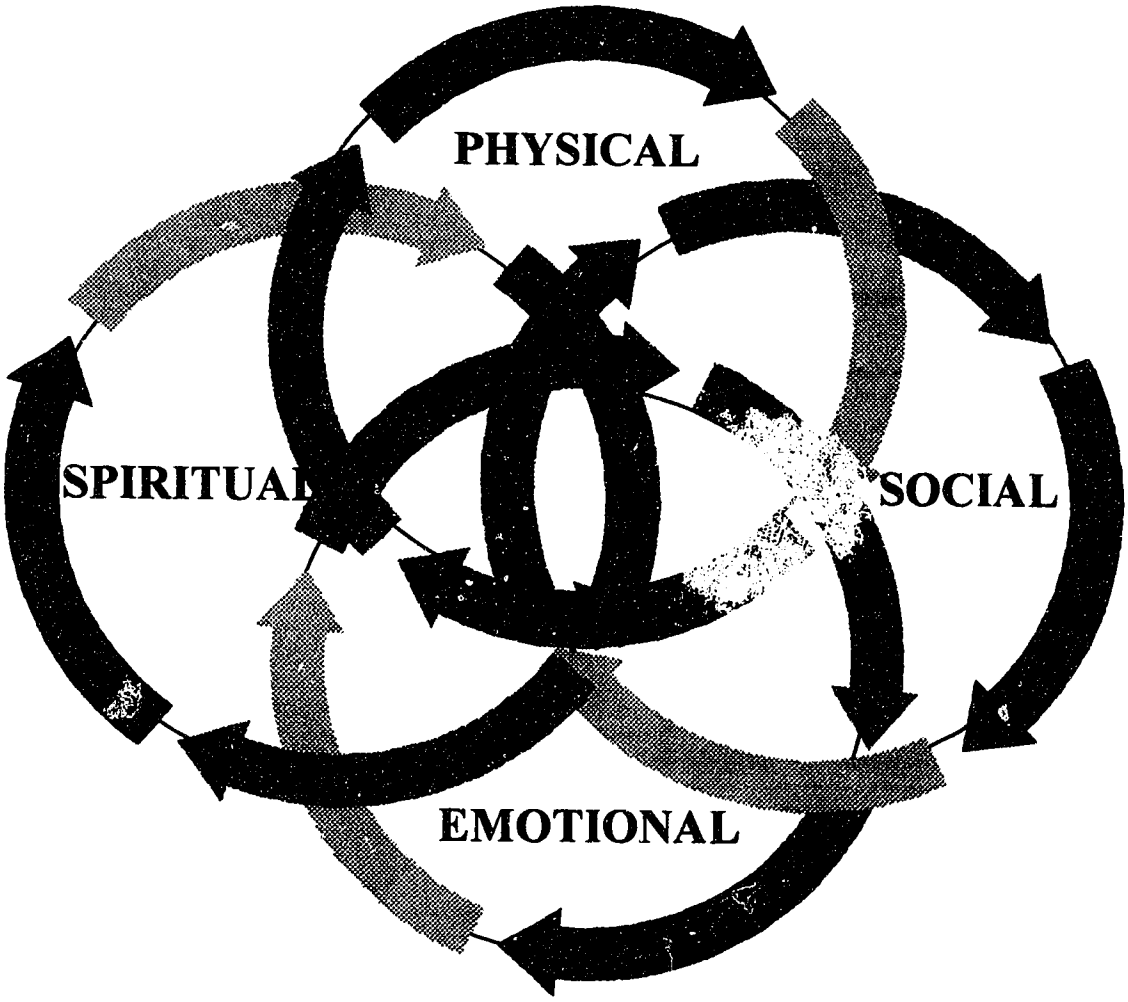
Long term care nurses described holistic care as having met all client needs. They believed each client required physical, emotional, spiritual and social care. These needs varied with each individual client. The informants gained insight into each client's needs through their long term relationships. This allowed them to learn about specific client needs, patterns and cultures.

Long term care nurses believed that their type of care is unique. They recognized that their clients have multidimensional and complex needs. Frequently, their clients have multiple physical needs because of the normal ageing process and acute illnesses. In addition to these physical needs, these clients have complex emotional needs. They are dealing with their loss of independence and freedom as well as impending death. Long term care clients frequently loose family and friends through death. Their

living family and friends may be sickly, busy or detached. This accounts for increased social needs. Their spiritual needs stem from deep inner feelings and beliefs which may be religious in nature. There are many issues, past, present and future, that elderly clients need to deal with. Spiritual care provides an avenue for increased reflection and inner peace.

The informants could not identify where the physical, emotional, social and spiritual care began or ended. They appeared to be intellectually unaware of how the process of holistic care blended together. Instead this type of care appeared to practised instinctively. This supported Nodding's (1984) belief that caring is emotional rather than cognitive. Koff's (1988) definition of long term care refers to the physical, social and psychological as being one; he argues they cannot be treated as separate entities. This author also notes that the concept of care can be thought of as a continuum. The informants' beliefs about meeting the client's total needs as they arise day to day is supported by Koff's description of a holistic continuum.

The following model of holistic care describes pictorially how long term care nurses viewed total care. The circles depict the concept of no beginning and no ending. The four separate circles illustrate four separate groups of needs. In the middle of the model, there is a small space where the four circles overlap. This space




MODEL OF HOLISTIC CARING
IDEALLY EXPERIENCED BY
BOTH CLIENT & CAREGIVER

represents the long term care nurses' perceptions of holistic care.

Factors to Consider When Assessing Research

A descriptive research design was chosen to paint a picture of the personal characteristics, group situations and occurrence of certain events. While describing the nurses' perceptions of caring for long term clients and how caring makes a difference, the single variable was caring. This study was undertaken to gain knowledge about nurses' perceptions of caring for long term care clients.

Snowball sampling is a factor to consider. This method was used to gain trust as nurses were going through many changes, including cutbacks and layoffs. Field and Morse (1985) state that this method follows a social concept because it is assumed that each nurse will refer a colleague he or she knows and respects. This colleague may be similar in philosophy and personality. However, it was anticipated that nurses who did not believe in the value of caring would not participate in this study. Twelve informants participated in this study. Six informants were interviewed twice. The researcher felt all categories were saturated following these interviews.

The qualitative design, semistructured interviewing process, emotional subject matter and subjective nature of the analysis made interpretation of data for similarities difficult. The informant's personality, individuality and

internal belief systems were illuminated during data collection and analysis.

Another factor is the considerable amount of experience the informants possessed. The limitation was that no new nurses were interviewed. The perception of caring for long term care clients by the novice nurse or how that perception varied from the expert nurse was not explored. There was little staff turnover within the facility at which the interviews were held. Some nurses planned to stay only a short time, but found themselves becoming attached to residents and unable to leave.

The possibility of bias also is a factor. The researcher had previously worked in the long term care field. Personal values were bracketed and the researcher engaged in self-reflection while memoing and doing data collection. The hands-on field experience of the researcher, and having a close relative in long term care, presented times of empathetic understanding as informants told stories.

The last factor to consider is the health care reform that the Province of Alberta was undergoing. It was, as it is now, a time of budget constraints, downsizing and new health care models. Nursing was experiencing cutbacks in hours and positions. Long term care residents remained in the facilities with increasing needs due to hospital bed closures. Nurses in long term care had increased duties

while they worried about the future of their careers. These changes caused many emotions to surface and these feelings were possibly reflected in the findings.

Relationship of Findings to Relevant Literature on Caring

Caring is described as a human trait (Morse et al., 1990). Other authors feel that caring is a "fundamental value" and it serves as the base of nursing care. Caring is perceived as an affect which comes from emotional involvement with a patient and which motivates the nurse. This study found nurses believing that caring is an innate value. They believed their caring enhanced their nursing base of knowledge. The informants' stories validated emotional involvement with the residents. Caring appeared to be the reason they worked hard and returned day after day. This supports Greenleaf's position (1991).

Watson (1988) believes that, "Caring is the essence of nursing" (p.33). Further she believes that caring and having high reverence of or for the person and human life are congruent. Caring connotes personal responses such as concern, empathy and being treated as a person. Watson also postulates that there is a "transpersonal" aspect of caring, where a nurse enters into the life space of another person and can detect the person's spirit. This transpersonal approach brings the "self" to the nursing interactions. The informants in this study agreed that nursing skills are performed better with caring and all nursing interactions

should be based on caring. They did not believe that all nurses base their practice on caring nor that nurses cared better than anyone else. All the informants felt their caring validated the residents' individuality and value system. They also believed that caring was a strong factor that individualized nurses within the profession and allowed a uniqueness to surface. The nurses' emotional accounts about their value systems, important people in their life and personal emotions, demonstrated a strong involvement of self.

Greenleaf (1991) considered the role of caring within a social context. She stated that caregivers are not given adequate credit but are instead ordered to care. This may cause the caregiver the personal bind of wanting to deliver a better quality of care while being ordered to care. The informants felt overwhelmed and torn between their vision of ideal care and reality. They frequently felt undervalued for their caring from society, friends, and administration, but were elated when residents acknowledged them in any manner.

Human caring is a universal phenomenon with varying patterns of impressions (Leininger, 1984). Leininger believes caring is essential for human worth, development, growth, survival and a peaceful death. The study informants validated the importance of caring through their narratives about dying and healing. Informants felt it was necessary

to remain well to care for the residents. Leininger (1984) also stated that curing cannot occur without caring but that caring can occur without curing. Although many of the informants in this study found caring and healing as dependent variables, they also discussed the value of caring without curing.

Caring according to Noddings (1984) is seen as emotional rather than cognitive, or as a way of being which is an end in itself. The nurses interviewed in this study frequently discussed relationships, win-win scenarios, give and take situations and emotional transference. Noddings (1984) acknowledged that caring was based on receptivity between the client and the nurse in which each one "feel with and receive the other" (1984, p. 30). Giordano (1994) expressed similar emotions at a "Celebrate Caring" conference in New Orleans. She validated caring as the art of healing in a world of technology.

Carework

Greenleaf (1991) introduced the concept of "carework" as caring in the realm of paid labour. She noted that the careworker needs time to listen, to focus and to reflect. The importance of caring acts are most noteworthy in their absence rather than their presence according to Greenleaf. The study informants felt strongly that their lack of time to care was a key factor in less than ideal care. Their statements about positive job satisfaction and completion of

assigned tasks within a given time also validated the concept of carework. All the nurses worried about not completing their tasks or not meeting the residents' needs. They feared the negative reaction of coworkers as well as less job satisfaction.

Caring in Long Term Care

In caring for older people, the physical, social and psychological [illegible] to be treated as one (Koff, 1988). We must think of [illegible] whole person functions when determining their required services. In their definition of caring, all the study informants discussed holistic care and joining of physical, emotional, social and spiritual needs.

Both Deckhard et al. (1986) and Pfaff (1987) have suggested that previous studies illustrate the belief that long term care nursing can be dull and unrewarding and that nursing homes rate at the bottom of the list because they are considered to give custodial care. It was suggested in a recent survey that there was a positive job satisfaction associated with long term care nursing (Deckhard et al., 1986). Robertson and Cummings (1991) believe that an individual with positive job satisfaction, who remains in the nursing field in long term care, is receiving personal satisfaction and feels she/he is making a difference. All the study informants openly discussed their feeling about long term care nursing. They recognized that family, friends and peers question this allegiance to long term

care. The nurses all experienced positive job satisfaction through their own personal beliefs that they were making a difference. The need for a solid knowledge base in addition to caring was also stressed.

The findings of this study were congruent with the findings of the above authors. In addition, the individuality of caring patterns was illuminated by the informants in this study. Nurses emphasized how their beliefs and values played an important part in their caring. They acknowledged the value of their nursing skills and knowledge base, but felt devalued by the lack of appreciation and the lack of priority given to their caring by health care administrators and society in general. All the nurses envisioned an ideal world as one which empowers the art of caring together with the science of nursing.

Implications for Nursing

The findings in this study have a number of implications for nursing. The informants strongly believed that caring is essential to long term care nursing. How does nursing educate, evaluate, role model and facilitate caring during the student nurse period? Perhaps nursing educators need to develop more flexible teaching methods to allow the individuality of caring to join with the professional knowledge base during the student experience.

It is important for long term care administrators to validate the importance of caring and to develop a screening

tool to facilitate appropriate hiring. The model of holistic caring applies to self, colleagues and clients. The nurse must care totally for herself or himself in order to care for a client. It is also imperative that nurses care for each other and for their fellow team members through respect, kindness and role modelling. This holistic caring allows for a strong client orientated team.

The accounts disclosed by the informants validated the importance of nurses caring holistically as they join the art and science of nursing. Nurses are educated to meet physical, emotional, social and spiritual needs within the nursing framework. As health care changes occur, more and more nurses are losing their jobs and being replaced by less trained personnel. Nursing leaders and professional organizations must publicly support the role of nurses and nurses' caring within the health care team. They must also continue to give a high priority to the well being of clients.

As technology continues to evolve and improve our health care system, caring tends to lose credibility. As we research, publish and teach improved technologies, we must also validate the caring with which these techniques are applied. The profession of nursing is special because we have the privilege of joining an art and a science as we practise.

The findings of this study have implications for future

research. Further research needs to be done on the beliefs and values of nurses prior to nursing and how these values affect their caring. This study could be duplicated in other populations (male nurses, novice nurses, various nursing specialities and cultures). Although snowball sampling was used to facilitate trust, it would be beneficial to repeat the study with purposeful sampling. A study describing the care by nurses who do not believe in the value of caring would be of special interest. Nurses want to live this model of holistic care and they want to be validated for this type of care. Further studies to illustrate methods of validation need to be completed. A research project could also be designed to explore nurses' perception of self and the amount of emotional involvement they experience with clients. The effect of caring on nurses' self-esteem, family, life and emotional stability could also be studied. Many nurses believe that in long term care, there is more giving than receiving and the chance of burnout is great. How do nurses evaluate this and how do they prevent this from occurring?

These findings and their implications could be broadened to involve other health care professions as well as nursing. This is especially timely, as we approach the time of interdisciplinary teams, multiskilled careworkers and community orientated proactive health care.

Personal Reflections

Since the interview process, I have read the transcriptions many times, as well as listening to the audiotapes. As I reviewed the stories I found myself laughing, crying, frustrated, warm and angry.

The nurses so eloquently disclosed touching stories that allowed me to reinforce my belief in the value of care and human spirit. The stories also stirred much frustration within me regarding cutbacks. I worry that touch, love, gentleness, special time and humour will no longer be valued.

I had the luxury of growing up in a family who respected and loved older people. All four of my grandparents died by the time I was 10 years old. My parents volunteered at the nursing home until my dad died at the age of 80 years. Just prior to my interviews, my mother was admitted to a nursing home. My innermost fear was always that her caregivers would not treat her in a dignified manner. Her relocation also made me look at my own mortality. My mother is physically disabled, blind and has 10% hearing, but luckily she is very mentally alert and remains a mentor to me. She has been a teacher for 30 years and has overcome many obstacles through a positive attitude.

I frequently shared my findings with my mother. Our discussions were emotional and guiding. After many discussions, we realized that the residents' perspective

requires more clarity and prestige. With much persuasion, she has agreed to write a book about her transition to a nursing home. She is near its completion and my dream is her narratives, in combination with this study and others, will describe the whole picture and process of long term care nursing.

Some of the nurses' funny stories allowed me the luxury of remembering my dad's Irish sense of humour and quick temper. Other reflections include my struggle to analyze the interviews and the amount of time and emotion spent on this process. I also experienced the frustrations of research and the pride of near completion.

My insight into research and how easily a prospect could be diffused has increased. I have grown personally and professionally through this process.

As I write these reflections, my physical body feels lighter as it holds less stress. I recognize that if I had this amount of emotion, my family has also experienced this spectrum of feelings. This causes me to feel sad in that I have caused a hardship in my family as they shared my workload and offered support. It also makes me feel honoured to be part of a unit that allows individual growth.

## Conclusions

As the technical world continues to grow and gain respect, the human spirit never dies. This human spirit lives in a nonageing manner from birth to death. Every day

we have the opportunity to start over or to make a difference. Nurses have the luxury of feeding their own human spirit and that of their clients through a profession that unites an art and a science. This gift of caring must continue to be empowered and respected.

The diagram on page 71 demonstrates my interpretation of the nurses' perceptions of long term care. It acknowledges the interaction of physical, emotional, social and spiritual needs in a holistic manner. The small part in the centre depicts the utmost of care in that the client is experiencing the highest level of care possible.

With health care experiencing changing and challenging times, we must never let our vision for the future and improving client-orientated care die. The belief in letting go and starting over again is illuminated in the nurses' descriptions as we demonstrate flexibility and creativity daily in our care.

The words to the song "Today is the First Day of the Rest of My Life" (page 84) by Deanna Edwards colourfully and eloquently tell this story.

Today is the First Day of the Rest of Your Life

Today is the first day of the rest of your life.
You can't live on memories or painful goodbyes!
This day is your birthday
And love is the prize.
Today is the first day of the rest of your life.

Yesterday all your heartaches and moments of pain
And somehow your losses were more than your gains
More failures than triumphs were hiding the sun
But you have to remember
That your life is just begun.

There is the sunshine and blue skies and daydreams to dream
There are sunflowers still blooming and fields by a stream.
And someone still needs all the love you can give
There is hope in your future and a reason to live.

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# APPENDIX A

## EXAMPLES OF GUIDING QUESTIONS

(These guiding questions were not necessarily used in this written order. If the desired information was obtained in spontaneous discussion or if the questions were inappropriate for the particular informant, some of the questions were not asked. If an additional interview was held, some of the same questions may have been asked.)

1. Describe the process of caring for long term clients.
2. Describe how you cared for a specific patient that stands out in your mind. Was this care any different than that provided to other clients?
3. Tell me how you care for a client's physical needs.
4. Tell me how you care for a client's emotional needs.
5. Tell me how you care for a client's social needs.
6. Tell me how you care for a client's spiritual needs.
7. Describe the best care you have provided.
8. Tell me about the worst care you have provided.
9. Describe the factors that interfered with your best caring behaviour.
10. What kind of care have you observed in other nurses? What was your reaction to this?
11. Tell me how caring for long term clients makes you feel.
12. How has caring changed over your nursing career?
13. How does your caring make a difference?
14. Describe other beliefs or values that make a difference in caring for long term clients.
15. Describe how caring affects your job satisfaction.
16. Tell me what makes you feel most satisfied after a days work.
17. Tell me what makes you feel least satisfied after a days work.

# APPENDIX B

## BIOGRAPHICAL INFORMATION OF NURSING INFORMANTS

Gender _____

Year of Birth _____

General Education _____

Nursing Education _____

Year of Graduation _____

Number of Years Employed in Nursing _____

Describe all Areas Worked.

_____

_____

Number of Years Employed in Long Term Care Nursing _____

# APPENDIX C

## INFORMED CONSENT FOR NURSES

Title of Research - Nurses' perceptions of the process of caring for long term clients as well as how caring makes a difference.

Researcher

Pat Jurgens
MN Candidate
Faculty of Nursing
University of Alberta
Phone: office - 460-1053
home - 458-0408

Thesis Supervisor

Dr. Olive Yonge
Associate Professor
Faculty of Nursing
4-130 CSB
University of Alberta
Phone: 492-2402

### Purpose of Study

The purpose of this study is to identify, describe, and provide an analysis of the nurse's perception of the process of caring for long term clients and whether their caring behaviours make a difference. The factors that interfere with or facilitate these behaviours will also be examined as well as the how caring affects the nurses' job satisfaction.

### Procedure

One to three tape-recorded interviews lasting about one hour will be used to record your experiences, feelings, and thoughts about your relationships with long term clients. All the information identifying you will be erased from the tape. A code number will be placed on all information about you, so that your name will not be used. I will be the only person who knows that number. Your name will not be mentioned in any of the reports, articles, or talks dealing with this study; however, excerpts from the interviews, that will be unidentifiable may be included in reports or presentations based on the study. Your code number, name, address, and phone number will be kept in a locked cabinet separate from the rest of the information and will be destroyed at the end of the study. All the data and tapes will be kept in a locked cupboard and will be retained for seven years following the study. Then it will be destroyed.

### Voluntary Participation

You do not have to participate in the interview process if you do not want to. You do not have to answer any question that makes you feel uncomfortable. You are free to withdraw from the study at any time just by telling me. Your confidentiality is guaranteed.

Risks

There are no known risks to you for participating in this study. However, if you divulge information about illegal activities to me,I will be obliged by law to notify the appropriate person or agency. If this should occur, I will tell you what action will be taken. You as an individual will not benefit directly from this study; however, it is hoped that future nursing practices may change based on the findings of this study.

If you have any concerns or questions at any time, please contact the researcher, Pat Jurgens, at 460-1053 or 458-0408.

CONSENT

**I, _____, have read this information, and agree to be in this study. I have had the opportunity to ask questions and all my questions have been answered by the researcher. I have received a copy of this consent form.**

**Nurse's Signature** _____

**Date** _____

**Researcher's Signature** _____

**Date** _____

I would like to receive the results of this study.

_____ _____

_____

_____

# APPENDIX D

## OATH OF CONFIDENTIALITY

Title of Research - Caring and long term nursing: The nurse perception of the process of caring for long term clients and how caring makes a difference

Researcher - Pat Jurgens
MN Candidate
Faculty of Nursing
University of Alberta

Supervisor - Olive Yonge
Associate Professor
Faculty of Nursing
University of Alberta

Since this study involves confidential information, individuals working on this study are asked an Oath of Confidentiality so that there is adherence to privacy of information. A breach of confidentiality may make you legally responsible for any damages. By signing this oath you indicate that you are committed to keeping this information confidential.

I, _____, swear that I will diligently, faithfully and to the best of my ability, execute according to law the duties required of me as an associate of this project. I will not, without undue authorization, disclose or make known any matter or thing which comes to my knowledge by reasons of my involvement in the service of this project.

Signature _____

Date _____

Witness _____
(Researcher)
Date _____