The spiritual care of older people at the end of life in nursing care home

Introduction

A fundamental goal of palliative care is to reduce stress and improve patients’ quality of life. The National Institute for Health and Clinical Excellence guidelines for supportive and palliative care (NICE, 2004) recommend, patients be offered physical, emotional, spiritual and social support. Spirituality is characterised as: 'It is my being, my inner person. It is who I am, unique and alive. It is expressed through my body, my thinking, my feelings, my judgement and my creativity. My spirituality motivates me to choose meaningful relationships and pursuits' (Carson, 1989(p7), cited in Ireland, 2010).

Spirituality is often seen as synonymous with religion but now is a growing proportion of people who regard themselves as spiritual, but not religious (Wasner et al. 2005).

Ireland (2010) described that spirituality is leveraged by heritage, gender, past knowledge, belief, financial rank, ethnic backdrop, and other beliefs.

From my involvement as a nurse of nursing care home which is located in the North East of England, I have no doubt that the focus on providing holistic care is present in local work, and it will take forward the development of new skills and competencies.

The aim of the study is to contribute to the debate on the nurse’s role in spiritual care at the end of life to people who are living in nursing homes.
This essay examines factors that delay the delivery of high-quality end-of-life care in nursing homes, such as inadequate staff and physician training, regulatory and reimbursement issues, poor symptom management, and lack of psychosocial support for staff, residents, and families. Finally, this article discusses educational programs and current educational initiatives to enhance end-of-life care in nursing homes.

Literature Review

Nursing homes care for people at the end of life (EOL) (Bercovitz et al. 2008) & (Forbes, 2001) & (Byrne, 2007).

Nursing homes are providing end-of-life care for increasing numbers of older adults who reside in this setting during the final weeks and months of their lives. Care homes remain an important place of care until death for a significant number of very frail older people. One in five of the UK population aged 65 years and older die in such institutions (Froggat et al. 2008).

In the study Orchard and Clark (2001) viewed the perceptions and practice of spiritual care in care homes. Over 1500 homes were sent a postal questionnaire and a response rate of 42% was achieved. This study showed that home managers have a broad understanding of spiritual care. They felt that responsibility for providing spiritual care lay with the home itself, rather than other parties, although concerns were expressed over the ability of some staff to deliver this care. They suggested that physical pain continues to dominate the focus of care at this stage (Orchard and Clark, 2001).
Wallace and O’Shea undertook a study analyzing the connection between spirituality and health and end of life in numerous populations. The occurrence of spirituality has been affiliated with respite from personal, mental, and addictive disorders, and has increased value of life (QOL) and survival. The results of this study indicated that older adult nursing home residents had moderately high views of general aspects of spirituality and spiritual care in both facilities. Spirituality became more significant with expanded age, is a source of hope, aids in contending with chronic illness, and influences value of life in chronically sick older adults (Wallace and O’Shea, 2007). Swinton and Narayanasamy (2002) stated that a good spiritual tool will focus the practitioner towards the patient’s spiritual needs and offer guidelines as to how best to care for them. Therefore it is important to understand it as a general issue, including our own feelings so that we are open to giving patients the support they need. The results indicate that nursing interventions are identified: arranging visits with religious personnel, showing kindness, spending time listening with residents (presence), showing respect for resident’s needs, supporting friendships, supporting need for forgiveness, playing music, and facilitating time with nature (Swinton and Narayanasamy, 2002).

The spiritual and religious aspects of resident’s life and end of life care have been chosen for this case study because this is the aspect that appeared to be most important to them and it raised important ethical questions for family, friends and carers. From my experience as a nurse in nursing home facility where are living 38 elderly residents who are facing depression, dementia, advanced chronic illness, and other physical and social challenges. Also can be settings where older adults thrive, despite
frail health. Thriving can happen as residents are incorporated into a community that exists to enhance their quality of care and quality of life (Kelly et al., 2008). From a review of Higuchi et al. (2002) study, the decision-making challenges involved in care home practice consisted of the following 4 major categories: (a) challenges that arise in the development of client-centered care plans, (b) challenges that arise from the home care practice environment, (c) challenges related to developing confidence in clinical decision making, and (d) challenges in ethical decision making. Higuchi et al. (2002) emphasized that there is respect for the inherent worth and dignity of each person and the right to express spiritual beliefs as part of his/her humanity and incorporates patients' spiritual beliefs in the plan of care appropriately. They suggest that nurses should assist patients and families to meet their spiritual needs in the context of health and illness experiences, including referral for pastoral services. This became especially apparent during provides appropriate information and opportunity for patients and families to discuss their wishes for end of life decision-making and care, regarding expression of spiritual beliefs (Higuchi et al. 2002).

Giving good spiritual care is a personal, professional, institutional and even cultural challenge. A person who is dying is vulnerable, and we should be careful not to strongly challenge their spiritual beliefs. It is appropriate, however, to offer them the opportunity to relieve at least part of the pain so that they can tolerate the suffering more effectively and continue to contribute to the well-being of others. The model of the impact of pain on important dimension of quality of life is defined by Ferrell and Borneman (2003) as physical, psychological, social, and spiritual well-being. They demonstrated the
importance of the relationship between spiritual concerns, pain, the experience of suffering, and quality of life. Pain has a marvellous influence on spirituality, and many religious traditions influence the experience of pain. Pain creates a sense of uncertainty and hopelessness, is interpreted as a sign that disease is worsening. Pain can be a metaphor for death for both patients and family members. The family caregiver’s experience of pain in advanced illness, beginning with the caregiver’s perceptions of the patient’s suffering (Ferrell and Borneman, 2003). Chadwick et al. (2008) noted that caring for an individual who dying is emotionally draining, sad, and stressful.

Elderly patients and nursing home residents are less likely to receive adequate pain management. Studies in nursing homes have found that 45 to 80 percent of residents have substantial pain that affects their functional status and quality of life (Ferrell, 2004). This under treatment of pain may be related to the concerns about prescribing these medications in elderly patients because of the side effects or limited training in pain management and pain control. AMA Code of Medical Ethics states: ‘Physicians have an obligation to relieve pain and suffering and to promote the dignity and autonomy of dying patients in their care. This include providing effective palliative treatment even though it may foreseeable hasten death’ (AMA Council on Ethical and Judicial Affairs, 2004).

Reflection on the practice context

Spiritual care of patients is expected of nurses and is reflected in nursing codes of ethics (Nursing and Midwifery Council, 2004). Home care nurses must have an understanding
of the client’s values and must be able to “agree to disagree” to a certain extent (Higuchi et al. 2002).

In this literature, many demands of aging create additional challenges of structuring and delivering end-of-life care. Care to persons with very different belief systems, values, culture, family structures, economic and education status, religious traditions, spiritual practices, and expectations of the meaning and value of life’s ending. This care may address spiritual conflicts between personal experience and religious beliefs. The care may also address the presence of guilt, the need for forgiveness, the experience of reconciliation, completion of unfinished or unresolved business (Byrne, 2007), fear of retribution and/or punishment for wrongs, the need for rituals and prayer, and the fear of abandonment and isolation (Kellehear, 2000). There is some debate about who should provide for the spiritual needs of the dying person. McEwen (2005) stated that "spiritual nursing care...is a responsibility, not an optional extra," asserting that "referral (e.g., to a hospital chaplain)...does not constitute spiritual care" --"Rather, spiritual care should involve (1) assessment; (2) nursing diagnosis; (3) nursing interventions; and (4) monitoring outcomes”.

Religious dimensions of spirituality will be dealt with most effectively by those so trained, and if social workers, nurses or psychologists are all to take some measure of spirituality to be a normal part of their work with dying people (Cobb, 2001). Nurses reported that spiritual care was part of their role and expressed a willingness to be involved it seems that, in reality, they responded less well. Burack and Chichin (2001) attributed that nurses feeling inadequately prepared to give spiritual
care at the end-of-life. The apparent mismatch between patients and clinician perceptions of spirituality and preferred spiritual care is of concern and requires further exploration, especially if service delivery and policy development are to be meaningful and appropriate. Nursing home staff members need to build their expertise in understanding the care needs of people with these conditions, including the psychosocial-care needs related to declining health from these chronic conditions.

All nursing home staff members have a role in anticipating and addressing resident pain if want to a high quality of life is to be a reality. Pain is a psychosocial as well as a medical and nursing issue. Living without pain and dying with dignity were the two wishes that end-of-life patients had. Sadly, there are many care homes in the UK when these wishes are not granted because physicians, nurses, and other professional have limited training in pain management and pain control (Ferrell, 2004). This lack of training can lead to a lack of confidence in giving the medications also lead misconceptions about the risks and harm of using opioids. Although the physician is willing to prescribe control opioids and the nurse is willing to administer them. Nurses require special handling or needing to have a specific type of prescription form.

A person who is dying is vulnerable, and we should be careful not too strongly challenge their spiritual beliefs. However, to offer them the opportunity to relieve at least part of the pain so that they can tolerate the suffering more effectively and continue to contribute to the well being of others. Suffering involves some symptom or process that threatens the patient because of fear, the meaning of the symptom, or concerns about the future (Byrne, 2007). It is an affliction of the person rather than the body.
However, suffering can also have a positive influence in theology where the patience and waiting it requires result in moving beyond the person to God, and eternity becomes an experience.

To support others spiritually, it is important to understand our own spiritual beliefs about illness. Even within families, among friends and in faith communities, people’s spiritual beliefs and experiences may be very different. People who are very ill often draw on their spiritual beliefs and experience as a source of strength. I recently nursed a patient with tumour brain. She was still able to communicate. On one occasion when I gave the patient medications I started asking her question about spiritual beliefs which she responded. Her spiritual needs in this case were a religious, one was to attend church. She has not been since she was married but felt that she needed to talk these issues with a Catholic priest. After the conversation I had to organise everything. However, facing the illness may also bring up a wide range of thoughts, feelings and questions: Woman 90 years old angry about her disability, she is full of the questions about her life. I do not know whether she would share or show her grief. Sometimes I suspected she would see this as another twist of injustice.

As a spiritual support, we can best support others by helping them explore these questions rather than providing the answers. Can make a significant difference in someone’s life or may help that person find the comfort, meaning and hope. Hope stand for hope or sources of hope, organized religion, personal spirituality and practices, and effects on medical care and end-of-life issues (Touhy, 2001).

The role of spirituality in health and health care is recognized by health professionals. The claim that nurses should take account of aspects of spirituality derives from
a holistic perspective on human functioning. Narayanasamy (1999) explains that nurses need to understand the concept of spirituality if they are to offer holistic care. Once the broad nature of spirituality is examined, the result should be a more knowledgeable practitioner in the spiritual dimension of nursing. Narayanasamy (1999) notes that the subcomponents of self-awareness and spirituality can be integrated from the onset of an educational program to assist in value clarification for participant.

While a boost in focus on geriatric nursing learning has produced in an expanded number of nursing programs that offer geriatric nursing techniques and integration of geriatric content into nursing techniques, spirituality is not consistently incorporated into undergraduate nursing curricula. There is much debate in the nursing literature about how, what, where and when spiritual care should be taught to nurses and who should teach it. Wasner et al. (2005) showed the effects of spiritual training for 63 Palliative Care professionals, included 51% nurses only. The course “Wisdom and Compassion in Care for the Dying” involved technical methods. Significant improvement and support were reported as far as a single aptitude towards working in a palliative care environment.

According to educational project across Mount Vernon Cancer Network (MVCN) where nursing staff have the opportunity to improve their knowledge on symptom control and care of dying patients, the challenge of this community has been neglected (Mathews and Finch, 2006). A total of 34 nursing homes: only three homes (eight per cent) had a palliative care education programme specifically designed for their own staff provided by an outside agency (hospice/CNS team), while 12 (35 per cent) had access to courses provided by local palliative care teams. In addition five managers had a palliative care background and
were keen to disseminate their knowledge to staff. The results of the interviews highlighted the lack of a clear and coherent policy on nursing home education for palliative care training across MCVN's area (Mathews and Finch, 2006). It appears that nurses received little education on the spiritual dimension of care in post basic courses. The reason of this study was to enquire insights of spirituality care amidst older nursing dwelling inhabitants at the end of life.

Implication for practice

Each person defines spirituality according to his or her own beliefs and experiences. Health care providers who are prepared to guide and consult patients in a concerned, caring way through the difficult transitions at the end of life to fulfil to comfort the sick (Bern-Klug, 2010). In my actual pieces of reflection which I am doing is improved patient care in nursing home and is putting it into practice. As part of my duties as nurse, I have already pleasant to work in caregivers team but I see fewer limitations. The major needs included a lack of knowledge and skills in symptom management; communication difficulties; conflicts with families and physicians; and emotional distress in dealing with death.

Cobb (2001) is suggesting that the best practices would be improved by several steps:

1) Education about the concept of spirituality, meaning in the lives of elders and the role of professional nursing in end of life care and enter the experience in terms of medical and physiological issues.

2) Use episodes of serious illness as opportunity to talk about death and dying and loss. About what gives the
patient’s life meaning, and about identifying values and goals in life.

3) Reassure family by explaining what is happening and counselling them on their own reactions to what is going on with both themselves and the patient.

4) Learn how to provide care that accepts death as part of life and relieving suffering (Cobb, 2001).

Conclusion

Spiritual aspects of care must be opened for research and reflections to all caregivers, doctors, and nurses, as well. Working together, we all may help the dying older adult fulfil the need for spiritual integration and can help to have a genuinely human death.

The literature suggest that attention to spiritual issues in the nursing process is present but not clear-cut, it seems very diverse and largely dependent on the personal expression of the individual nurses. These findings confirm the conclusion of many researchers that the approach to spiritual care at the end of the life is apparently largely unsystematic and delivered haphazardly. These components will provide a framework, a set of guiding principles, for educating and preparing staff at all levels of organizations to meet the spiritual needs of diverse communities. However, the results of this article suggest that these aspects of spiritual care are poorly structurally embedded in nursing practice and barely form part of the professional competence of most nurses. Future research regarding spirituality in palliative care can be better achieved when nursing has an increased understanding
of how to thoroughly assess for spiritual needs and how to implement a more thorough plan of care.

References:


