Expertise in Nursing in Long-Term Care in Ireland

Dr. Amanda Phelan & Professor Brendan McCormack
Project Aim: To examine nursing expertise in long-term care of older people in Ireland

OBJECTIVES

1) Build on previous work undertaken by AIGNA in identifying the role of RNs in residential care settings for older people;

2) Articulate and demonstrate the expertise of RNs in residential care settings for older people;

3) Contribute to knowledge related to the discipline of nursing so that such expertise is recognised and valued;

4) Inform public policy in Ireland regarding the role of the RN in residential care settings for older people and inform decisions regarding ongoing role development as new models of residential care emerge.
Literature Review

- **Databases**: CINAHL, Medline, PUBMED, Policy Reports, CSO reports, HSE data, UCD Library.

**CONTEXT**

- In the 2011 census (CSO 2012), there were 535,393 people over 65 years of age in Ireland.

- 94% community, 6% communal care (CSO 2012).

- The number of older people requiring residential care in Ireland will rise by 12,270 by 2021, representing an increase of 59% since 2006 (Normand et al. 2012).

- **Statutory regulation**: Health Act (2007) and particularly HIQA

- 0.9 percent of the Irish Gross National Product is spent on long-term care for older people, and this is expected to rise to 1.8 percent by 2050 as the population continues to age (Standard & Poors 2010).

- Nursing Homes Support Scheme (NHSS) (‘Fair Deal’).

- Numbers of Nursing Homes= 574: 387 (Pr), 4 (V), 123 (Pb) (HIQA 2012)
Nursing homes

- Changes in care delivery
- Admission: Post acute episode, End of Life care, Chronic illness (Spillbury et al 2011).
- Increasing age-55% of older people aged 100 years live in residential care as opposed to 7% 80 year olds (CSO 2012).
Role of the nurse in Long Term Care

- Meeting need of individual resident

- Palliative care, end of life care, physical and cognitive support and varying care models can govern the nurse’s role (Bass 2011).

- Leading and co-ordinating multi-disciplinary teams, becoming nurse prescribers, expansion in relation to palliative and end of life care and the development of additional roles as clinical nurse specialists and advanced nurse practitioners (Heath 2010).

- ‘Role Blurring’
Nursing Expertise


- Person Centred Care (McCormack & McCance 2010)

- Quality of Care (Cooney et al 2009)

- Communities of practice
  (Lave & Wenger 1991)
Methodology

CASE STUDY

Demographic profile

Shadowing

Interview nominated colleague

Interview: Older Person

DON survey

FOCUS GROUP
Study Ethics

- UCD
  (Human Research Ethics Committee
  (LS-11-121-Phelan)

- Assistant Director for Services for Older People

- Individual ethics from Private & Voluntary Nursing Homes Criteria: DON support of the project, Registered RN (ABA), minimum of one year experience.
Participants

- Recruited through NHI & AIGNA (n=23)

<table>
<thead>
<tr>
<th>County</th>
<th>Case study numbers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cork</td>
<td>4</td>
</tr>
<tr>
<td>Kerry</td>
<td>3</td>
</tr>
<tr>
<td>Wexford</td>
<td>3</td>
</tr>
<tr>
<td>Sligo</td>
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<tr>
<td>Galway</td>
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<td>Westmeath</td>
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<tr>
<td>Dublin</td>
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<tr>
<td>Kildare</td>
<td>1</td>
</tr>
<tr>
<td>Roscommon</td>
<td>1</td>
</tr>
<tr>
<td>Tipperary</td>
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</tbody>
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- Private/voluntary facilities=17

- Public facilities=6
## Demographic profile

### Case study nurse’s length of time working with older people

<table>
<thead>
<tr>
<th>Length of Time</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-3 years</td>
<td>7</td>
</tr>
<tr>
<td>4-6 years</td>
<td>3</td>
</tr>
<tr>
<td>7-10 years</td>
<td>6</td>
</tr>
<tr>
<td>10+ years</td>
<td>7</td>
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</tbody>
</table>

### Specialised education/ training on older person care

<table>
<thead>
<tr>
<th>Level of Training</th>
<th>Case Study Nurse</th>
</tr>
</thead>
<tbody>
<tr>
<td>Education Days</td>
<td>17</td>
</tr>
<tr>
<td>Certificate</td>
<td>8</td>
</tr>
<tr>
<td>Diploma</td>
<td>3</td>
</tr>
<tr>
<td>Degree</td>
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</tr>
<tr>
<td>Post-graduate **</td>
<td>4</td>
</tr>
<tr>
<td>Did not respond</td>
<td>1</td>
</tr>
</tbody>
</table>

* Some respondents ticked more than one box

**Professional Certificate, Graduate Certificate, Graduate Diploma, Master’s Degree, PhD
Methodological lens for qualitative data: Directed content analysis

Expertise in Nursing Domains and attributes (Manley et al. 2005)

<table>
<thead>
<tr>
<th>Attribute</th>
<th>Observable actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Saliency</td>
<td>Discriminating cues to inform the situation. Observation of non-verbal cues to understand the individual’s own situation. Listening and responding to verbal cues. Regarding the patient as a whole to inform practice. Ability to recognise the needs of the patient, colleagues and others in actions taken.</td>
</tr>
<tr>
<td>Holistic Practice Knowledge</td>
<td>Using all forms of knowledge. Ongoing learning and evaluation from new situations. Drawing from a range of knowledge bases to inform practice. Embedding new knowledge and accessing in similar situations.</td>
</tr>
<tr>
<td>Attribute</td>
<td>Observable actions</td>
</tr>
<tr>
<td>---------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| Knowing the Patient (resident) | Respect for people and their perspectives  
Respecting perspectives of the patient on his/her illness or life world  
Willing to promote and maintain a person’s dignity at all times.  
Conscious use of self to promote a helping relationship.  
Promoting the patient’s own decision making  
Willingness to relinquish ‘control’ to the patient.  
Recognizing the patient’s /other’s expertise |
| Moral Agency               | Providing information to enhance people’s ability to problem solve and make decisions on their own behalf  
Consciously working to promote another person’s dignity, respect and individuality.  
Conscious awareness of one’s work and behaving impeccably.  
Working and living own values and beliefs, while respect other’s values and beliefs |
| Skilled Know How           | Respect for people and their perspectives  
Respecting perspectives of the patient on his/her illness or life world  
Willing to promote and maintain a person’s dignity at all times.  
Conscious use of self to promote a helping relationship.  
Promoting the patient’s own decision making  
Willingness to relinquish ‘control’ to the patient.  
Recognizing the patient’s /other’s expertise. |
A category which included **Attributes**: Being a catalyst for change, being a risk taker, fostering interpersonal relationships, recognition by others (generated through the literature)

**Skilled companionship (Titchen 2001)**

Considers the ontology and epistemology of practice

**Three Domains**

1. Relationship domain
2. Rationality-intuitive domain
3. Facilitation domain
Data for each case study individually reviewed, then themes were populated with all data sources. Manley et al’s (2005) & Titchen’s (2001) and general frameworks were used and two additional themes generated.
OP 1: I fell too often, I was falling too much. I fell one time between the wardrobe and the bed...I damn nearly choked.

OP 23: It is another chapter in your life, you know, really and truly, you sort of say, here am I now, leaving a home, leaving everything and I am helpless.

OP 18: I wouldn't have been able to look after myself, none of my brothers and sisters were around anyway

OP 3: So I felt that coming here was going to be the end of my life...but apart from the first couple of months [when] there were buckets of tears, slowly but surely I realized that it wasn’t the end of the world, I can do my own thing and I am left to my own freedom
NC 13: Initially you would have to have care, I mean you would have to be a caring person and an empathising person. A person who can really put themselves in somebody else's shoes...

OP 20: I loved it from the very beginning I came in...and I am safe and I really love it [nursing home].

DON 12: Residents in [nursing home] XXX have a residents’ committee and they have a monthly advocacy meeting where they are afforded the opportunity to voice any changes they would like to see, also what they are happy about/unhappy about and any changes to their care can be communicated to the nurses in this way. Residents can also make decisions about their care in their monthly care plan update.
OP 12: I remember one time her [case study nurse] saying to me, ‘you are very quiet this morning and yesterday and normally you are very’, she called it ‘bubbly’. And I said, ‘well I wasn’t conscious of it.’ And she said, ‘are you ok?’ And I said, ‘I am firing on all cylinders’. But it just shows you the way she picked up on the fact I wasn’t as outgoing as I normally would be.

Focus Group: saliency was considered to be knowing the skill of gathering information, recognizing the progress of sickness in an older person rather than picking up simple ‘classic signs’ and the use of appropriate pace with residents so that enough time is taken to look at the resident holistically and individually.

DON 1: An in-depth knowledge of patients, coupled with life story work and a relationship with families allows her to understand the needs of patients and families which assists her to know the cues that require action or non-action.

Shadowing 1: Fabric of nightdress, careful assistance to move, observation of skin, observation of resident.
Holistic practice knowledge

DON 15: The [case study] nurse demonstrates personal practice knowledge, theoretical knowledge, procedural knowledge, organizational knowledge, reflective knowledge, especially in her area of expertise, which is palliative care.

Shadowing of Care ‘symphony of care delivery’,

OP 3: Because I sat in an ordinary wheelchair yesterday getting my hair done, so she [case study nurse] tells me I shouldn’t go for showers and stay out of the ordinary wheelchair I can’t relax back and take the pressure off the bum. The ordinary wheelchair doesn’t do that at all. She’s sharp…she notices the differences… I can trust [name] XXX, no reflection on the other nurses, but I think [name] XXX is that bit more, maybe she feels she can give instructions but any time [name] XXX comes to see the wounds I know I am going to get a proper result or verdict.
Knowing the patient

FOCUS GROUPS:


- Families: Shared care approach - in communication and open door policy. Openness-getting to know family dynamics - acceptance, non-judgmental approach. Using technology for communication when not present.

- Colleagues: recognizing each other’s skills, sharing, openness and communication’

NC 7: She [case study nurse] would have conversations with them like if she knew [sic] they had a farm, she would talk to them about crops. Like if they spoke about their life she would show an interest in that, yes.

OP 19: Oh and she’d [case study nurse] sit down on the chair with you. Sit down on that chair inside in the room and you feel she is interested in me
NC 1: She [case study nurse] gave the patient the opportunity to decide what she wanted for her care and then eventually interacted with the family and the GP and decided on what to do so she gave her [resident] the decision on what to do.

Shadowing 7: a health care attendant had styled a resident’s (who had cognitive impairment) hair in pigtails. The case study nurse gently explained that this made the resident look like a child and it was inappropriate. This resulted in the resident’s hair being restyled.

NC 9: She [case study nurse] has got a very respectful disposition. I have noticed that about her from the start. She treats everyone, not just the residents, all the staff and colleagues in a very respectful manner. I have noticed that about her. She is also very straight and honest, she is not...she is very sincere.
NC 7: Yes we had a lady up there and I think, I think it was a urinary infection she was getting up a lot and not herself. She [nurse] seemed to anticipate it because she was in there trying to push fluids and opened the windows and freshen her up and it turned out that the lady was going on to get a bad UTI. So before any more obvious symptoms happened, yeah, she was kind of dealing with it doing the right thing to help her.

DON 2: Recently admitted resident had two falls. Nurse enquired to family regarding medication regime- turned out family were giving medications at different times. Medications reviewed and no further falls.

Shadowing 7, an issue arose with a supra pubic catheter and this was discussed with the resident in depth and arrangements made for medical review. Further discussions with this resident involved the improvement in healing of her [resident’s] pressure wound, the imminent arrival of a pressure relieving chair and a review of diet.
Attributes

Catalyst for change: Kardexes

Being a risk taker: Patient with Huntington’s disease

Fostering interpersonal relationships:

DON 5: [Nurse] XXX leads by example in relation to respectful communication and care to the residents and their families.

Recognition by others: Residents, colleagues, management and relatives
Discussion

- Multiple data sources
- Ordinary becomes extraordinary.
- Admission to nursing homes traumatic
- Context - Social system conducive to care: personal participation and reification occurs for a practice logic.
- Expertise: ‘diagnostic reasoning’ (Ritter 2003)
- High degree of expertise demonstrated
- Combination of all forms of knowledge - immersed in context.
- Older people require such knowledge for optimum care
- Demographics - this expertise will become more pertinent.
• **Limitations:** Self-selection, Shadowing (Hawthorn effect), Cognitive status of residents, sample volunteering, participant sample.

• **Future:** Lobbying for value of expertise in residential care, Sourcing other stakeholders (relatives), looking at expertise of nursing older people in other environments.