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AFFECTION IN ELDERLY CARE FROM THE NURSES' PERSPECTIVE

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ORIGINAL ARTICLE

Affection in elderly care from the nurses' perspective

AFETIVIDADE NO PROCESSO DE CUIDAR DO IDOSO NA COMPREENSÃO DA ENFERMEIRA

AFECTIVIDAD EN EL PROCESO DE CUIDADO DEL ANCIANO, EN LA COMPRENSIÓN DE LA ENFERMERA

Teresa Cristina Prochet[1], Maria Julia Paes da Silva[2], Dejanete Mendes Ferreira[3], Viviane Canhizares Evangelista[4]

ABSTRACT

The objective of this study was to describe, from the nurses' perspective, the meaning of effective/affective care, the interference factors, and the learning promoted from dealing with elderly inpatients, as well as their perception of feeling ready or not to engage in caring. This qualitative study was performed with nurses from a hospital located in the Midwestern region of the State of São Paulo. The findings show that the meaning of providing effective/affective care involves knowing the client within his/her social framework, while it crosses the borders of sheer technical care and encompasses fulfilling the client's needs and requirements. Interferences in dealing with the elderly refer to those situations connected with the patients' conditions, work dynamics, and environmental and management adaptations. All surveys showed that despite feeling well prepared, nurses are aware of the need to study fields such as geriatrics and gerontology to a deeper extent. Complete and quality care is only possible if it includes techniques, knowledge and the ability to deal with others with patience and attention to detail.

DESCRIPTORS

Aged
Hospitalization
Nursing care
Communication
Geriatric nursing

RESUMO

O objetivo deste estudo foi descrever, na visão da enfermeira, o significado do cuidado efetivo/afetivo, os fatores de interferência e o aprendizado promovido pela convivência com o idoso hospitalizado, bem como a percepção de sentir-se ou não preparada para cuidar. Estudo qualitativo desenvolvido com enfermeiras de um hospital do interior paulista. Entre as descobertas, identificou-se que o significado sobre a promoção do cuidado efetivo/afetivo envolve o conhecimento do cliente em seu contexto social; extrapola o cuidado técnico e envolve o atendimento das necessidades do cliente. As interferências na convivência com os idosos foram as ligadas à própria condição do idoso, à dinâmica do trabalho e às adaptações ambientais e administrativas. Todas as entrevistadas informaram que, embora se sintam preparadas, percebem a necessidade de estudar melhor a área de geriatria e gerontologia. O cuidado percebido como adequado e de qualidade é o que engloba técnica, conhecimento e o saber conviver com paciência e atenção.

DESCRITORES

Idoso
Hospitalização
Cuidados de enfermagem
Comunicação
Enfermagem geriátrica

RESUMEN

Este estudio objetivó describir, según visión de la enfermera, el significado del cuidado efectivo/afectivo, factores de interferencia y aprendizaje promovido por convivencia con el anciano hospitalizado, así como la percepción de sentirse o no preparada para cuidar. Estudio cualitativo desarrollado con enfermeras de hospital del interior paulista. Entre los resultados, se identificó que el significado de la promoción del cuidado efectivo/afectivo involucra el conocimiento del paciente en su contexto social; extrapola el cuidado técnico e involucra la atención de necesidades del paciente. Las interferencias en convivencia con ancianos fueron aquellas relacionadas a su propia condición, a la dinámica laboral y las adaptaciones ambientales y administrativas. Todas las entrevistadas informaron que, a pesar de sentirse preparadas, percibieron necesidad de estudiar mejor las áreas de geriatría y gerontología. El cuidado determinado como adecuado y calificado es el que engloba técnica, conocimiento y saber convivir con paciencia y atención.

DESCRIPTORES

Anciano
Hospitalización
Atención de enfermería
Comunicación
Enfermería geriátrica

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INTRODUCTION

The increase in the elderly population, defines as people with 60 years of age or more, is a global phenomenon occurring at an unprecedented level. Studies have highlighted a rapid increase in the number of aged individuals in Brazil. The Brazilian Institute of Geography and Statistics (IBGE) has estimated that by 2025, 15% of the Brazilian population with be aged, corresponding to approximately 30 million people. This reality imposes fundamental issues to be considered in the implemented health policies, which should not only be adjusted to the needs, expectations, and preferences and rights of the elderly but also to the regional and local settings, and the implied use and distribution of financial resources [1].

Although the majority of the aged population are healthy and active, those with diseases demand, compared to the other age groups, health services more frequently and for a longer period of time. In general, the diseases affecting the elderly are chronic and multiple, lasting several years and requiring constant medical follow-up and a continuous use of medication[2].

In addition to a higher number of appointments, there is an increased consumption of medication, complementary exams, and hospitalization. Therefore, the elderly comprise a representative portion of the hospital clientele. Because of the particularities of the elderly, their mean length of stay is three fold that of any other age group[2-3].

When aged individuals are hospitalized, they ten do lose their main reference, as they change environments and have to deal additional difficulties[2]. As clients, whey arrive at the hospital carrying a heavy emotional burden, because, besides their worries regarding their disease, they are exposed to the weaknesses of their condition and need to adapt to the existing routines, which imply stress and suffering. In these conditions, the simplest and trivial things assume a serious character for the elderly, which they had not considered before. In addition to the treatment, exams, and physical needs, it is necessary to consider their emotional aspects, such as the affective e needs that surround them. Hence the importance of valuing, in the relationship established with the elderly, the way one interacts and communicates, because they (elderly) have specific needs, including their need for affective security that must be dealt with carefully.

In addition to the treatment, exams, and physical needs, it is necessary to consider their emotional aspects, such as the affective e needs that surround them. Hence the importance of valuing, in the relationship established with the elderly, the way one interacts and communicates, because they (elderly) have specific needs, including their need for affective security...

The hospital is an environment that also predisposes the elderly to breaking with social activities and losing their autonomy[4]; the professionals who care for them not always have the technical preparation to provide effective care and/or are willing to establish attachments, which eventually creates emotional insecurity[5].

In order to provide efficient care, in addition to having the necessary skills, professionals must have the will, intention and involvement, which are key factors to promote the quality of personal interactions, and thus obtain better outcomes in terms of health recovery[6].

Difficulties exist and permeate the hospital environment, but seeking an alternative and effective path to meet the needs of the elderly, despite being arduous, is, in fact, possible. In the effective/affective care, the relationship is subject-subject rather than being subject-object; it is not a relationship of domination, but of living together; it is not of pure intervention, but of interaction with the other[7]. The care, therefore, is a phenomenon resulting from the dynamic process of caring that requires the capacity to change one's own behavior in face of the others' needs and attitudes of honesty, humility, hope, and courage. These requirements are considered key characteristics for caring/care and *should permeate care, but never create any dependence on the cared individual, because the care giver should teach the other, so he or she can use their own capacities*[8].

Therefore, caring/care is not an easy task or relationship; it is a two-way street, where one (client) and the other (professional) are continuously challenged to learn, negotiate and establish an aware dialogue. These are the requirement that provide new perspectives for improving quality of life[5,8].

In the health area, it is timely to emphasize that every worker should found their work on human relationships, whether it is with clients, families or the multidisciplinary team[9]. The affective-expressive dimension, therefore, is part of the treatment and can be expressed by the trust relationship, in treating with affection, being kind, showing understanding, talking, speaking, listening, looking, supporting, being interested, and counseling, and others[10].

Research shows there are gaps between the concept and practice of care; some consider that the quality of the process of care is associated with personal availability and characteristics, such as variables that are affected by the culture (when care is provided and who is the target of that care). Some defend using virtue ethics (moral imperative), which involves doing good and maintaining the dignity of the subject, should be the main center of the process of care [11]; some reveal that breaking with the classic Cartesian paradigm offers the chance to better understand the phenomenon of care, in which cognition (doing) and affectivity (being) are dynamic, complex, and inseparable dimensions expressed buy the act of being with

the other [12]; yet, others state that science and technology are becoming increasingly sophisticated and are, thus, replacing the act of being with the client and obscuring its valorization as a bio-psycho-socio-spiritual being, with feelings and emotions[13].

In this article, we defend that nursing practice must be characterized by care actions and behaviors that have scientific spirit, emotion, sensitivity, and skill in the doing.

Nurses, therefore, must know-know, know-do, know-be and know-live together, in which affection is included. The demonstration of affection is identified as a form of expression of care involving love, warmth and friendship, all of which are forms of care towards the other and to what is done; and may reveal interest, zeal, and importance towards the other[10].

Expressions, either verbal or nonverbal, of affective-expressive attitudes are essential principles of nursing; deserve attention and must become a natural practice of nursing actions.

The present study objective were to understand the meaning that effective and affective care have for nurses, related the interfering factors of the dealing daily with elderly inpatients, identify the learning promoted by the everyday relationship established between nurses and elderly patients, and reveal if nurses feel prepared to take care of the elderly.

METHOD

The study was developed in a public hospital in the interior of the state of São Paulo, after being approved by the Ethics Committee for Studies involving Human Beings (document number 52/2008), and was performed from December 2008 to April 2009. The study participants were nurses who worked with activities involving direct care for the elderly inpatient, and worked at the medical and surgery units, accounting for 50% of the total of nurses working there.

This qualitative research counted on the script-based interview technique, comprising seven guiding questions: What is the meaning assigned to effective care in nursing? What is the meaning assigned to affective care in nursing? What interferes in dealing everyday with the elderly? What do you learn from dealing everyday with the elderly? What do the elderly learn from dealing everyday with you? Do you feel prepared to take care of the elderly?

The qualitative data were processed by interpreting the statements, based on the content analysis method, which refers to applying a set of communication analysis techniques aiming to obtain, through systematic and objective procedures of describing the contents of the messages, indicators that permit to infer knowledge related to effective and affective care in the hospital environment and the effects of that care[14].

To do this, the recordings were transcribed and, later, read and heard as many times as necessary. This allowed us to highlight the essence of the discourse and define the titles of the categories that emerged.

RESULTS

The mean age of interviewed nurses was 38 years. They were married, with children, and had 14 years since graduation, in average. All the participants reported enjoying working at that unit and being fulfilled. Their mean time working at the unit was eight years, and they held a second job, which added up to a total weekly 60 hours workload.

Based on the content analysis of the nurses' discourses – the meaning of promoting effective care in nursing -, three categories were created: *a) it involves knowing the client and his or her social context; b) it involves more than technical care; c) it involves meeting the client's needs.*

The fist category - *it involves knowing the client and his or her social context* – covered the importance given to observing the client in his or her familiar context, and not only at that specific present moment; knowing his or her social and financial situations; knowing why he or she needed to be hospitalized; identifying his or her diet and the treatment being followed. The following discourse is an example:

> I think that the nursing staff has to know patients in a way that they also see where they live, what they do; how they live and get along with their family and what difficulties they have, because they often cannot afford to buy the medications they need... (E1).

In the category *it involves more than technical care*, the emphasis was no promoting care that requires not only technical skills, but that also values being with clients in the many different moments, as well as, the importance of talking with them.

> I know it is group work, but sometimes we don't have the professional we need, today, for example, one patient is very depressive and he needs the psychologist, but she isn't in. So, I have to do it my way, and get involved so I can be effective in what he (the patient) needs. I go there and talk to him, because he doesn't need a wound dressing, he needs attention, someone to be there for him (E3).

> It's not enough to do everything right, you need other ingredients, sometimes, what they need is to talk for a while (E5).

The category *involves meeting the client's needs* referred to the importance given to diagnosing the client's problems; determining the priorities; providing the clients' needs with or without their participation, with a view to solve problems, and provide referrals.

Trying, at least, to supply all the needs, you must cover everything. I try to solve everything, if they are in pain, I have to give them the medication; if they can't eat, I have to help; if there is a need for an earlier appointment, I have to put some pressure on the physician, otherwise it won't happen. Too bad I can't always do everything, so, I determine priorities (E1).

The nurses' answers regarding their understanding of affective care permitted to create two categories: a) *the well-being and self-knowledge of professionals who provide care;* and b) *psychological actions.*

The category *the well-being and self-knowledge of professionals who provide care* comprised the discourses that value how much the nurses' individual conditions, emotional balance, and self-knowledge affect the quality of affective care; the highlights were on facial expressions and the tone used to give patients any news.

In order to provide affective care, the person also has to be well, caregivers have to know how they are, themselves; emotional balance is important, or else you lack patience, and everything goes downstream. The way you give instructions, you have to wear a nice face...(E1).

As for the category *psychological actions*, it combined the association made between affectivity and the role of psychology, with the importance of the psychologist being there for support and help.

Here, we get involved, whether you like it or not, there are many patients from the vascular clinic, many amputees, and where is the psychological care to make them feel they are being cared for appropriately in terms of affectivity? The patient should be followed up since the ambulatory appointment, but here it does not exist, there is a shortage of psychologists. They help and soothe patients (E2).

When the participants were asked about the effects on their experience of dealing everyday with the elderly, the answers were classified into: *associated with the elderly; associated with the work dynamics;* and *associated with the environment and administration adjustments.*

The answers *associated with the elderly* were translated as the fact that the elderly were more patient, because they had seen many things and therefore were more accepting of the care, or, yet, because they were quieter and made fewer questions, demonstrating a submission to the team.

Actually, taking care of the elderly is a lot of work, it's a good thing they accept things that happen and let us do our job. They want to tell us stories of their past, but they don't really ask a lot of questions, and that makes it easier… They don't ask questions because of their experience, they know the routine, they are always here and they have to trust the doctors (E4).

Answers *associated with professional dynamics* emphasized on the routine of the service, the amount of work that accumulated in the shift, and that the dedication to the elderly is not as expected because of poor conditions, time is too scarce to be spent with them.

There are many elderly patients at the unit, many tasks to accomplish, and so the time to be with them is really short (E5).

Those *associated with environment and administration adjustments* valued the environment as a whole, which implies more safety for the elderly, such as grids on every bed, making safety adjustments in the bathrooms (floor, bars, and wider doors) and granting the authorization for every patient to be allowed having a companion during their hospitalization.

They fix the hospital, they even install safety bars and made adjustments in the bathrooms. Now, they can even stay with their family, and the family helps us (E1).

Both what the elderly can learn from nurses while in the hospital, and, on the other hand, what nurses can learn from them were also factors addressed in this study. The perceptions that nurses have regarding these two institutions permitted to create the following five categories: a) *the elderly learn the global meaning of care*; b) *the elderly learn how to identify who the nurse is*; c) *the elderly do not have a lot to learn*; d) *nurses learn how to control their emotions*; and e) *nurses learn to value the nonverbal dimensions of communication*.

The elderly learn the global meaning of care is the category that combines the discourses that emphasize on the fact that the elderly have the chance to assign meaning to the care they receive, considering they can understand, through practice, the value of quality care, the positive impact that following the diet and recommendations has on their health.

I think that the elderly are able to realize the meaning and the reasons for doing what we do with them. When they understand, they start to pay more attention and accept the procedures. This helps them get better and leave the hospital soon (E5).

The elderly learn how to identify who the nurse is is the category with discourses related to the opportunities that they are given to understand the role of each member of the team.

The elderly patient come and go so often in the clinic that they have learned who is who, and start claiming their rights; they know who the head nurse is and that the nurses' aide does only what is prescribed. They know that any doubts they have regarding the disease, they have to ask the doctor. From dealing everyday with us, they learn who we are and what we can do (E3).

The elderly do not have a lot to learn is the category that combined the understanding that the elderly, because of their experience, are resistant and will not change their opinion, and will continue doing and following what they believe in.

Maybe I'll shock you, but I don't really see the elderly learning more than they have already learned in life. Do you actually think my recommendations will make any changes for an 80-year old man, for instance? If he smokes, he won't quit...(E2).

The category *nurses learn how to control their emotions* consists of the statements that mentioned that the elderly demand attention and wand everything to be done quickly, and that, because of this need for affection, they do not understand the complexity of the routine at the unit.

Actually, I learn how to be more patient, because they are demanding, they want attention the whole time, and they don't know we have so many other things to do; they want to tell those log stories about their past and there is no way we can stay there with them. So I need to control myself. Today, I learned exactly that, to be in control (E2).

Finally, the category **nurses learn to value the nonverbal dimensions of communication** comprised the perception that dimensions such as paralanguage, tacesics, and kinesics are tools in healthcare and favor the learning promoted in the relationship.

I really like working in this unit, it is a place where I put my patience to the test to observe them better. When I visit them, I stand before them and look into their eyes to see what they say and need, they request for attention that is not spoken. I hold their hand, talk and listen, I pay attention and this way I have a better response. I am thankful for being able to learn with them (E1).

Regarding their feeling prepared to take care of the elderly, 100% of the nurses reported that, despite feeling prepared, they realize they need to study aspects specific of the fields of geriatrics and gerontology; that they have a team (nurses and nurses' aides) who *may be prepared*, but do not feel in harmony with the field, and this is a hindrance to their professional performance; they have had other professional experiences, such as working in nursing homes, which has a significant positive effect on quality of the care they give and, furthermore, that they would appreciate being informed about courses in the filed, which are scarce.

DISCUSSION

The results attributed to the meaning of effective care in nursing assumed dimensions that defend the construction of the competence of the nursing being and are stated in the National Curriculum Guidelines[15], which include the technical-scientific competences, expressed when nurses are capable of combining science and techniques, of knowing more about the client than is expected by realizing and intervening in actions that have a positive effect on health-disease situations; include the socio-educational competencies, as an effective way to promote social responsibility and commitment toward individuality and citizenship, in addition to the ethical-political competences, by recognizing and working ethically, valuing the individual differences, besides the medical diagnoses.

The importance assigned to the interaction of the nurse-aged individual binomial meets that described in the literature[16], which states that an effective care is not limited to exclusively technical procedures or applied scientific knowledge; it transcends the physical aspects, because it represents a union between two human beings, constructed and based on their life experiences, in which both reveal their being, sharing and rescuing the humanity that exists in each one of them.

The nurses stated well-being and self-knowledge as important characteristics for the affectivity of care, which agrees with the study results[17] that affirms that learning self-knowledge permits greater sensitivity in the touch, look, and knowing to feel and capture emotions of who is giving the care, besides providing an empathetic behavior that promotes well-being and their recognition of their own limits. An effective/affective human care is achieved by dialogue, in which listening is privileged and with space for open questions.

The psychological actions were also highlighted by the nurses as being consistent with affectivity, and this is in agreement with some authors[12] who affirmed that the psychologist, by incorporating and valuing the multidimensional character of the individual, collaborates with the search for the humanized and quality healthcare that is aimed to be provided to the client-family-team. Promoting conditions that promote expressing affectivity creates, in clients, the chance of feeling supported, clarified, informed, strengthened, and autonomous to deal better with the team caring for them as well as with the family supporting them.

Regarding the interferences in their daily experience with the elderly, the discourses that value aspects associated with the elderly are consistent with the study developed at a geriatric unit of a public hospital in São Paulo[18] with nurses' aides, which found that, although they did not agree with the sentence *every dependent elderly individual should follow our work routine,* the subjects recognized that the sentence was a reality of the everyday routine at the hospital; furthermore, it was a need, because they were required to complete their work in the limited time and the elderly tended to be submissive.

On the other hand, the discourses that comprise the category of interferences associated with the work dynamics, which stressed the lack of time to spend with the elderly, confirm studies that evaluated the course of the nursing profession, considering it has undergone changes in the dimension of its working process. Nurses experience a stressful work routine that usually has no operational plan regarding the daily activities, leading to weariness, tiredness, and overburden mainly because of the long work hours[19].

The imposed routine and difficulty to manage the time spent with care are well-known aspects of the profession, but when we take care of someone, the relationship is established compulsorily, including when performing the *technical* actions of care. The guarantee for the quality of the daily relationship and attachment relies on the choice of *wanting to be with the other*; it refers to the nurses' decision on how they will spend the time dedicated to the other, with the purpose to see and observe and to consciously communicate with the other[20].

In the daily relationship with the elderly, the interferences associated with environment and administration adjustments point to the findings that identified the physical structure of the hospitalization units as items that affect the quality of the care that is provided to the elderly inpatient. In this study, subjects expressed being unhappy with the lack of restrooms in the rooms or, when they were available, they were unsafe, because they did not have safety bars, the floors were slippery, and the door was too narrow for the shower chair to pass through with safety. This condition refers to the current legislation [21], which regulates the issue and recommends that hospitals be adapted so as to permit safe locomotion and accommodation of patients and their appropriate treatment.

From the nurses' view, their daily relationship with the elderly permits them (the elderly) to learn the global meaning of the care they receive and identify who the nurse is; sadly, not as an autonomous professional responsible for every stage comprising the systematization of nursing care and who intervenes in the health-disease process, but as someone who only delegates work tasks to the other team members[22]. Other nurses consider that, because the elderly are *resistant,* they do not learn more. This fact was ratified in a study[5] about the perception that health care professionals have about human aging, which found that they understand it as a stage in life in which diseases, weaknesses, and incapacities are present. They recognize that the elderly often have a lot of experience, but that does not add much advantage, considering they live alone, do not receive any affection or support, and do not accept new things, revealing pessimist and negative responses.

The outcomes regarding the learning promoted on nurses by their daily relationship with the elderly revealed two categories. In the first, referred to as emotional control, it was evidenced that they improved their patience, which disagrees with the literature that affirms that the rushes and disagreements caused by the stressful events that permeate hospitals cause weariness on nurses as well as on other team members, which eventually generates impatient, indifferent, apathetic, and tired professionals who are dominated by stress and feel discouraged[19]. The second refers to the value of the nonverbal dimensions of communication, considering that nurses develop an appreciation of the elderly inpatients' silent observation as a tool for the care they are providing. Valuing the aspects of nonverbal communication has been referred in many articles that discuss the importance of knowing which position to assume, how to look, how to come close, and use the appropriate tone of voice to improve the quality of the interactions[3,5-6,20].

The preparation for gerontological care was the object of investigation with the nurses, who affirmed that, despite feeling prepared to perform their activities, they realize the need to study specific aspects of the field, and that sometimes the team they lead lacks preparation or are not in harmony with this specific type of patient. This result is similar to a study that detected that health care professionals confirm they lack knowledge in gerontology and that dealing with the limitations of the elderly is unclear, their technical preparation is outdated, there is some confusion about what the aging process *per se* is, there is prejudice and stereotypes about who the healthy elderly are, all of which are aspects that eventually result in care centered on the medical diagnosis, often hindering the survey of specific nursing data and of expressing affectivity[5].

CONCLUSION

According to the proposed objective, we realized that the understanding about effective care involved the knowledge one must have regarding the client in his or her social context, as well as meeting their needs, thus surpassing the technical care. Effective care was understood as one that requires the nurses' well-being and self-knowledge, because the nurses' personal conditions affect the promotion of affective care. The actions promoted by the psychology staff of the hospital were referred to as being the condition that promotes support and help to the elderly, therefore favoring affectivity.

Regarding their daily relationship with the elderly, the identified interferences were those centered on the patient, in term of being patient and accepting the care they receive with minimal questioning; together with the work dynamics, in which the accumulation of tasks and the lack of time were values; and those associated with environment and administration adjustments, because they promote safety and comfort.

According to some nurses' view, the daily relationship with the elderly permits them (patients) to learn the global meaning of care and to identify who the nurses are; for others, the elderly are incapable of learning, considering they are stubborn and resistance, and not open to new things. Regarding the nurses' learning with the elderly, it is considered that they learn to improve their patience and emotional control, because the elderly demand attention and want the activities to be performed immediately. They also learn that using nonverbal communication resources can help them provide better care for the elderly, and stated there is a need for specific courses in the field to support their aim of providing quality care.

Knowing what nurses think, feel and do offers the chance not only to review nursing practice, but also to take real measures to improve the attachment between who cares and who is taken care of. The physical environment and the technological resources are important, but not more significant than human essence. To achieve effective health changes and include affectivity as an ingredient in the quality of gerontological care, changes must be made regarding professional concepts, the perspective of practice, reformulation of the care model, of studying and one's will to become involved with oneself, with the other, and with the specificities of the field. In addition to following the changes required by the new social context, health professionals must recognize that the care must be centered on the subject considered as a whole. To do this, they must use creativity, initiative and personal resources to create integration and interaction between people, those providing and those receiving the care.

Care is considered appropriate if it provided with quality and combining technique, knowledge and knowing to live together. Emphasis was given to human relationships and affectivity, and it demonstrates the importance of the art of communication. Doing in nursing should not be centered exclusively to accomplishing a task. In fact, it should rather be planned and promoted centered on the client.

This study advances in nursing knowledge, because it contributes with information about establishing competences of knowing-living together in gerontological nursing, and how important that it. Furthermore, it reveals that the effective/affective time in quality care is a possible and necessary attitude in interpersonal relationships.

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