Indian Journal of Gerontology

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Indian Journal of

Gerontology

Special Issue on

Challenges in Gerontological Care

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and
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FOR OUR READERS

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Those who are interested in becoming the member of *Indian Geronto-logical Association* (IGA) are requested to send their Life Membership fee is Rs. 2000/- (Rupees Two thousand) and for Annual Membership Rs. 500/- (Rupees Five hundred only). Membership fee accepted only by D.D. in favour of Secretary, Indian Gerontological Association or Editor, Indian Journal of Gerontology. Only Life members have right to vote for Association's executive committee. Members will get the journal free of cost.

REQUEST

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YOU ARE INVITED TO JOIN US

We are Working to Protect the Rights and Social Welfare of the Elderly

Indian Gerontological Association (Registration No 212/1968) is an independent grassroot non-profit organization based in Jaipur (Rajasthan). Our efforts empower and support the underprivileged elderly in rural and urban communities.

We strive to ensure social justice and welfare for people over 60, focusing on those elders who are the most disadvantaged such as elderly women. We protect the civil liberties of elderly citizens as a part of the struggle for individual rights and social progress in India. Currently, the elderly community comprises approximately 10 per cent of the total population of India. This number will increase to nearly 25 per cent within the next twenty years. Neglected and abandoned by society and sometimes by their own families, elders are increasingly subject to conditions of disease and poverty. They lack access to health care, and often face serious discrimination as well as physical and emotional abuse.

As a public interest group, we work for and with the elderly to protect their rights and access to a better quality of life. We seek to both empower and serve by working directly with rural communities. By facilitating the growth of citizen's groups, raising public awareness on ageing, promoting public action and participation, and advocating public policy changes, Indian Gerontological Association hopes to alter the current trends in elder relations for the better.

Our Work Includes

- Community Centers for the Elderly that Offer Communal Support and Interaction
- Training on Legal Rights by Offering the Elderly Practical Knowledge on Their Rights
- Public Hotline for the Elderly that offers Legal Referrals and Assistance
- Public Accessibility for the Elderly Advocating More Available Access to the Public Sphere
- Use of various forms of media to Raise Public Awareness on Elder Rights
- Counselling and Helping elderly to Relieve Psychological Stress and Depression
- Elder Women's Cooperatives that Provide Grants and Assistance to Elderly Women
- Public Awareness Raising to Promote Public Action for Helping Disadvantaged Elderly
- Field Study of Rural Areas to Analyze Challenges Faced by Ageing Rural Population

Our Plan of Action Includes

- Campaign for Elder Rights
- Campaign Against Elder Abuse especially toward Elderly Women
- Training of Social Workers and Caregivers
- Capacity Building of Civil Servants or organizations Working on Ageing
- Research & Publication

Editorial

Educating Professionals to Care for Older Adults: Multiple lenses and multiple approaches for multiple disciplines

While gerontological professionals are in agreement about the rapid growth of the ageing population worldwide, there is less consensus about how to educate professionals, or future professionals, in the care of older adults. The "how to" educate professionals, both in regards to fostering interest in and commitment towards gerontological practice, as well as communicating the sophisticated and nuanced knowledge to effectively care for ageing individuals, seems more complex. When it is best to introduce students or health and human service professionals to ageing adults and how to do so (e.g. what kind of practice settings) has been debated within the literature for over 30 years. While we have made some progress over the decades, according to studies in nursing, social work and other disciplines, we continue to have challenges in captivating future and current professionals about the joys of providing care to older adults, as well as imparting important knowledge about how aged adults differ from their younger counterparts in physiology (e.g. normal changes, such as those pertaining to the senses), pathophysiology (e.g. that delirium may be the only sign of a urinary tract infection), responses to illness (e.g. expressing symptoms of depression differently than younger adults), and challenges in facing into transitions.

Although we do not provide answers regarding how to unravel the complexities of educating students and health and human service professionals, we aim to present a variety of articles that address educational challenges in gerontological practice within diverse settings, using disparate approaches and to and from professionals from varied disciplines. For instance, Vandewater addresses the aforementioned challenges of "selling" gerontological nursing to registered nurses and

then highlights her on-line course (through a university distance programme) that teaches older adult content to nurses from many countries. She notes that even when nurses are not "sold" on geronto-logical nursing, they admit that the learnings from this course have impacted their lives positively. Hirst and Cole offer a model to guide gerontological nursing practice in acute care (hospitals). This model is specifically geared towards registered nurses working in hospitals who may not conceptualize themselves as gerontological nurses, but who are nonetheless, working with older adults. Strategies are presented to positively affect nurses' attitudes towards seniors, increase their interest in and their knowledge of this population, as well as enhance their skills in working with older adults.

Aldiabat and Le Navenec take a step back from promoting a course/programme in gerontological nursing to address what nursing students need to learn about delivery of care to seniors living in rural Canada. They outline important issues such as who comprises the older adult population, the normal physiological changes associated with ageing, what the term "rural" actually means and the health challenges faced by rural older Canadians. Similarly, Osuji argues the global need for addressing gerontological nursing within under-graduate curriculum. He astutely points to the fact the ageing of our population is universal, not just western; developing countries are ageing and student nurses in undergraduate education in these countries need to learn how to provide expert care for ageing individuals. Even within westernized countries, however, disparities in living conditions and therefore health, can and do exist for older adults. As a nurse working in public policy in Canada, Cruttenden outlines a study that will examine the social determinants of health impacting older adults living in Atlantic Canada. Results from this study will then influence public policy with the aim of enhancing the health and resilience of older adults within this Canadian region.

Two featured authors in this special edition are not nurses. Reed (as a chaplain) presents ideas on how to educate staff in the palliative care setting to provide spiritual support to ageing individuals who are dying. She describes the approach she took in teaching and mentoring palliative care staff (from varied disciplines) to provide spiritual support. Interestingly, she makes a valuable distinction between education that is both "taught" and "caught", with both forms of

education being necessary and important. As a social worker, Stares addresses the use of Complementary and Alternative Medicine (CAM) by older adults. She emphasizes what CAM is and what professionals need to know about CAM to work effectively with older adults in managing their health. With older adults taking a greater interest in actively managing their health and in CAM, this will be an important area for knowledge acquirement in gerontological professionals.

Utilizing a broader and more conceptual lens – one that does not directly apply to the care of older adults – Zhu and colleagues highlight lessons learned in cross-cultural nursing; within those experiences, they shed light on issues that specifically pertain to older adults. If gerontological content is to be introduced into curricula in developing countries on a global scale (as argued for by Osuji), these lessons offered by Zhu and colleagues may be helpful for professionals from varied disciplines teaching in countries/cultures unfamiliar to their own. Finally, taking a slant different from that of Zhu and colleagues, and yet, still similar in the conceptual nature of the argument, Dykalski and Lane examine how emergency room nurses conceptualize and appraise incidents as critical. They draw attention to the role of chronological and professional age in the appraisal of criticality. The age of patients seen in the emergency room not only impacts how nurses appraise incidents as critical, but their ages as individuals and as professionals (years within nursing) influence how they view the criticality of injuries and how these critical incidents impact them personally.

We hope that the articles contained within this edition of the Indian Journal of Gerontology reveal, in a small way, the breadth and depth of considerations and opportunities that pertain to educating professionals on the care of older adults. This includes both practical "how tos", as well as conceptual offerings that challenge professionals to think differently about older adults entrusted into their care. We trust that you will find this edition interesting and informative.

Annette M. Lane
Sandra P. Hirst

"Selling" Geriatric Nursing

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ABSTRACT

What does it take to "sell" geriatric nursing to registered nurses? Within this article, a distance programme on geriatric nursing provided to registered nurses who are working towards their Bachelor of Science in Nursing is described. The means of course delivery and experiences of the educator and students are presented.

Key words: Geriatric nursing, Education, Distance education

Introduction

I suspect that if you are reading this article, you are:

a. already a geriatric nurse

b. a nurse looking for information about an aspect of geriatric nursing

c. someone looking at a health care discipline as a career and considering nursing, or

d. you saw the word "selling" and thought there might be something interesting to buy…

Well, the correct answer is d) "selling" geriatric nursing, or to be more specific, "selling" a course on geriatric nursing to 'non-believers', in other words to nurses who may say that they "don't take care of old people".

The purpose of this article is to discuss some of my experiences and observations about how some students have managed with the geriatric nursing course I teach and their personal outcomes. However, a brief description about the nursing programme in which I am involved might be helpful first.

Have you heard of Moodle?

I have the privilege of being a professor at a Canadian University that offers nursing courses through a division of the nursing department called Distance Nursing. The course I teach on geriatric nursing is a part of the Distance Nursing curriculum available to practicing Registered Nurses (RN) who wish to attain a Bachelor of Science in Nursing degree (BScN) on a part-time basis. The "curriculum is designed to reflect and enhance the professional knowledge, competencies, and experience of Post RN students. It enables students to customize their programme, and select nursing electives in areas that will support individualized needs and interests, and professional nursing practices." (DC & DE 2014)

The course is based upon home-study reading (online reading and textbook) and assignments, all of which are accessed through an online web portal management learning system called 'Moodle' (Modular Object-Oriented Dynamic Learning Environment). Moodle is "a learning platform designed to provide educators, among others with a single, secure and integrated system to create personalized learning environments" (Moodle 2014). Because Moodle is totally web-based it can be accessed anywhere in the world which is why this degree attracts nurses from all over North America and abroad (Ibid.) While the majority of students are from Canada, I have had the pleasure of working with students living in the United States, Europe, and Africa, which also lends a very different dynamic perspective to the cultural considerations of gerontological nursing – more about this specific aspect will follow later in the article.

To use Moodle a student needs to have basic computer and web-browsing skills. Because the majority of students are mature learners in their 40's and 50's there can be frequent and significant stress with the learning curve associated with using a computer at all, let alone working with a specific web-based programme such as

Moodle. Several students have confessed to me that their teenage children have helped them to upload papers, respond to online discussions, and even to save a document to a USB flash drive!

Learning via a distance web-based programme was a challenge for me initially, as not only did I need to learn how to prepare course content for the Web and to use the programme, but I also had to be able to converse with students by online only. (In past years the students could call me on the telephone at prebooked call-in hours on a 1–800 number, but this option is not offered with online courses). Also, evenwith many courses now totally web-based, some students still think I am on campus and that they can actually "drop in to see me in my office," when in reality I am hours away from them geographically in a 'virtual' office. Thus, my contact with all students is through the Moodleonline environment where by the students can "talk" (type) interactively amongst themselves as well as with me, the course professor.

The Distance Nursing programme can be completed in three years but students have up until ten (10) years to do so. From past experience, I have found that once students "gets their feet wet" (as they have often said to me), with an initial course towards their BScN degree, mature learners, who are also experienced RNs, will often decide to undertake at least two courses simultaneously, plus work full-time and have a family (including children, adolescents, parents and grand-parents). At times, this amount of commitment can prove to be overwhelming for some of the RNs, who bemoan, "but I am usually so organized!"

Geriatric Nursing Course

Although I teach several courses for the university, my heart and my passion is the healthy ageing course: *Care of the Older Adult* for which I have been a professor for more than 15 years. The course was originally in a paper format: a 3-ring binder and a textbook with a number of additional printed articles to read as well. However, in the last two deliveries the course presentation format has changed to an online design. *Care of the Older Adult* is one of the required courses for the post-RN degree. I find this requirement very encouraging.

Attitude Shift

Over my 35+ years as a Registered Nurse, most of my practice has been associated with the care of the elderly in geriatric settings such as long-term care, day hospitals, ambulatory clinics, and geriatric assessment units. Through the first two decades of my career I found myself "defending" and "rationalizing" why I worked with older individuals...because I obviously "couldn't make it in any other area of nursing!" Appallingly, these types of attitudes have been prolific throughout my interactions with both nursing and non-nursing healthcare colleagues. I would try to counter these very negative and biased judgments by trying to articulate why and how nursing of the elderly is in itself rewarding and fulfilling. I can state that my own knowledge and expertise was severely tested as I navigated my own parents' end of life needs into their 90's.

In the last decade, however, I truly believe that attitudes towards the elderly are shifting in a more positive direction from my perspective. I suspect that a major influence for this attitudinal shift is the projected increase in the elderly population in Canada and worldwide making the study of ageing relevant to everyone. Due to social, economic, and political changes that have had an impact on the ageing process, individuals, especially health care providers, will need to acquire an understanding of the normal processes of ageing for the rapidly growing older generation (the baby-boomers or 'silver-tsunami'). In Canada, the population will continue to age rapidly until 2031, when the entire baby boom generation will have turned 65. It will continue ageing after 2031, but at a less rapid pace. By 2041, seniors are projected to comprise nearly a quarter (24.5%) of the Canadian population, as compared to 14.8 per sent today. Those individuals aged 85 and over are expected to nearly triple to 5.8 per sent of the total population by 2041 (Kembhavi, R. 2013).

Student Experiences

As with my health care colleagues, as a professor, I have often feel that I am required to "sell" geriatric nursing to the nurses (students) who going to be taking this course. The online *Care of the Older Adult* course addresses practical issues of health and wellness important to an increasingly ageing population. Students learn how to improve the

function, quality of life, and self-care abilities of the well elderly to assist them in maintaining independence. They examine the impact these factors have in making the older adult who s/he is today. Through interaction with a senior in the community, the student learns how the older adult defines and promotes his or her own health. Course content also includes: ageing-related changes; the role of the family and other aggregates; and the use of community resources (St Francis Xavier University 2013, 2014).

Even though this course is compulsory, prospective students still contact me in advance of the start of the course to ask for more content detail, stating that they won't "use" it in their practice or that they "don't like geriatrics". Many of the queries come from pediatric and obstetrical nurses, who state that they truly do not want to work with or study about older individuals, because they do not have older individuals in their practices. This hesitation may reflect past negative practice experiences with elderly clients over the course of their careers. But even pediatric and obstetrical nurses have interactions with older individuals: what about grandparents?

However, it is those reluctant students who have ageing parents from whom I hear the most feedback during and after they have completed the course. These individuals are commonly known in geriatric circles as members of the "Sandwich Generation". (Abaya, C. nd.) These individuals (mostly women) take care of, or are involved with the health and care of their aging parents, while juggling their own children and families, and a nursing career at the same time. I have received countless, positive comments indicating their surprise and gratitude at how the course content has helped them personally to understand what their parents may be experiencing (or soon will be).

One particular situation comes to mind where I received several email conversations with one older RN who had a widowed mother. The nurse stated that it wasn't until she read the information on cognitive impairment and dementias that a possible explanation for her mother's recent changes in behavior crystallized for her: her mom might very well be suffering from an early dementia. The nurse arranged a consult for her mom, and apparently, with the correct dementia diagnosis, the nurse was then successful in providing the appropriate supports and care for her mom to remain as independent

as possible in her quality of life processes. The nurse told me that she was so relieved; she now understood more of what was happening with her mom, and what was likely to happen and thus something for which she could plan. Her stress level had also been reduced to a more manageable level. In other instances, students were able to assist family to intervene in unsafe situations involving other elderly family members. These nurses again verbalized their great satisfaction with being able to provide positive interventions. In all the feedback, the growing understanding and knowledge of the ageing changes in older adults – their family, was gratefully appreciated.

Thus, I feel it is my personal responsibility and my mission to not only assist these RNs to pass the course, but hopefully to also achieve a small measure of interest and positive feelings towards providing care for older adults. Of the over nine hundred (900) students who have successfully completed *Care of the Older Adult* to date, I have never received any negative feedback in terms of the usefulness or application of the contents of this course.

The Cultural Consideration

As was mentioned briefly at the beginning of this article, students registering for this course come from many different countries and cultural origins. Over the years, the enrollment has become increasingly diverse and this diversity has had a constructive benefit upon the students, the course content, and myself. The sharing of personal backgrounds and experiences through their online postings has been positively influenced through the interactions of the students with one another. Since the course requires that the student select and interview an older person to determine a nursing diagnosis that could enhance his/her quality of life, the selected elderly clients are now reflecting broader multi-cultural backgrounds as well. Additionally, the nursing diagnoses that are now being identified by the student and the well elderly person often reveal issues reflective of their specific cultural beliefs and needs. Consequently, the course content will continue to evolve to reflect this more international perspective with increasing emphasis upon cultural safety (Canadian Nurses Association 2010).

Conclusion

This article has outlined the reactions of some Registered Nurses who were required to enroll in a geriatric nursing course as partial fulfillment for a part-time post-RN BScN degree. Of the more than 900 students who have successfully completed the *Care of the Older Adult* course, the majority of individuals did not work with the elderly, and many indicated that they did not care to do so. However, the feedback from the course sent to me personally via email indicated that a large number of these individuals who completed the course now had a much more positive attitude than when they had started.

However, there is still a major question to be answered which impacts on the topic of this article: how can the practice of geriatric nursing/gerontology be made attractive to nurses...and other health care personnel? Throughout my nursing career I have grappled with this question, but I have yet to learn of a winning strategy. Care of the elderly will certainly not appeal to all nurses or other healthcare personnel, nor should it. This specialty must attract individuals who want to work with the elderly and who will derive personal satisfaction and fulfillment from their commitment.

I think a key point is the perception of the elderly as they appear to the public, and to nursing students as they begin their studies. An attitude shift is required to change the perspective that the elderly are less than viable members of society who use a majority of the healthcare dollars. From the healthcare industry viewpoint introducing nursing and other disciplines' students to the well elderly first is a critical strategy. As only a minority (7.1% in 2011), of older Canadians are living in health care facilities (Curry, B. 2012) introducing new nursing and healthcare students to these individuals at the beginning of their clinical rotations may only serve to reinforce the students' pre-conceived negative impressions that all older people are sick and dependent. Rather, we need to focus on the vast majority of elderly individuals who are maintaining their independence and quality of life. Nursing professionals and people generally, need to see the positives in the elderly and reflect these positives throughout geriatric nursing/gerontology courses.

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The Process of Gerontological Competence in the Delivery of Acute Nursing Care

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ABSTRACT

Several models of service delivery and education have emerged to meet the challenge of caring for an ageing population. Described in this article is one model by which increasing recognition is given to the uniqueness of older adults within the acute care hospital setting. Specific strategies are provided for on-site educators, administrators, and staff themselves to promote the constructs of the model. The expected outcome is improved care for older patients.

Key words: Models of service delivery, Education, Acute care

"This is an acute palliative care unit. It is not suitable for a seniors' health placement for students."

"I'm a surgical nurse; we have orthopedic patients on this floor."

(On these same acute care units, over half of the patients were 65 years or older.)

The changing demographics of a growing ageing population and the long-standing disparities in service delivery for older adults are placing significant demands on the health care system, registered nurses and other staff, patients, and families. With the number of older adults increasing in the global population, the need to ensure that they receive appropriate health and medical care also increases. In Canada, older adults account for an increasing percentage of acute care hospital

admissions and readmissions (Canadian Institute for Health Information [CIHR], n.d.). These challenges necessitate that acute care hospital on-site educators consider gerontological competency as a priority for staff development.

The repercussions of hospital admissions can be costly: for hospitals, the cost of avoidable complications associated with acute hospital care, prolonged lengths of stay, and access and flow issues in the system due to bed shortages; for patients, recurrent admissions, premature admission to long-term care facilities, development of co-morbidities (Nair, *et al.*, 2000) and permanent loss of independence and diminished quality of life; and for families, additional stress and worry about their older member. To explicate, for a number of older adults, admission to acute care units result in lengthy stays and possible relocation into long-term care or alternate living arrangements (Canadian Institute for Health Information[CIHR], n.d.). Even when an illness is treatable or appears uncomplicated, older patients may not return to their pre-hospitalized functional status. In studies of patients who had hip fracture repair, less than 50 per sent returned to their preoperative functional level (Roder *et al.,* 2003). Functional decline after admission was also found in older patients admitted with acute exacerbation of chronic obstructive pulmonary disease or with congestive heart failure (Formiga, *et al.,* 2005).

Professional nursing staff provide most of the care to older patients in acute care hospitals. They are supported by para-professional and unlicensed staff. For all staff, clinical decisions and the processes that underpin them are an integral part of care delivery to older adults and those important to them. However, many staff working in acute care settings have little if any specialized gerontological education. Coupled with this lack of knowledge is the low status that older patients are accorded in acute care settings (Gallagher & Bennett, 2006; Higgin, *et al.*, 2007; Moyle, *et al.,* 2011; Black, *et al.*, 2013).

Most acute care staff who work with older patients do not consider themselves gerontological practitioners, as the opening quotes indicated. Consequently, it often falls upon on-site nurse educators to address the learning needs of nursing staff and other

health care professionals working within these same acute care hospital sites.

The Model

The proposed model is suggested as a framework to support acute care on-site educators and administrators, and to move staff forward in their understanding of the implications of an ageing population upon their clinical practice.

There are four assumptions, which underlie the model:

1.   Ageing is a normal part of the life span,

2.   There is more variation within the population of older adults than found within other age cohorts,

3.   Gerontological competence is an essential component in rendering effective and age responsive services to older patients in acute care hospitals, and

4.   There is a direct relationship between the level of gerontological competence of staff and their ability to provide age sensitive care.

Figure 1
The Constructs of the Model
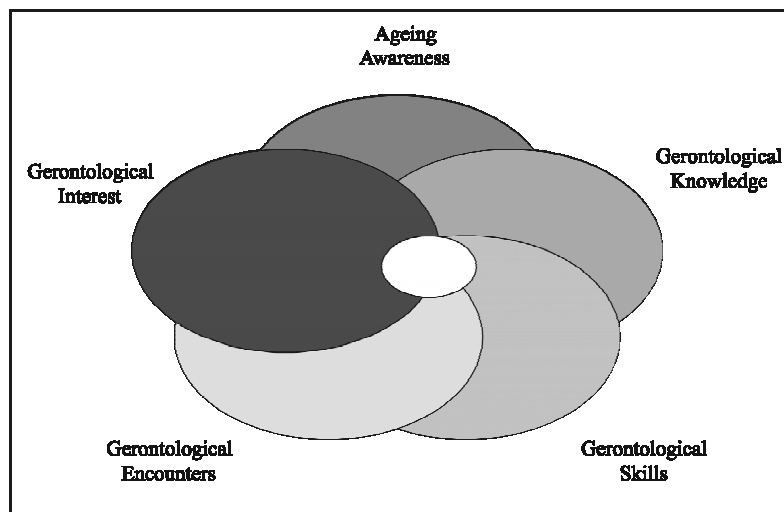
There is no single model or approach that best supports integrated care for older patients. However, the one proposed, in this article, is a starting point. It is a clinical/service model designed to improve care for older patients.

Ageing awareness: Ageing awareness is the in-depth exploration of one's own ageing and preparational background. It is one component of the model. The process involves the recognition of one's biases, prejudices, and assumptions about individuals who are different because of their age. Without being aware of the influence of one's own perspective, there is the risk that a staff member may engage in ageism. It is well recognized in published research that nurses hold ageist views (Black, *et al.*, 2013; Happell & Brooker, 2001; Herdman, 2002; Lovell, 2006). These views are not limited to nursing staff. In examining the attitudes of nursing assistants, registered nurses, physiotherapists, and occupational therapists, Blomqvist (2003) reported that participants perceived older adults as a homogenous group in reference to the reporting and experience of pain. The implication is that participants did not understand the processes of ageing, nor the fact that each older adult is unique.

Acknowledging attitudes of the staff and working with them to facilitate change are essential towards the enhancement of the care of older adults. This is a challenge being taken up by on-site nurse educators. The question then, is how do on-site nurse educators promote ageing awareness in acute care staff? Ongoing conversation with staff is one strategy. Sample conversational questions between the on-site nurse educator and staff to promote ageing awareness include: What older patients did you care for last week? What surprises you about providing care to older adults? Now that we have identified several possible barriers to providing care to older adults, which one(s) can you relate to the most? What action might overcome these barriers?

Other strategies include

- Introduce staff to their own knowledge levels, e.g. Palmore's (1988) landmark *Facts on Ageing Quiz*,
- Review orientation programmes to ensure that time is allocated to the needs of older adults admitted as patients,

- Use of a writing group for staff nurses (DeMarco, *et al.*, 2005), or reflective journal writing (Burbank *et al.*, 2006), and

- Facilitate focus groups for staff that discuss ageism, ageist language, and how ageism impacts delivery of acute care to older patient.

Educators can begin journal clubs on nursing units, using articles that address the care of older adults with particular health care needs seen on these units. Staff nurses can then read these articles and attend the journal club meeting to discuss ideas coming from the material, and to compare the material with what they see clinically on their units. Educators can contact informational societies (such as the local chapter of the Alzheimer Society or Diabetes Association) to provide free in-services to staff nurses. Also, educators can access important informational brochures or booklets through these societies or associations that educate both staff nurses and family members.

These strategies will help guide staff participants through activities designed to help them identify their views and possible biases towards older patients and to move towards understanding both the processes of normal ageing and the needs of older patients.

Gerontological Interest

Gerontological interest is also a construct of the model. It is described as the motivation of the staff member to want to work with older patients and those important to them. This interest may already be kindled in some staff by previous experiences with older adults, a concern about the implications of an ageing population on health care delivery, or by a moral or ethical sensitivity towards a vulnerable population.

Possible strategies to increase gerontological interest include:

- Employ a mentor(s) who has/have certification in gerontological nursing,

- Support staff who are thinking about obtaining certification in gerontological nursing,

- Employ a panel presentation by older adults who represent a variety of personal patient experiences,

- Provide reading material on a nursing unit that draws from the popular literature on ageing,

- Offer a six week shared staffing experience between acute and long-term care facilities, and

- Support acute care staff to attend conferences, which focus upon ageing and health issues of older adults.

Gerontological Knowledge

Gerontological knowledge is the educational content about the ageing process and older patients required by staff. All staff require a basic level of knowledge in this area; however, the amount and level of content is influenced by their personal and professional education. In obtaining this knowledge base, the staff member must focus on three specific content areas: normal ageing processes, disease incidence and prevalence, and gerontological care principles.

There are physiological changes that are normal with ageing. Some of these changes include decreased sensory abilities, decreased lung and immune function, decreased peristalsis, and changes in sleep patterns (Boyd & Stanley, 2005). The staff member needs to understand how these changes impact an older adult's ability to relate to others and to cope with activities of daily living and co-existing health problems. Examples of psychological variations include grief reactions to multiple losses that may accompany ageing and slowed reaction time (Boyd & Stanley, 2005).

Part of understanding the normal ageing process is recognizing the older patient's worldview. This worldview will influence how an older adult interprets his or her own ageing process and how it guides personal thinking, doing, and being. It will give the nurse and other staff members an understanding of what the older adult values, and what brings meaning to one's life. Understanding the older patient's worldview is important when the individual is faced with multiple losses. This view impacts how the older adult will face into transitions that often occur with advancing age (Lane, *et al.*, 2013a).

Recognition of the normal changes that accompanyageing provides the foundation to recognize deviations from the norm. Disease incidence and prevalence among older adults is another

knowledge need required by a staff member to provide competent care. This includes knowledge about disease pathologies, including incidence, presenting signs, and symptoms. Disease incidences vary along the life span; for example, osteoarthritis and cardiovascular disease are more commonly present in older adults. The incidence of dementiaalso increasessignificantly with age (Alzheimer Society, 2010).

Increasingly, knowledge of the emerging sub-populations within the older adult cohort is important. There are various sub-populations of adults who are identified as aged, not based upon chronological age, but rather upon physical age. For instance, individuals who have lived with HIV/AIDS are considered to be older adults by age 55, due to the effects of HIV, as well as the impact of treatment (Lane, *et al.*, 2013b). Similarly, individuals who have been homeless for many years, or incarcerated for a lengthy time, are considered elderly at 55 years, due to the difficult environmental circumstances they have faced (Beckett, *et al.*, 2003). Additionally, there is a growing cohort of adults with intellectual disabilities who are now living into their 50s and 60s. These individuals are considered to be old anywhere from their late 40s and into their 50s, due to the prevalence of dementia-like symptoms in individuals with Down's syndrome in their late 40s (Hirst, *et al.*, 2013).

Treatment efficacy is alsoknowledge required by staff. This involves acquisition of knowledge in such areas as drug metabolism in older adults and the impact of dehydration, urinary tract infections, or delirium upon mental status. Nurses require astute knowledge in this area; not only do they need to understand a wide variety of medications commonly used by older adults (such as cardiac medications), but they also need to recognize principles around drug prescribing ("start low and go slow") and quickly identify side effects that may be due to multiple treatments.

Strategies to enhance this component of the model include:

- Attend webinar-based educational programmes (Black, *et al.*, 2013), and

- Provide access to on-line and other learning resources (Bletcher & Vonderhaar, 2006).

Gerontological Principles

Another construct of the model is gerontological principles. It is important to remember that no older patient is a stereotype of the ageing process, but rather a unique blend of the diversity found within each age group and a distinctive accumulation of life experiences. Staff who do not have accurate knowledge to guide decisions about treatment, health education, screening, and treatment programmes will not be able to positively impact health care outcomes.

Strategies to enhance this component of the model include:

- Offer in-services focusing on disease pathologies common to the older patient population on a specific unit,

- Initiate joint appointments between the acute care hospital (or a specific unit) and an academic faculty member with recognized expertise in gerontological nursing practice,

- Purchase one or two on-line journals that focus on the care of older adults for acute care units,

- Provide access to relevant, peer reviewed web sites specific to health needs and care of older patients,

- Encourage participation through on-line forums or accessing Webb logs on dementia (Hope, *et al.*, 2007), and

- Offer financial support for conference attendance.

To implement these strategies, the on-site nurse educator may be supported by advance practice nurses. The advance practice nurse may conduct a workshop where material specific to ageing, health concerns (medical and psychiatric), relevant assessment tools (such as the Confusion Assessment Model, Mini Mental Status Exam, and the Geriatric Depression Scale) and ethical issues faced by older adults and family members (relocation to another facility, end-of-life care) are presented. This advance practice nurse could also teach staff how to address issues of loss and grief in older adults, differentiate bereavement reactions from depression and interpret mental status.

Gerontological Skills

Gerontological skills involves the ability to collect relevant assessment data regarding the older patient's presenting problem,

interpret the data based upon gerontological knowledge, and intervene accordingly. It might be as simple as recognizing that older male patients often experience hearing loss and this might require modifications in the data collection process, or that hearing loss impedes the communication process.

Strategies to enhance this component of the model include:

- Initiatea "train the trainer" format to help staff see connections between physical health assessment findings and relevancy to older patients,
- Implement a workshop for staff to learn "hands-on skills", and
- "Borrow" an advance practice nurse in gerontology from a long-term care unit or a community based facility to work with staff for a month.

For example, during a workshop, staff may role play scenarios using assessment tools with an older patient, or conducta family meeting. An actual example of a formal educational programme strategy impacting older patients and their family members is drawn from an acute care hospital in western Canada. Mental health nurses, both adult and geriatric prepared, were taught how to conduct family interviewing by instructors (including the second author) trained in family work. The staff attended a two day workshop on family theory, as well as observed through a one-way mirror an on-site educator conducting a family interview. The staff were then expected to conduct 3 family interviews over a span of several months, with an on-site educator behind the one way mirror observing and offering feedback. When the educatorwas comfortable with the demonstrated skills of the staff nurse, he or she was then able to offer family meetings independently.

Gerontological Encounters

A gerontological encounter is the process that encourages staff to directly engage in caring for older adults. Face to face interactions with older adults will potentially refine or modify one's existing beliefs about the ageing process and older adults.

Strategies may include:

- Ask an older female patient to tell you about her wedding day, or ask an older gentleman about where he went to grade school,

- Introduce Comfort Rounds (intentional rounding every two hours that includes pain assessment, encouraging mobility and assistance to go to the bathroom), and

- Initiate planned interactions or care conferences with family members.

A gerontological encounter often involves direct involvement with family members. Staff need to gain insight and skill in addressing family members, assessing family members' perceptions, and, where appropriate, intervening with the family. Interaction with family members should never be used as a substitute for interacting with older adults. Rather, it augments a gerontological encounter; this is particularly important where the staff member suspects that an older adult is experiencing depression, dementia, or delirium. Developing skills in supporting older adults and their family members concurrently, particularly when there is longstanding conflict between family members or between family members and older adults can be difficult (Lane *et al.,* 2013a).

Relationship between Constructs

The constructs of gerontological competence have an interdependent relationship with each other. It is a circular model in that a practitioner can enter through any one of the constructs. Entrance might be by a gerontological encounter with a distressed son of an older patient that initiates the model for a staff member. Or perhaps entry to the model is through gerontological knowledge gained by responding to a confused older patient climbing out of bed after surgery; in this situation, the nurse identifies that confusion was not present before the operation. No matter where the staff member enters into the process, all five constructs must be employed. Staff members can work on any of these constructs to improve the harmony between all of them.

However, it is the intersection of these constructs, as demonstrated by the smallest circle in the middle of the figure that depicts the true process of becoming a gerontological practitioner. As the area of intersection of the constructs becomes larger, staff more deeply internalize the constructs upon which gerontological practice is based. The

important feature of any complex system is the interconnectedness of all its constructs, and the relationship between them is more important in understanding their influence upon the staff member and care of the older adult than the individual constructs themselves. A process that changes one construct of the model will, through feedback loops, affect all other parts of the system.

Areas for Further Reflection and Development

Measuring gerontological competence is a necessity to promote quality care for older patients. There are numerous activities that will enable the on-site educator to evaluate the success of the implementation of any one or all of the strategies of the model. For example, after a workshop, staff are responsible to demonstrate the skills learned on the acute care unit. The on-site educator can observe the staff completing skills such as using assessment tools. However, it is the informal opportunities that arise between the staff member and the older patient or family member that provide the "evaluating moment". Whether the strategy is informally or formally evaluated, the learning of its usefulness is put back into the model. This provides for the continued refinement of the model.

Conclusion

Up to this point in time, relatively few staff members in acute care have pursued competence in gerontological practice. With the challenges experienced within acute care hospitals to provide effective care and the changing demographics in western societies, staff need to view gerontological competence as a professional responsibility. The proposed model offers a way to conceptualize gerontological competence and strategies to enhance that competence. The future of quality care for older patients may well lie in the hands of those responsible for staff development.

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What do Nursing Students Need to Know About Health Education for Older Adults who Live in Canadian Rural Areas?

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ABSTRACT

During the last three decades, the number of older adults over 65 years in Canada has increased significantly whereby one third of them live in rural areas. Because of their unique needs –as older adults living in rural areas, nursing students –as future nurses – are in a unique position to provide health education Programmes that meet their individual health needs. For this reason, this paper addresses what nursing students need to know about health education for older adults who live in Canadian rural areas. Nursing students can play a salient role to educate and raise the awareness regarding rural older adults and their different health issues and can conduct thorough assessments of age related changes and specific social and environmental rural contexts. Before understanding specific assessment and intervention health education strategies, the authors concluded that knowing the following information is very important for nursing students: who are older adults? What are the cognitive and sensory age related changes that they face? What does the term rural areas mean? And, what unique challenges face older adults who live in rural areas? What does health education mean and how does it differ from health promotion?

Key Words: Older Adults, Health Education, Rural Areas, Age Related Changes, Cognitive Changes

During the last three decades, the number of older adults (those 65 years of age and older) in Canada has increased from 2.4 million in 1981 to 4.2 million in 2005, and the number is expected to be 9.8 million at the end of 2036 (Martin, 2012). In 2006, 33 per sent of those older adults were living in rural areas in Canada (Dandy & Bollman, 2008). According to McCracken *et al.* (2005), two factors contributed to increase the percentage of older adults in rural areas: (1) the rural areas are considered attractive and less noisy places for older adults to relax, and (2) the movement of the youth to other places to improve their quality of life (e.g., higher education and better jobs) has increased the relative number of older adults. With age, unfortunately, there is an increased risk of chronic diseases and disabilities; here health education is needed to achieve better health and enhance quality of life (Martin, 2012; Raingruber, 2012). Because of their unique needs –as older adults in a rural setting – health education Programmes have to be designed to meet this demographic' sophisticated health demands. Health education is projected to be one of the most significant nursing roles in the future, therefore nursing students –as future nurses – are in an ideal position to be prepared for this role (Halse, 2014). For this reason, this paper seeks to address the question: what do nursing students need to know about health education for older adults who live in Canadian rural areas?

The above major question will be answered by discussing the following sub-questions: who are older adults? What are the cognitive and sensory age-related changes that they face? What does the term *rural area* mean? And what unique challenges face older adults who live there? What does *health education* mean and how does it differ from health promotion? What do nursing students need to know to assess and intervene in the learning needs of rural older adults? Our conclusion and the implications will be addressed in the final section of this paper.

Who are older adults?

Older adults, elderly people, aged persons, and seniors are different terms found in literature with various definitions and marked ages. For the purpose of this paper, older adults are those people who are 65 years or older. According to Turcotte and Schellenberg (2007),

although *older adults* referred to adults aged 65 and over, there is still no general agreement that 65 is the age at which a human being becomes old. World Health Organization [WHO] (n.d.) acknowledges this issue: the "use of a calendar age to mark the threshold of old age assumes equivalence with biological age, yet at the same time, it is generally accepted that these two are not necessarily synonymous" (WHO, n.d.a). In other words, there are variations in onset and intensity of the age-related changes such physical and social changes among older adults of the same age (Center for Addiction and Mental Health [CAMH], 2010). The understanding of this fact is essential for a nursing student to perform anindividualized health education nursing care plan for each older adult, based upon his or her unique needs, rather than based upon false beliefs or stereotype related to age.

Age stereotyping is not an uncommon phenomenon and it refers to generalized beliefs and judgments about characteristics of older adults (Kruse & Schmitt, 2006). According to Rana and Upton (2009), negative stereotypes about older adults by nurses or nursing students will interrupt the sequences of effective nursing care. For example, if nursing students have a misconception that all older adults are hearing and visually impaired because of their ageing process, without conducting an individualized assessment for each case, then the result will be providing health education using a technique (e.g., speaking up or using large font written material) that is not suitable for all cases and does not meet all older adults' real needs. Therefore, enhancing critical thinking among nursing students and challenging any false beliefs about ageing and older adults is a responsibility of nursing educators. Nursing students have to realize that 65 years of age is not a fixed point for all age-related changes to appear.

Understanding the normal physical and cognitive changes related to age, as well as knowing how to provide effective health education for older adults, are crucial skills for nursing students to develop. Nursing students also need to know how to distinguish between normal and pathological age-related changes. Although normal age-related changes take place to cardiovascular, pulmonary, renal, genito-urinary, oropharyngeal, gastrointestinal, musculoskeletal, and immune systems (Smith & Cotter, 2012), the aim of this section is to briefly discuss the most common normal sensory and cognitive

age-related changes (Cacchione, 2012) that nursing students need to know and be able to assess before providing health education to older adults. The characteristics of these changes experienced by older adults determine the complexity of the health education interventions provided by nursing students.

According to Glisky (2007), memory and attention are the first cognitive aspects influenced and changed by age and may impair language processing, problem-solving, the planning of goal-directed behaviours, the speed of information processing, and decision-making. Whereas working memory, which is a multidimensional cognitive construct that involves active manipulation, reorganization, short term memory, and integration of information to perform complex everyday tasks (e.g., abstract thinking), is impaired by age, the long term or remote memory becomes active and sharper. (Ibid.) elaborated that the normal changes in cognition are not equal among all older adults, but its characteristics are variable from one person to another. Understanding the normal cognitive changes among older adults by nursing students, as well as it underpinning mechanisms, is very important in the assessment and design of health education interventions.

According Glisky (2007), older adults exhibit significant decline in their divided and switching attentions, but not in their sustained attention. The divided attention is needed when two or more tasks have to be performed at the same time or when these tasks need more than one source of information to be accessed. For example, driving a car is a good example of using this kind of attention: older adults need to use different skills and knowledge at the same time. In contrast to divided attention, switching attention is needed when older adults move from one task to another (Verhaeghen & Cerella, 2002). The sustained attention is the third kind of attention; it does not decline or change with age; older adults can focus and concentrate on one task for longer time (Glisky, 2007). Knowing these facts is very significant in the assessment of attention among older adults as well as in the design of health education material for them.

Gradual decline in the sensory system of older adults is one of the normal age-related changes (Schmall, 2000). Hearing loss related to age among older adults not only severs their effective communication and

prevents them from engaging in social interactions with others, but it also contributes to the development of depression, social isolation, and frustration (Schamall, 2000). Visual impairment related to age among older adults influences quality of life by limiting their mobility in the physical environment (Glisky, 2007, Schmall, 2000). Therefore, changes in hearing and vision among older adults are the most important two sensory deficits to be understood and assessed by nursing students, that they may modify the health education and materials to assist older adults to adapt to these deficits.

In a multicultural country like Canada, not only is the number of older adults increasing, but also the diversity of this population is expanding. Therefore, nursing students need to know how to provide a culturally competent and sensitive health education for older adults based on the cultural backgrounds of those older adults. According to Kropf (2003), living within a rural context is one of characteristics that diversify older adults and therefore, in recognition of this diversity, older adults living in rural areas have to be assessed and helped based on their unique needs and challenges. Before discussing the challenges that face older adults who live in rural areas, let us discuss what the term *rural area* means.

What does *rural area* mean?

Although there is no universal consensus on what *rural area* means, for the purpose of this paper rural area can be defined as: those living outside the zone of a larger urban centre (the urban setting possessinga population of 1,000 or more); this area is distinguished by its restricted infrastructure and economic resources with low level of services (du Plessis *et al.*, 2001; Kulig *et al.*, 2008; Romanow, 2002). Health in rural areas is an area of concern because there are many health determinants that put those people who live in these areas, including older adults, at risk. For example, limited resources, lower income, less formal education, poorer lifestyle behaviours and higher occurrence of chronic disease, limited access to health care professionals and facilities, and increased expenses related to healthcare travel lead to a lower health status for rural populationscompared with their urban counterparts (Romanow, 2002; DesMeules *et al.*, 2006; Kulig & Williams, 2011). A thorough knowledge of these

determinants by nursing students is the first step in providing effective health education intervention. However, in order to empower nursing students to take an active role in health education for older adults who live in rural areas, material on the unique challenges that face older adults who live in rural areas needs to be included in undergraduate nursing Programmes,

What unique challenges face older adults who live in rural areas?

Age is no respecter of location! Older adults who live in rural areas experience the same stereotyping and physiological changes of ageing that are experienced by their counterparts in other settings. For example, older adults in rural areas–like other older adults in Northern America are stereotyped for some issues related to their age such as: older adults are all alike, they are all lonely and depressed, they dependent upon others, have cognitive impairment, have difficult personalities, and cannot cope with age-related changes (Cooley *et al.*, 1998). Cooley *et al.* (1998) advocated that: older adults are diverse and not a homogenous group. As such, they may have many social ties and have family close by, they often have lower rates of depression than younger adults, and most of them live independently. Although some cognitive abilities may decline with age, it does not mean that older adults cannot manage their daily living activities by themselves. Often, their personality does not change with age, and a high percentage of older adults cope very effectively with age related changes and challenges. However, although rural older adults are experiencing the same stereotyping and age related changes as other older adults who live elsewhere, rural older adults may still experience challenges in addressing physiological changes due to their geographical location, as will be shown next (Lyons, 2004).

Although there are many advantages (e.g., fresh air, peaceful life) for older adults to live in rural areas, many challenges face them that may hamper their quality of life and influence their health outcomes (Davy, 2011; Kelly & MacLean, 1997; National Advisory Council on Aging, 1999). For example, rural areas, in contrast to urban areas, have limited public transportation that serves a wide radius of area, and may have an inconsistent and inconvenient schedule. This will influence the mobility of older adults, especially if they are not allowed to drive

because health reasons. Older adults in rural areas have limited access to health, professional, and commercial services and amenities and they have lower of formal education. They often have less social and family support because most of their children generation migrates to urban centres for better education and jobs. Because of their low income status, they have lower quality of housing, less affordable food options, and cannot travel to seek specialized health and social services. A lack of wide, smooth green areas for exercise, as well as the unavailability of sidewalks for walking and street lighting are considered barriers for rural older adults to be physical active.

Therefore, all above mentioned demographic, social, and geographical challenges, as well as, stereotyping related to age have to be taken in consideration by nursing students when designing health education interventions for rural older adults. Special consideration has to be given by nursing students to First Nation older adults and immigrant older adults from different cultures who live rurally by conducting in-depth assessments of the barriers and challenges (e.g., language barriers, and lack of culturally sensitive health care) faced by each older individual.

Because of the aforementioned challenges that place older adults at higher risk for diseases and disabilities, health education and health promotion play a salient role in reducing the mortality and morbidity of rural older adults and enhancing their quality of life. Although the terms health education and health promotion are used interchangeably within the literature, nursing students need to know they are completely different strategies (Raingruber, 2012), as will be discussed next.

What does health education mean and how it differs from health promotion?

Health promotion is one of most significant roles assumed by nurses. The American Nurses Association defined nursing as: "the protection, promotion, and optimization of health and abilities, prevention of illness and injury, alleviation of suffering through the diagnosis and treatment of human response, and advocacy in the care of individuals, families, communities, and populations" (n.d). Based on this definition, Raingruber (2012) considered health promotion as an

umbrella strategy that focuses on socioeconomic and environmental health determinants, while health education is a narrow activity and an integral part of health promotion. Whereas the aim of health promotion is to empower people to participate in the functioning of individual and community life, policy-making, and the enactment of social justice (Cohen, 2012, see chapter 6 community health), the aim of health education is to enable people to make informed decisions about their health and lifestyle behaviours by giving information and teaching individuals and communities (Dallas & Neville, 2012, Raingruber, 2012). Therefore, health education is defined as "any combination of learning experiences designed to help individuals and communities improve their health, by increasing their knowledge or influencing their attitudes" (WHO, n.d.b).

Nursing students can play a significant role by using their skills and knowledge to assess learning needs for rural older adults and provide them with an educational intervention to raise their understanding on a particular health issue or to challenge their self-imposed beliefs in order to improve their health status. Assessing the learning needs and health teaching techniques for rural older adults by nursing students will be discussed next.

Unquestionably, nursing students today are playing a noteworthy role in providing care and health education within their scope of competence to an increasingly diverse population of older adults who are experiencing various levels of physiological changes and challenges. To successfully assess and intervene in relation to the learning needs of rural older adults, nursing students need to know the following strategies that were retrieved and adapted from the *APA Guidelines for Psychological Practice with Older Adults* (American Psychological Association [APA], 2013):

1.   Know and treat older adults with respect, dignity, equity and welfare whatever their cultural or socio-demographic status is. Nursing students have to assess and provide health education to rural older adults in an ethical and legal manner based on human and nursing codes of ethics.

2.   Have an indepth understanding of all age related changes such as cognitive and memory changes, as well as hearing and visual

changes among rural older adults and build health education interventions that are compatible with these changes.

3. Understand that rural older adults are a diverse group in regards to the onset and severity of age related changes and regarding health determinants, such as socio-cultural urban/rural residence, facilities and geographical areas, language, and history that may influence their ageing experience. Nursing students need to take all these factors and health determinants in consideration when assessing and providing health education to the rural older adults.

4. Be knowledgeable with practical and theoretical nursing gerontology, as well as with culturally sensitive assessment tools to assess rural older adults' specific characteristics, contexts, and health needs.

5. Nursing students should familiarize themselves with factors unique to each rural environment so that modifications can be made to successfully implement health education that meets the health needs of those population. For example, with limited resources in rural areas, nursing students can use their critical thinking to modify the method of providing health education for rural adults using all possible alternatives in rural settings. Nursing students have to be aware and consult with all community resources, services, agencies, as well as, with other disciplines for help.

Conclusion and Implications

As the health care system has become more complicated with nursing shortages and increasing numbers of older adults, investing in nursing students to take a role in health education for rural older adults is not only necessary, it is imperative. Nursing students can play a salient role to educate and raise the consciousness of rural older adults about various health issues, by first taking conducting a thorough assessment of age related changes and specific social and environmental rural contexts. Before carrying out specific assessments and intervention health education strategies, the authors assumed that knowing the following facts are vital for nursing students to know: who are older adults? What are the cognitive and sensory age related changes that they face? What does the term *rural areas* mean? And,

what are the unique challenges faced older adults who live in specific rural areas? What does health education mean and how does it differ from health promotion?

The goal of this paper was to answer the question: what do nursing students need to know about health education for older adults who live in Canadian rural areas? Knowing how to assess and provide health education with specific protocols and strategies will help nursing students to choose various evidence-based protocols that fit with their assessment and meet the needs of rural older adults.

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Building Global Capacity for Better Health Through Increased Gerontology Content in Undergraduate Nursing Education Curriculum: A Commentary

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ABSTRACT

Ageing is a phenomenon found not only in westernized countries, but throughout the world. And yet, many nurses are not effectively prepared to care for aging individuals. As such, nurse educators across the globe need a unified approach to educating students to provide care of their aging clients. There needs to be increased gerontological content in undergraduate nursing programmes globally, as well as other strategies put into place to enhance the knowledge and skills of future nurses to care for aging individuals in all parts of the world.

Key words: Undergraduate nursing education, Curriculum, Ageing

It is evident that there is a global phenomenon of population ageing. The world population is growing older and living longer. We are experiencing not just an increase in the number of the aged, but also an increasing proportion of elderly people within populations. The good news is that population ageing is no longer a phenomenon attributed to the developed countries of the world alone; developing countries like China, Mexico, Jamaica, India and many others are also recording accelerated growth in the numbers and proportions of the elderly among their populations (Ingman *et al.*, 2010). The fastest growing age groups both in most developed and developing countries

consists of individuals fondly referred to as "seniors", aged 55–65. It has been projected that the number of people aged 60 and above will reach 1 billion by the year 2020 and almost 2 billion by 2050 "representing about 22 per cent of the world's population (Lutz *et al.,* 2008). According to Lutz *et al.*, individuals aged 80 and above are projected to grow from 1 per cent to 4 per cent of the global population between 2011 and 2050. The National Institute on Ageing (NIA, 2013) calculated the number of years it will take for individuals aged 65 and above to increase from 7 per cent to 14 per cent of the population in many developing and developed countries and found that the trajectory is downwards, albeit at differing rates in developed countries like France, Sweden, Australia, Us and developing countries such as Azerbaijan, Chile, China, Jamaica, and Sri Lanka among many others.

Map 1
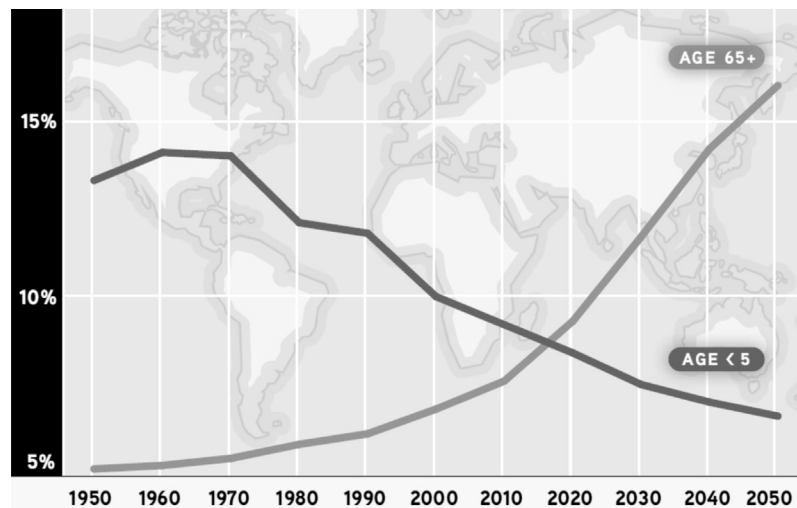
Source: United Nations Department of Economic and Social Affairs, Population Division, *World Population Prospects. The 2004 Revision.* New York: United Nations, 2005.

The explosion in the growth of the elderly segment of the population is a success story and one of the crowning achievements of mankind in the last century. It is a testament to the improved public health care and technology, improved socio-economic status, availability of improved drugs and medical advancements, and the reduced incidence of communicable diseases. This landmark achievement also

presents unique challenges to the health care system and social institutions across the globe. The World Health Organization (WHO, 2002), noted that population ageing is increasing pressure on all aspects of the health care continuum, from health promotion, to disease prevention, and long term and palliative care. There is an ongoing consequential increase in the rates of chronic diseases, disabilities, and other conditions made worse by advancing age such as degenerative conditions. This has led to a growing call for the health care community to introduce reforms both in education and practice in anticipation of these challenges and to better prepare and equip practitioners with the skills necessary to "respond to the needs and demands that will ensue from this demographic shift to an older society" (Ingman *et al.*, 2010, p. 395).

In this commentary, I argue for a unified emphasis and a deliberate effort on nurse educators to ensure increased gerontology content in undergraduate nursing educational programmes across the globe in order to better prepare nurses for the challenges at hand, build capacity for improved health care to the ageing population, and for a more responsive health care systems all over the world.

Global societies are facing a crisis of "lack of adequately trained and emotionally oriented personnel to work with ageing persons in all fields, especially health and human services" (Lun 2011, p. 1). Registered nurses are acknowledged to be at the centre of health care services all over the world and constitute the front line staff in most health care organizations. The anticipated outcome of the increasing ageing population across the globe is that schools of nursing globally will recognize that nursing the older adult will be a major part of the job nurses do, both during university practicum placements and after graduation as professionals (Berman *et al.*, 2005, Hirst, *et al.*, 2012; Rosenfeld *et al.*, 1999). Population ageing will force Registered Nurses to utilize gerontological competencies in order to be successful and make the greatest impact in their professional practices. Unfortunately, there are discrepancies in the amount of gerontology content across the curricular of most undergraduate nursing education programmes across the globe. It is the responsibility therefore of the the "nursing community to ensure that every nurse graduating from a baccalaureate programme has a defined level of competencies in the care of the elderly" (Rosenfeld *et al.,* p. 84). This calls for a deliberate and systematic effort to institute educational initiatives that are

intended to influence nursing practice in order to enable positive change, recognition and valuing of gerontological practice in nursing and positive attitudes towards the elderly client

Before adjustments are made on health policies related to manpower, it is recommended that a careful assessment of current and projected workforce including the proper ratios of health care workers to older adults in a particular population be the beginning of possible changes to better prepare for the challenges ahead. Health care reforms all over the world must have to take into consideration the resourcing of services in order to meet the care needs of the increasing number of older citizens, and this will include embedded training in gerontology for health care practitioners, especially Registered nurses. Gerontological nursing has been defined as a health service that incorporates generic nursing methods and specialized knowledge about ageing and the aged in order to establish conditions both within the client and the environment that will improve health behaviours of the aged, compensate for the health related losses resulting from ageing, enable comfort through the disabling events of ageing, and facilitate diagnosis, treatment, and palliation of diseases in the aged (Lach 2007).

In spite of the increased need for nurses practicing in this field, gerontological nursing is not a popular choice among practicing nurses (Happell, 1999; Slevin, 1991) because often nurses lack adequate systematic preparation to care for older adults. Research on student nurses attitudes and lack of interest towards ageing and this population abound in literature (Goncalves, 2009, Joyner & DeHope, 2000; McCleary *et al.*, 2009; Mckinley and Cowan, 2003). It is not clear what specifically determines the lack of interest among students on this specialization, but some have suggested ageism (Holroyd *et al.*, 2009), health care systems (McLaffety & Morrison, 2004), or inadequate knowledge and practice in positive environments (Ferrario et al, 2008). Ageism encompasses a complex set of social values and attitudes that influences older adult's position in the society and actually "retards recruitment of health care professionals to work with older adults" (Ibid.). Ageism manifests in a variety of ways such as unskilled labour, less attractive working environments and conditions for those caring for this population, under resourced services, and unappealing career structures for health care professionals. Other studies have tried to determine whether students knowledge and attitudes-positive and negative, impact their career choices and ability to work with older

adults (Cohen et al., 2004; Heuberger & Stanczak, 2004; Kimuna *et al.*, 2005; Lun, 2011).

Negative attitudes about ageing and the older adult may also influence curricular based solely on the medical paradigms as obtainable in most countries across the globe. With this, nursing students may therefore develop negative attitudes that prevent them from pursuing interest in the care of older adults. According to Cottle and Glover, (2007), ageism among students extend even beyond graduation as they continue to form their own opinions independent of any new knowledge gained during course work. Ferrario *et al.,* (2008) citing various authors suggested four conditions that might improve student nurses attitudes and beliefs towards working with older adults, these include; "emphasizing normal changes and positive aspects of ageing, training as much faculty as specialists in gerontological nursing, placing experiences with well older adults early in the curriculum and requiring course work and clinical experiences with well community living older adults" (p. 58).

In many instances, analysis of nursing curricular have indicated that the gerontology content in nursing education curricular in different countries is inadequate and has resulted in the graduation of nurses who are often less prepared to provide the specialized and complex care needed for the growing elderly population (Baumbusch & Andrusyszyn, 2002; Fagerberg & Gilje, 2007; Rosenfeld *et al.,* 1999, Hirst, *et al.*, 2012). Several factors have been identified as contributing to the lack of attention given to gerontology in undergraduate nursing curriculum. These include; lack of specificity in testing knowledge related to gerontology in nursing licensing exams, an overload of nursing curriculum, lack of interest among faculty and students with working with the elderly population, no consensus as to what specific knowledge related to gerontology do nurses need, inadequate clinical experiences in gerontology and lack of academic resourses (Abbey *et al.,* 2006, Mossop & Wilkinson, 2006). In order to deliver high quality care to the ageing populations across the globe, nurses must receive educational preparation in gerontology nursing and acquire the necessary competencies required to care for the elderly, both in health and illness.

The very little geriatric training and exposure of the nursing care workforce encourages stigma and other negative attitudes towards the

elderly population and becomes an impediment for nurses to pursue this specific line of specialization and practice after graduation. Although recent research reveals that a greater number of nursing students still hold negative attitudes towards older adults and are disinterested in working with older adults upon graduation (Holroyd *et al.*, 2009; McCleary *et al.*, 2009), it is noteworthy that students attitudes are not homogenous and are subject to change depending on their learning environments (Hirst, *et al.*, 2012). It is a well known fact that the learning resources and opportunities that are provided in nursing curricular have the potential to positively or negatively impact attitudes towards older adults and their care (Williams, *et al.,* 2007). According to Von Dras and Lor-Vang (2004), a single learning activity about ageing can significantly improve students' attitudes towards the elderly, and influence their career choice after graduation. Lee and Waites, (2006) argue that an infusion of gerontological content into BN programmes will lead to enhanced students attitudes towards older adults as well as improved knowledge. Strategically increasing gerontological content in nursing education curricular across the globe might be challenging, when we consider increased technological advances and complexity in diversity of health care needs and priorities and the other significant amount of new content competing for inclusion in BN programmes, but Baumbusch and Andrusyszyn (2002), insists that increasing the gerontology content in nursing education curriculum will go a long way to improve the global capacity for confronting the consequences of the increasing ageing population.

A prescription for the appropriate amount of gerontology content and how specifically this can be achieved in undergraduate nursing education curriculum globally is beyond the scope of this commentary, but as Perkinson (2013) aptly cautioned, "it is important to recognize that our westernized, medicalized model of gerontology and geriatric education should not be transferred intact on a global level" (p. 2). Considerations must be given to regional and cultural differences in different parts of the world when considering the appropriate gerontological content in nursing education curriculum. According to Deschodt *et al.* (2009), "a minimum standard curriculum and specific competencies for care of the older people should be formulated for all baccalaureate nursing Education programmes" (p. 139). Differing opinions exist on whether an integrated curriculum or

stand alone gerontological courses is the best way to go in expanding the gerontological content of nursing curricula. In different parts of the globe, considerable work has been done to enhance the gerontology content of some nursing programmes.

According to Rosenfeld *et al.* (1999), exemplary practices in institutions with adequate amount of gerontology in the curriculum were influenced by factors such as, offering stand-alone courses in gerontology, have two or more clinical placements that focus specifically on gerontological nursing, offering an advanced practice degree in gerontology, having at least 1 full time faculty with specialty and certification in gerontology, and having a center for ageing within the institution. Wallace *et al.* (2006) constructed a programme to highlight what theoretical knowledge base and clinical practice specification that best suites the care of the elderly. According to Wallace *et al.,* (2006) such knowledge must include theories of ageing, common geriatric problems, assessment protocols, normal versus abnormal ageing, and best practices in gerontological nursing.

Currently, there is a growing shift towards integration of gerontologyin nursing curricular (Berman *et al.,* 2006), but this effort has not grown in relation to the need and is at best disjointed with a non-uniform approach from institution to institution and from country to country. In the United States, through the work of The American Association of Colleges of Nursing (AACN) and the John A Hartford Foundation, "care of the elderly adult" competencies have been integrated in nursing programmes curricular and implemented in more than 30 schools of nursing with huge successes (AACN, 2000). Other descriptive studies on approaches to incorporate and enhance the gerontology content of nursing educational curriculum have been suggested by several authors (Aud *et al.*, 2006; Barba & Gendler, 2006; Blais *et al.*, 2006;Hancock et al., 2006; Latimar & Thornlow, 2006; Wendt, 2003). What is not clear is what is happening in other parts of the world and it is suggested that Nursing Education programmes in these countries understudy these successes and adapt as necessary.

Other recommendations and best practice models that have been suggested include:

1. The inclusion of innovative learning techniques such as the use of the internet and gerontology training websites (Von Dras & Lor-Vang, 2004)

2. One on one mentoring of nursing students by elderly clients in order to achieve student learning outcomes (Brown *et al.*, 2007;MacDonald & Gallant, 2007; Ryan *et al.*, 2007).

3. The use of gerontological learning modules across the curriculum or as a stand – alone course

4. Building capacity among nursing faculty and increasing certification in gerontology nursing among faculty (Earthy, 1993; Fradkin *et al.*, 1999; Latimer *et al.*, 2006; Mclafferty & Morrison, 2004).

5. A required course on gerontology nursing that have both seminar and practicum components for all nursing students (Berman *et al.*, 2005)

Conclusion

Nurses are key providers of care to the older adult, both in acute centers, institutions and in the community as in the home. Nurses practicing with the older adult take a holistic approach to caring and are concerned with health preservation, prevention of illness and cure. Therefore gerontological nursing interventions are based on a unique set of knowledge, directed towards enabling the elderly achieve independence, optimize their rehabilitation potential, minimize disability, and provide supportive care till the end of life. Lun (2011) concludes that when students are exposed to older populations – and otherwise obtain gerontological knowledge about this growing population, it will increase their competency level in practice" (p. 9) and this is exactly what we need to build capacity for better global health in the face of an aging population.

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Theories-guided Research for Health Policy with Ageing Populations

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ABSTRACT

Atlantic Canada is rapidly ageing and is ageing faster than other regions in Canada. Social determinants of health, such as housing, are becoming an issue as Baby Boomers reach the age of retirement. Within this paper, the Atlantic Seniors Housing Research Alliance is discussed.

Key words: Ageing, Social determinants of health, Housing Health policy

Canada is recognized as a young and affluent country, a land of health and opportunity and, for the most part, this is a fair observation. Some regions and populations within the country, however, are ageing faster than others. The four Atlantic provinces are a case in point, where housing, care and services have become a funding issue that needs to be addressed by all provinces and territories as Baby Boomers reach retirement. As a western liberal democracy, Canada redistributes income to the provinces and territories to publicly finance health care services for approximately 70 per cent of the provincial health care dollars (Canadian Institute for Health Information, May 2013). Health Canada is responsible to the Federal Government to oversee a number of national roles and responsibilities

including the Public Health Agency of Canada that is charged with health promotion and illness prevention.

Although the social determinants of health (SDH) are part of Health Canada's mandate, much of health and illness prevention is historically practiced as 'downstream' rather than "upstream health promotion" (Public Health Agency of Canada, n.d.). As birth rates drop and some regions in Canada age, particularly in eastern Canada and the prairie provinces, population ageing is emerging as a national issue in Canada. The concept of 'ageing across the lifespan'(Lerner, *et al.*, 2012) has re-opened the door to the issues of social determinants of health across all sectors, policy development and the role of the community in decision-making, to name just a few pledges from the Rio Political Declaration (World Health Organization, October 21, 2011). The role of the Public Health Agency of Canada has expanded to introduce and measure the ongoing state of health equity for all populations and ages across Canada. Likewise, the Federal Government has begun age-targeted funding to the Canadian Institute for Health Research (CIHR) and to the Social Sciences and Humanities Research Council of Canada (SSHRC). As retrospective interpretation (Thorne, 1994), new health related questions are expected to more thoroughly examine a qualitative analysis. Therefore, researchers need to understand and appreciate the depth of the study before undertaking secondary data analysis for the Atlantic Seniors Housing Research Alliance (ASHRA) study and five ageing populations.

ASHRA Study (2005–2010): Source of the Secondary Data Analysis

The 5-year Community University Research Alliance (CURA) funded research initiative was undertaken: *Projecting the Housing Needs of Aging Atlantic Canadians,* and funded by SSHRC (2005–2010). The alliance was initiated in 2004, encompassing the four Atlantic provinces and represented 7 universities, seniors' and other community-based organizations, housing developers, service providers, and government departments. From this diverse group of university researchers, community partners, and stakeholders, the Atlantic Seniors Housing Research Alliance (ASHRA) was formed (Report on

the Atlantic Seniors' Housing and Support Services Survey, 2007). The ASHRA goal was to carry out amixed methods study in four very distinct Atlantic provinces: Newfoundland & Labrador, New Brunswick, Nova Scotia, and Prince Edward Island. Going into the study, policy needs of some populations were clearly evident to the researchers. Canadian Aboriginal populations, for example, are "at the bottom of almost every available index of socioeconomic well-being, whether [they] are measuring educational levels, employment oppor- tunities, housing conditions, per capita incomes or any of the other conditions that give non-Aboriginal Canadians one of the highest standards of living in the world" (Report on the Royal Commission on Aboriginal Peoples, 1996).

ASHRA Study Questions

The Atlantic Seniors' Housing Research Alliance (ASHRA) was designed as a 4-part study. The questions asked of Atlantic Canadian seniors were:

1. What will the housing needs of Atlantic Canadians be over the next 20 years?

2. What housing options, support services, and policies should be developed to meet these needs? (Report on the Atlantic Seniors' Housing and Support Services Survey, 2007, p.13).

The quantitative randomized control trial (RTC) survey was designed to collect information about housing and support needs from seniors aged 65 and over. The 5-year study began with the collective efforts of a research alliance initiative in 2004, encompassing all four Atlantic provinces and represented universities, seniors' and commu- nity-based organizations, housing developers, service providers, and government departments. The numbers continued to grow by the alliance members' efforts to reach out and develop relationships with other organizations and individuals interested in seniors' housing and support issues. Participant members more than doubled over the length of the 5-year study and many continue to actively engage other sectors (Report on the Atlantic Seniors' Housing and Support Services Survey, 2007). As a result of the alliance and relationship building throughout the 4 provinces, 1702 of 2200 seniors responded to the RCT survey. Alliances with the communities further provided access

to five specific groups whose socio-economic and cultural contexts meant they were unlikely to participate in the survey. And it is secondary data from this group that researchers will analyze.

The ASHRA alliance as a partnership illustrated the intent shown by Minkler and Wallerstein (2008) for relationship building leading tomeasureable dimensions in Community-Based Participatory Research for Health (Minkler & Wallerstein, 2008). Using community-based participatory research, researchers in western Canada have studied healthy ageing in place, utilizing the healthy ageing insights of older adults in rural communities (Bacsu, *et al.*, 2014). In her doctoral planning study of seniors in the province of Ontario, Cruttenden (1996) used moral political theories to evaluate a delivery system: the use of information as a fairness/equity network to evaluate an integrated delivery system. Why are the Canadian studies so critical? Let us return again to the Rio Political Declaration on social determinants of health (WHO, October, 2011) that recognizes global "health equity as a shared responsibility and requires the engagement of all sectors of government, segments of society, all members of the international community in an 'all for equity' and 'health for all' global action (p. 1). Canada, with Public Health as the signee, has agreed to the WHO Rio Declaration.

Secondary Data Analysis

Trustworthy researchers and their data collection procedures are critical for secondary data analysis, as stated above (Thorne, 1994). In this secondary data analysis, focus group actions and qualitative data will be analyzed from the ASHRA study. Stakeholders, community partners, students and researchers formed the Focus Group Working Group (FGWG). In turn, the FGWG identified 5 populations that were under-represented in the quantitative survey. Members of the 5 populations and their day-to-day housing and support experiences needed to be heard for equitable seniors' housing and supports. The 5 populations totaled 123 older adults, including Aboriginal, disabled, francophone, multicultural, and rural/remote seniors living throughout Atlantic Canada. FGWG members designed and implemented focus group procedures based on Morgan and Krueger (1998), including the moderators' guide to ask questions of participants

residing in the Atlantic provinces. (See Appendix D: Guide for community focus group moderators.) The FGW Ginvolved communities in the 4 provinces to locate possible focus group participants for each of the 5 populations. (See Appendix B: Focus Group Consent Form.) Researchers were not involved in locating the participants and relied on the FGWG to locate and invite study participants.

Confidentiality is and must be maintained in accordance with Canada's Tri-Council Policy Statement on Ethical Conduct for Research Involving Humans (2010). To maintain privacy, the first moderator question was designed to introduce participants to the moderator and to each other. Names of moderators and participants do not appear on the transcripts. Comparisons of the survey and focus group participants were distinct and support our questions below. Honouring survey and focus group participants' identities were critical to the study as a whole. ASHRA surveys were destroyed following data analysis by Maritime Data Centre (MSVU). Focus group survey data were similarly destroyed, and the data are stored on discs in a locked, metal cabinet in the researcher's private office.

Social Determinants of Health (SDH) to Define Evidence-based Policy and Practice for Five Populations

Methodology: Interpretive Descriptive by Thorne (2008) will be used in this secondary analysis of focus group data for 123 participants within five populations, along with policy papers and media commentary. The researcher and analysts bring their expertise to the analysis, being three gerontological nurses (educators and researchers), and a sociologist, whose focus is Gerontology and Demography Research analysis. Moreover, the voices of study participants are clearly heard and woven into the analysis to ultimately reflect health equity.

The questions the researchers are asking in this secondary data analysis include:

- How would the social determinants influence health equity as 'fairness' among each of the 5 focus group populations?
- Based on measurements of the SDH, will the 5-population analysis lead to active engagement inolder adults within their communities?

- What educative supports are needed to achieve health promotion/illness prevention, in order to maintain and support resilience?

Conclusion

Findings from this analysis of the social determinants of health with 5 identified populations will be the foundation for a theory-based study. Use of Knowledge Translation/Knowledge Exchange will support participants' voices throughout the following analysis to create policy and practice grounded on the social determinants of health for equity as health promotion and resilience among at-risk, ageing Canadians.

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Me and My Shadow: Interprofessional Training in and Modeling of Spiritual Care in the Palliative Setting

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ABSTRACT

Providing spiritual care to older adults who are dying is a crucial aspect of caring for individuals in their final days. However, spiritual care is often not understood. What is spiritual care and how can professionals be taught to provide spiritual care for their aeging patients who are dying? Within this paper, I discuss what spiritual care is, how it can be taught to professionals from varied disciplines working in a palliative care situation, and in particular, focus upon the role of shadowing as a form of teaching and mentoring.

Key words: Spiritual care, Dying, Palliative care

Me and my shadow
Strolling down the avenue
Me and my shadow
Not a soul to tell our troubles to ... (AZ Lyrics)

In a palliative setting, the need for spiritual care cannot be over-emphasized. Death – the anticipation and then experience of – is understood to be profoundly spiritual for older adults! Hence, adults often become more sensitive to spirituality as they grow old (Meraviglia, *et al.*, 2008). Many palliative patients (the bulk of these patients being elderly) have spiritual needs and want these addressed

(Dombeck, 1998; Dwyer, *et al.*, 2008; Sinclair *et al.*, 2006). Ultimate end questions – *what is the meaning to life? What happens after I die? Has my life mattered?* – abound. Unresolved issues – disconnection with self, with others, and with God, can also affect dying people. They often need assistance in forgiving self and others; they may need aid in receiving forgiveness from others and/or God. Spiritual pain can exacerbate physical pain; the term coined by Dame Cicely Saunders "total pain" applies here. At times, physical pain that does not respond to analgesics needs to be explored at deeper, soul levels.

How do we teach health professionals to understand and meet the soul needs in older adults, in colleagues, and in themselves? The above quote from the famous song recorded by many popular singers of the 1900s, including Judy Garland, speaks of the distress that one feels with "not a soul to tell our troubles to." In the discipline of palliative care, all members of the interprofessional team can feel a sense of "soul aloneness" – in their patients, sometimes in one another, and in the self (Dombeck, 1998); this form of spiritual dis-ease can present itself in the form of feelings of inadequacy or despair (Sinclair, Raffin, *et al.*, 2006). Besides working directly with dying patients (including older adults) and their families, a key challenge of the Spiritual Care team within a palliative care setting is to nurture the "collective soul" of the interprofessional team (Ibid.) and to work with individuals on that team in their areas of soul need (McClung, Grossoehme &Jacobson, 2006). Shadowing – a subset of mentoring – can be one way of doing this.

Within this article focus on the role of the chaplain in educating the interprofessional team about the importance of spiritual care in the palliative setting; more specifically, focus upon the importance of shadowing as a means to mentor professionals on the team. To begin with, I suggest what spiritual care is and is not, and provide rationale for why understanding spiritual care is important for those on the interprofessional team. I then briefly present a literature review addressing the role of chaplains in educating the interprofessional team; specifically, I address two major approaches to teaching spiritual care. I will discuss the strengths and weaknesses of these approaches, as well as gaps in the literature. Next, I will consider both formal and informal ways of teaching staff what spiritual care is, how it is done,

affirming the abilities of these staff members to care in spiritual ways, and to support staff members in their own spiritual/existential struggles. In particular, the role of mentoring (with the subset of "shadowing") will be highlighted. This discussion is largely based upon my experiences of providing and teaching spiritual care within a palliative setting. Finally, I conclude with recommendations to those who both provide spiritual care for their colleagues and educate them in providing spiritual care for patients.

What is spiritual care?

While a palliative setting is widely understood to arouse within patients existential issues (Dombeck, 1998; Lane, *et al.*, 2013), there is often limited understanding of what spiritual care in palliative settings involves. Many understand spiritual care to be "religious" care – to say a prayer, read a religious text, or sing a hymn. Others feel that spiritual care is simply holding the hand of the dying individual. In understanding the practice of spiritual care, it is important to delineate and distinguish between religion and spirituality.

Spirituality and religion are related, but are not synonymous. In the last 20 years, many researchers have distinguished between the two (Benner *et al.*, 2004; Hawley, 1993; McKernan, 2005; Wright, 2005). Briefly, religious faith is structured, generally involves a group of people (community), and includes a standardized set of beliefs, code of conduct and practices. Rituals and practices for the transitions of life – including dying – are included. Spirituality tends to be less structured and is more private in nature. Individual beliefs vary widely; however, those beliefs common to all religions – kindness, charity, etc – are typically included. Spirituality involves "an awareness of relationships with all creation, an appreciation of presence and purpose that includes a sense of meaning" (Vande Creek & Burton, 2002, p.2). Religious practice is one way of understanding and expressing one's spirituality (Benner *et al.*, 2004; Hamilton, 1998; Mount, 1993). Using this framework, religious practice is one aspect of the expression of spirit, of spirituality. "Religion, at its best, provides a home for the nourishment and development of the spiritual life" (Wright, 2005, p. 5).

As the spirit can be understood as the non-corporeal aspects of personhood (Lane *et al*., 2013), caring for the older adult's *passion*, *soul*,and *essence* involves supporting that individual in what is most important to him. It is the affirmation of personhood (Hirst, Lane & Reed, 2013). This can involve both religious and non-religious interventions. A very helpful understanding of the expression of the spirit – spirituality – is the concept of *connection* – with self, with others, and with the Transcendent (Walsh, 1999; Weingarten, 1999). Spiritual care facilitates this. So the chaplain – or other professional providing spiritual care – attends to the soul needs of the dying older adult. For the patient who is feeling lonely, this may involve the presence of one sitting beside her, and perhaps a hand held.

For another dying older adult, spiritual care may involve discussing the older adult's past experiences, affirming that which is praise worthy, providing a listening ear for those aspects that were painful, and providing interventions when there are specific needs to be met. The older adult may need to ask forgiveness – of God or another. Or this individual may need help in forgiving herself. Religious rites may facilitate this.

The foundation of spiritual care is respect – respect for the person being cared for, and providing the care that the dying individual desires. It involves intuition, discernment, and wisdom and humility in understanding the needs of dying people and being able to meet them in the sacred places of their lives. It truly is a spirit (of the professional) to spirit (of the patient) connection. In speaking of nurses providing spiritual care, Pittroff (2013) elucidated this beautifully: "The humbled expert nurses...embody spiritual skills of caring that include presence, courage, silence, touch, nonjudgment, and empathy for patients and their families" (p. 169).

Why mentoring of professionals in spiritual care is important?

Professionals providing palliative care to patients, such as older adults, often do not understand what spiritual care entails. They may feel uncomfortable in the concept or in how to provide such care. Similarly, students preparing for the helping professions generally do not receive significant training and experience in spiritual care or palliative care. They bring into their subsequent work environment

the general skills garnered in their disciplines – whether nursing, medicine, social work or ministry. But the distinct philosophy of palliative care, the understanding of spirituality within such a particular setting, as well as personal and corporate practices used to not simply survive, but thrive, have to be learned as well as absorbed. The education of palliative care staff in the role/experience of spiritual care is essential for the care of the dying adults and their families. It also is essential in the well-being of staff members.

Literature Review

In order to situate my experiences within the context of the literature, a review was conducted. I utilized the CINAHL database, using the following search terms: *end-of-life*, *palliative*, *spiritual care* and *mentorship*. The search yielded thirteen articles, which commonly spoke of the growing volume of literature in academia in the area of spiritual care in medicine, particularly since the 1990s (Dombeck, 1998). In American studies, the value of spiritual care within health care settings has been established: those patients receiving spiritual care in hospitals have shorter stays, do better when they go home, and, are less likely to launch lawsuits (McClung *et al*., 2006).

Broadly speaking, the literature revealed the value of spiritual care,[1] but a generalized lack of confidence within non-pastoral health care staff in providing it. Doctors, nurses, social workers and psychologists are afraid of "making a mistake," (Ibkd., 2006), feel uncomfortable asking questions in this area and report being ill prepared to receive the answers (Sinclair *et al*., 2006). Staff members may also not know what they believe themselves, and so struggle to help others (Dombeck, 1998). The literature that proposed the need for interprofessional education in a palliative setting is limited. Pittroff (2013) spoke of the "paucity" of research in spiritual care in the in-patient setting for end-of-life care. In the volume of literature regarding actual plans to educate staff about the value of spiritual care, doing a spiritual assessment, accessing chaplains, and providing some spiritual care themselves, the dearth is even greater. Five of the 13 articles did not involve spiritual care *and* adult palliative care (Carey & Weissman, 2010; Kassam, *et al.*, 2013; McClung *et al*., 2006; Sasahara, *et al.*, 2005; Vosit-Steller, Morse & Mitrea, 2011). Sadly, none of the

thirteen articles solely dealt with palliative care and spiritual care in the context of older adulthood. It is evident from this search that there are 2 major approaches to teaching spiritual care to members of interprofessional teams in palliative care: a structured approach and a less structured approach.

Structured Approach

A structured approach to educating members of the interprofessional palliative care team involves more formalized programmes. These programmes can be specific to one profession, be geared to all members of the interprofessional team, or be specific to a unique kind of palliative care setting.

For instance, several authors discussed programmes specifically to educate physicians in palliative care. Marr, *e al.,* (2007) addressed the growing recognition of the need for spirituality training for palliative fellows, but stated, in this American study, that there is not a "robust" way of providing this type of education and evaluating whether objectives are met (p. 169). They advocated a programme that has similarities to Clinical Pastoral Education (for professional chaplains); this programme has a strong knowledge component, but also would use experiential methods of developing physicians' understanding of and appreciation for spirituality; utilizing chaplains to teach the fellows, as well as opportunity to shadow chaplains, is involved.

A unique programme called *Education for Physicians in End-of-Life Care* (EPEC) (Bodek, 2013) was originally conceived after 9/11 in New York. The initial intent was to bring nurses, social workers and chaplains together, to educate physicians regarding end-of-life issues, including spirituality. While this emphasis remains, it has developed a broader focus: to train community ministers and chaplains in end-of-life care, as well as to train other members of the interprofessional team (the term used is *transdisciplinary team*) about spirituality. This programme is currently a work in progress; relationships are being developed in this state between ministers and palliative care teams.

Other programmes focus more broadly on all members of the interprofessional team. For example, Egan and Abbott (2002) discussed a very developed programme involving all members of the

interprofessional team (they used the term *interdisciplinary*). They began their model with a discussion of foundational hospice principles of autonomy (choice), advocacy and acceptance – and the need to teach all new employees about these basic guidelines. From there, they addressed their *Patient/Family Value Directed Model of Care*. All disciplines within a palliative care unit or a hospice are to attend to the dimensions of personhood: mind, body and spirit. The focus is upon meaning for the dying older adult and his/her family, and each member of the team works to facilitate that. In the context of this type of spiritual culture, the members of the interprofessional team will receive regular training. They have developed an initial training programme, with clearly delineated goals and defined competencies. The actual training will involve classroom learning, a formal peer or preceptor mentoring programme, opportunities for field learning (for example, shadowing a member of the team from a different discipline, as she performs her duties). Over time the facility will establish continued learning for its employees, including clearly stated goals and competencies.

Lennon-Dearing, *et al.,* (2012) advocated interprofessional education between disciplines, particularly as it applies to spiritual care for medical, social work and chaplaincy students. Through their approach, all the disciplines on a palliative care team will be attentive to spiritual needs, with the chaplain being the specialist. Workshops would be used to instruct these professionals in the topics of spirituality – as it relates to patients, as well as to themselves. Each member of the team would be taught how to perform a spiritual assessment. In this approach, team members would work collaboratively, each member alert to the spiritual needs of the patients in their care.

Less Structured Approach

In the less structured approaches, there were two general suggestions. Though not specifically referring to palliative settings, McClung *et al.* (2006) provided a simple spiritual assessment for nurses, and they encouraged nurses to get to know the chaplains on the unit; collegial relationships with chaplains facilitate Spiritual Care referrals. Though not including the discipline of spiritual care, Carey and Weissman (2010), addressed the guidance of new physicians professionally,

highlighted peer mentoring and "mosaic" mentoring (a new physician having a number of different physician mentors to guide him/her is specific areas).

Continuing with the less structured approach, in the research dealing specifically with spiritual care in palliative settings, there were a number of propositions. Dombeck (1998) wrote of inter professional collaboration through dialogue, learning each other's "language" and assisting nurses to learn how to administer a very basic spiritual assessment upon admission. Providing rituals as opportunities for closure, as well as the conscious creation of space to allow staff to explore spiritual concerns, is advocated by Sinclair and colleagues (2006).

Strengths and Weaknesses of Each Approach

There are both strengths and weaknesses in more structured and less structured approaches. A more structured approach obviously affords a more comprehensive education in spiritual care for palliative older adults. It could both educate those already in professional palliative settings, as well as students preparing for the helping professions. Unfortunately for many professionals, only experience has been their teacher – leading to some stressful situations that could have been avoided with both classroom instruction and Clinical Pastoral Care-like programmes. Evident weaknesses of such structured approaches are that programmes described here are both costly and time consuming. Within the Canadian health care context, resources are stretched to the point of snapping: waiting times in emergency rooms in hospitals are lengthy; and the time that it takes for individuals to access specialists and undergo surgeries is very long. And, in the medical model of our nation's system, palliative care (whose focus is comfort care, rather than curative), is not likely to receive dollars that may be deemed better spent in seeking cures. To formally and extensively educate staff members in spiritual care is not likely to occur in the near future.

A second weakness is more subtle. How is something like spiritual care, that is, in some ways, intangible, taught? Cavendish *et al*. (2007) alluded to this in their article about nurses providing spiritual care; while some skills in spiritual care can be taught, the depth to

which a nurse can deliver spiritual care is, in part, tied to the depth of her own spiritual development. Indeed, a significant part of spiritual care is the bringing of one person's spirit to another – that soul connection – so that one knows he is not alone. While some spiritual/pastoral care skills can be learned, others that come directly from the soul of the person providing that care, cannot.

The strengths of a less structured approach are, to some degree, the flip side of the weaknesses of the more structure programmes. Less structure involves less cost and less time commitment from non-chaplain members of the team. It may be said that such an approach affords greater flexibility: those members of the team who are most interested in spiritual care can spend more time with chaplains, the establishment of rituals after the passing of an older adult can be optional, rather than compulsory – again, filling the need as it seems to present itself, rather than assuming all staff are equally needy/interested.

A very obvious weakness is that in the less structured approaches, "quality control" can be an issue. How is effective teaching (and learning) ensured? How can this be measured? Related to this is that in the care for dying older adults, the very people who could provide evaluation of the effectiveness of the spiritual care on a palliative care unit pass away! Hence, incompetence may only be "caught" if a complaint is lodged from patients' families.

How to Approach Teaching Spiritual Care in Palliative Care

My experiences as a chaplain have entailed a more informal approach to educating professionals about spiritual care. An informal approach entails shadowing as a form of mentorship and education, as well as promoting interprofessional communication and indirect mentorship through various unit activities as a means of fostering a spiritual culture. Therefore, I will first address shadowing, as a form of mentorship and education. Then I will address various means of fostering a unit culture of spirituality.

Shadowing as a form of Mentorship

For new employees on a palliative care hospital unit or within a hospice, there needs to be specific education about what palliative care

is, what spiritual care is, and how they are administered in the particular institution. This type of education could be given to new employees during orientation days. In this way, some of the distinctives of each of these specialties could be highlighted immediately. New employees could meet the more seasoned employees who give the interprofessional education on that day(s). A copy of the spiritual assessment, a part of a patient's chart, could be discussed with each new member of the interprofessional team by the chaplain.

Second, shadowing/buddying for new employees, for a series of shifts, would help develop an ease for the space in which they are working, allow for relationship to develop with some colleagues, and provide the space in which specific questions could be asked. This type of buddying works best, initially, within respective disciplines. A new hospice nurse is buddied with a seasoned one; the new nurse is functioning as a nurse, but together with another – a team. Here, inherent weaknesses (or, in the area of palliative care, sometimes total unsuitability) become apparent to the seasoned nurse. Management can be alerted if serious difficulties persist. While the education is not directly spiritual here, in a spiritually nurturing environment, new nurses will begin to sense the spirituality of the unit. For example, a new unit clerk was shadowing an experienced one. The mentor said, "Oh, meet Marlette, she's the chaplain. That announcement we make every morning about a 'brief time of prayer and meditation' – she leads that. You can attend that if you want, and you can always go to her if you're having a problem."

What about nurses, social workers and physicians shadowing the chaplain to understand the work of spiritual care? There are a number of reasons why this activity is so valuable. First, the chaplain – in a very spiritually sensitive palliative setting – can be a mentor to many. The chaplain can be available to provide support for staff members (McClung *et al*, 2006), can be a safe person to debrief to, and can be one who nurtures the personhood of others on the team. Interprofessional team members who will occasionally shadow a chaplain can learn how spiritual care is administered, can be affirmed in the ways he/she relates to patients, and can be coached by chaplains when dealing with difficult situations. This mentoring of other staff members translates into further growth of personhood in the mentees, which ultimately

benefits patient care. It can also do much to alleviate stress in staff members; as interprofessional relationships are developed, mutual respect grows. The sense of "aloneness" spoken of at the beginning of the article is eased.

The actual mechanics of a shadowing session can vary – and is dependent upon the circumstances on the unit that day, the time of both the chaplain and the "shadow". Sometimes a whole day is set aside for this mentor/mentee activity. However, it is my experience that this can be "overload" for a person of another discipline, or a student, to handle. In a typical shadowing session, a time limit of 2 hours will be set. I will specifically target different learning experiences; patients with differing needs, different faiths (or no stated faith at all), and different ages. Initially, "me and my shadow" will pay a visit to a patient. After the visit, I will debrief with the shadow. *How was that for you? Did anything surprise you?* This debriefing happens in the Spiritual Care office, or some other place the shadow can be honest. No comment about what was seen or experienced will be dismissed. So often, even seasoned ministers will say, "Oh, please forgive me, that was insensitive." Or, "Am I allowed to say that?"

Shadowing can also happen, on a well-functioning interprofessional team, informally. Occasionally, there is a very difficult situation occurring, one in which staff has limited experience. A nurse who is struggling, for example, with the family's stress at the impending passing of an older adult, may ask to buddy with the chaplain, to watch the interaction between chaplain and family. This can give the nurse greater confidence in how he or she deals with grieving family members, or with the dying older adult. "How do I handle a comment like 'Where is God?'" "What do I do when the family members are fighting with each other?" It is often assumed that nurses fulfill the nursing role, doctors their role, social workers theirs. But in actual practice, difficult existential questions are posed to members of *each* discipline, at all times of day and night. A chaplain may not be readily available. Front line workers are keenly aware of this. When the team functions well, all members can benefit from each other's expertise – including in spiritual care.

Another example of informal shadowing – and truly mentoring on an ongoing basis – happens when chaplains are the surreptitious

watchers of other staff members. As nurses give medications, interact with the patients' family members, and provide personal care for patients, chaplains can affirm that which is truly spiritual care in their work. For example, a Health Care Aid repositioned a dying older man, whose diabetes and cancer made lying in one position painful. He was blind and struggling with confusion. I was present with the gentleman, to whom the HCA spoke gently throughout the process. When she had completed the nursing tasks, she tenderly stroked his arm, spoke his name, assured him that he could use the call bell at any time, and that she would check on him shortly. After I had left the room, sometime later, I caught up with this staff member, and affirmed her for her truly *spiritual* care as she provided presence caring for his sense of existential aloneness, and reassurance. This HCA regularly speaks with me regarding her care for patients, her impact upon them, her desire to minister spiritually (not religiously) to them. In this way, with me as the "shadow" watching her, I am able to mentor her.

Caution needs to be exercised in all forms of shadowing. Professional observation of another colleague needs to be done with care, humility and respect. A chaplain is not the formal supervisor of a nurse, a physician, a social worker or bereavement counsellor. So the issues of professional standards within each discipline need to be handled within that context. But formal and informal mentoring – with willing mentees, can be a powerful tool in sharpening the ability of staff members to provide care in a spiritual way.

Creating a Spiritual Culture

There are various ways in which a spiritual culture can be fostered. In establishing a culture that is spiritual, Sinclair and colleagues (2006) spoke of developing a "collective soul" – a team atmosphere, a "we." They elucidated a number of methods of doing this, such as an active approach to nurturing a safe environment for staff. Only in a safe place can personhood (the soul or spirit) be expressed. These researchers also noted the importance of rituals for staff members, after a difficult passing or stressful event. This may come in the form of a candle lighting service, a debriefing, etc. If an in-patient setting has a chapel, these rituals/debriefings may be held

there; such opportunities must be optional – as spirituality is, at its foundation – respectful of boundaries! Coercion – obvious or subtle – does not promote a spiritual culture! A sacred space that is set aside also makes it possible for people of different faiths to come in and pray, think, read – at various times of the day or night.

Within the hospice in which I previously worked as a palliative care chaplain, one of the very simple ways that spirituality is nurtured is through daily inspirational sayings. A whiteboard at the front door, and one on the nursing unit, have displayed a new saying each day. These sayings are broadly spiritual, and meant to encourage. Patients and family members, as well as staff and volunteers, regularly comment on them; some take pictures of the sayings on their I-phones or ask for a copy of "Tuesday's saying" (for example). The quotes resonate with people who are keenly sensitive to the larger-than-life issues they are experiencing, and lead to dialogue with the chaplains, as well as among each other. They are "carried" in hearts and minds by residents and their family members, as well as staff, as they meet the challenges of the day.

Including representatives from each discipline (including Spiritual Care) at interprofessional rounds can facilitate communication (McClung et al, 2006), give a better picture of the issues of each patient, and promote understanding and appreciation of the various disciplines between colleagues. Such connection would also facilitate referrals to chaplains. Workshops and seminars can be offered in areas such as spirituality, bringing further information and growth to staff.

Chaplains in palliative settings have an "advantage" over their colleagues who work in health care settings. This edge is that there is a sense of spirituality inherent within palliative care itself. There tends to be less of a challenge to prove the value of the discipline, as dying people seek to access their sources of meaning, go back to what was meaningful earlier in life (i.e. many older adults return to the faith of their childhood (Lane et al., 2013), and sometimes access new sources of meaning. They look to the professionals in the palliative care sector to help them with this. In this final section of the paper, recommendations will be offered to chaplains desiring to educate colleagues in providing spiritual care. These recommendations can be utilized

within shadowing as a form of mentorship, or in other ways of fostering a spiritual culture.

Basic education – initially – and on-going is essential. For instance, staff may need to have the similarities and differences between religion and spirituality highlighted a number of times. In situations where spiritual needs of patients are complex, they may need help in understanding why "prayer isn't working" or why "throwing out religion" is not an option. For example, I worked with an older woman who believed that if she had enough (religious) faith, she should be healed of her cancer. As her death approached her religious activities – prayer, reciting Scripture, reading literature – increased, as did her anxiety. At this point, some staff members felt that her religious beliefs were not helping her. Indeed. However, her entire life was based upon her faith. To encourage her to discard this would have been very destabilizing. So, staying within her religious faith, but seeking to use broader principles of life (a characteristic of spirituality), I worked with her to understand that: her God is love, and loves her; the end-of-life process is a part of the human experience; and that she was not failing herself, others or God by accepting her impending death. As in interprofessional team, we spoke openly about her distress and my work with her; this helped to relieve some of the internal pressure staff were experiencing with this woman's "total pain."

In situations with great emotion, it is important for chaplains to reinforce fundamental spiritual care principles – primarily, that the felt/stated needs of the patient take precedence. In one situation, an older man was dying. His sisters were fearful, as they felt that unless he prayed a certain prayer, he would not go to heaven. With tears, they begged me to lead him in this prayer. The patient had made it very clear that he did not feel the need for this, and that he did not want to do this. The tension in this family was strong, as one of the sisters bordered on being overcome with emotion. It was my task to ensure, to the best of my ability, that the patient's wishes were respected, that the sisters received spiritual care themselves, and that staff members, of differing understandings and belief systems, were supported. If staff are not regularly reminded of this basic principle, they can become swayed in acting in ways that are not ultimately helpful or respectful,

or they may be traumatized themselves that "we didn't do everything we should have."

A third recommendation for chaplains working with staff members to provide spiritual care is that they assist staff members in realizing that older adults, in their dying, often go back to the existential "pillars" of the past. Very often an older adult may desire a ritual from the religion of their youth, even if he has not practiced the faith for his entire adult life. A common example is that many Roman Catholics desire the Sacrament of the Sick in their dying. This surprises staff members and family members. Staff members can help chaplains greatly by being alert to expressions of spiritual/religious need from their patients, even if it does not make immediate sense to them.

Finally, cultivating an atmosphere of team work does much to create a spiritual culture – that which Sinclair et al. (2006) refer to as the collective soul. Chaplains who encourage referrals to Spiritual Care can develop that sense of "we" by helping nurses in sitting with anxious patients, by running for that cup of coffee (so that the Health Care Aide does not have to), etc. That teamwork goes a long way to demystifying the chaplains on a palliative team, builds trust and fosters that sense of connection – inherent in spirituality!

Conclusion

The purpose of spiritual care is to facilitate connection – of great importance to those who are approaching death, to their family members, and to those who care for them! By encouraging shadowing, and other ways of developing a spiritual culture, the existential aloneness that is felt can be eased. In this way, "me and my shadow" is not an expression of angst, but rather, one of relationship, mentoring and learning.

Notes

1. One exception to this rule was the observation that oncologists in pediatric end-of-life tend not to value spiritual care to the extent that the parents of these dying children do. See Kassam, *et al.*, 2013.

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Complementary and Alternative Medicines: Educating Service Providers to Ensure Best Fit for Older Adults

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ABSTRACT

Complementary and alternative medicines (CAM) are becoming increasingly popular in usage today. Older adults are one sector of the population that are also accessing CAM. However, what are complementary and alternative medicines? What do professionals need to know to effectively counsel their aging clients? Within this paper, the author has discussed what these medicines are, what professionals need to know to advise their ageing clients, as well as issues such as risks associated with CAM.

Key words: Complementary and alternative medicines, Education, Professionals

A range of health experiences are being observed among older adults today. We are seeing individuals presenting with complex bio-psycho-social needs, multiple co-morbidities, and on the opposite side of the health spectrum, an increasingly active ageing population taking control of their lifestyles and medical care choices. With such diversity in medical experiences, we are noticing a parallel trend in diversifying interventions, with a rise in both alternative and complementary therapies. Predictably the rate of engagement among seniors in Complementary and Alternative Medicines (CAM) will continue to increase as the population of older adults grows.

The terms *alternative* and *complementary* serve as umbrellas for multiple practice approaches geared towards minimizing symptoms, addressing the causes of illness, and enhancing health and wellbeing. The options for available interventions are numerous – allowing individualized care regimes to be implemented. However, the popular conception that 'natural' equates with 'safe' minimizes potential explorations into consequences associated with the use of CAM, and assumes that all CAM modalities offer similar benefits. Moreover, to ensure best fit practices for older adults, there is a need to confirm that these practices are safe, cause no harm, attend to desired goals, and are used to enhance wellbeing (van der Riet & Levett-Jones, 2011). As clinicians within the conventional medical system, informing ourselves about CAM is important in working with patients who are utilizing these therapies. A thorough knowledge of CAM is vital for practitioners in this growing field, so that our clients are matched with appropriate resources and that those resources remain appropriate for the duration of the client's engagement. Education further enables us to be discerning in our assessments, treatment planning, and the implementation of our interventions to ensure that clients are utilizing best fit practices. Mitigating risk also becomes of importance as the use of CAM increases among seniors; not every practitioner is equally trained, no ris every treatment safe, and the industry is not completely standardized. As older adults are a vulnerable population, extra care needs to be taken in referring seniors to practitioners, and in treating them.

What are Complementary and Alternative Medicines?

The terms *complementary* and *alternative* represent a classification of intervention accessible to individuals as part of their health and wellness plans. According to the National Center for Complementary and Alternative Medicine (2013), complementary services are defined as those utilizing a non-mainstream approach *in conjunction* with conventional medicine strategies. Alternative therapies, in comparison, are defined as non-mainstream approaches which are used *in place of* conventional medicine strategies. Both of these umbrella terms are further divided by the National Center for Complementary and Alternative Medicine (2013) into five categories of interventions: whole medical systems (e.g. homeopathy), biologically-based practices

(e.g. herbs and supplements), manipulative and body-based practices (e.g. massage and chiropractic), mind-body interventions (e.g. meditation and yoga), and energy medicine (e.g. Reiki and healing touch). Important to note is that the distinctions between CAM interventions aren't always clear; there can be significant overlap among practices.

Accounting for Increases in Application Among An Ageing Population

The popularity of CAM is constantly increasing, with estimates of engagement ranging from 46–80 per sent within the general American population (Pan *et al.,* 2012) and a growing trend seeing older adults seeking referrals for skilled practitioners. With the increase in engagement, researchers have begun to explore motivating factors to better understand the movement towards CAM and to shape practitioners' abilities to ensure that the needs of seniors are being met. In reviewing current literature, it was suggested that many older adults utilise complementary therapies to supplement their primary care plans to compensate for aspects perceived to be lacking. These factors include dissatisfaction and disillusionment with conventional medicine (Moses, 2005), poor responses from conventional treatments (Lorenzi, 1999), limited access to conventional medicine when symptoms present (McMahan & Lutz, 2004) and the inability, real or perceived, of the medical model to meet their biopsychosocial needs – which includes belief systems, values, preferences, etc. Moses (2005) offers additional factors: the perception that natural medicines are more 'compatible with health', a perceived simplicity associated with CAM, ease in accessing services and providers, and the availability of over-the-counter remedies as additional influences.

Whether this movement represents a shift in cultural attitudes, as proposed by Behrman and Tebb (2009), is unknown. However, enticing advertising – which now targets older adults specifically, peer pressure, and the readily accessible information on CAM and its benefits, is drawing more and more individuals. Regardless of the motivating factors, the prevalence of CAM as a more publicly acceptable avenue for health care interventions provides opportunities for discussion, choice and empowerment (Chadwick, 1999), as

increasingly older adults want to negotiate their treatment plans and interventions. Also appealing are the philosophical underpinnings of CAM: holistic and client-centred methods leading to a more individualized treatment approach for each client, based upon his or her personal goals, treatment needs and abilities. This contributes significantly to the overall satisfaction reports: 80 per sent of respondents rated CAM highly (Cheung, *et al.*, 2007).

Additional information supplies captivating benefits and supports a continually wider scope of application for CAM within the field of health and wellbeing. Some practitioners assert that CAM can be equally effective to conventional medicines. CAM interventions are being used for many physical and mental health conditions: osteoporosis, memory challenges, anxiety and depression, menopause, cancer, etc. The list of benefits is lengthy: heightened mood (Horowitz, 2013), increased personal functioning (Nguyen *et al.,* 2010), increased mobility, better sleep, etc. The increased usage of CAM converges with the rising number of geriatric clients with medical concerns, incurable illness and complicated health needs (Pan *et al.*, 2012).

Addressing the Clinician's Need for Education

A working knowledge of CAM is imperative for those working in the medical system serving older adults. As McMahan and Lutz (2004) state, "if health care professionals are to effectively support individuals in making informed, safe, and appropriate choices, it is critical that they develop greater awareness of the nature of, and potential efficacy of, and reasons for patients' use of unconventional therapies" (p.101). As referrals for CAM interventions are increasingly sought from Americans, there is a professional obligation to be knowledgeable about factors impacting treatment and outcomes for ageing clientele, to ensure a best fit with their engagement.

When a senior views a conventional service provider as having limited knowledge about these therapies, he or she is unlikely to discuss personal views and use of CAM strategies. Non-disclosure of CAM engagement is reportedly high among older adults, with reasons being identified by Sandberg and colleagues (2013) as the senior's belief that CAM represent a personal decision rather than a medical decision, as well as the habitual exclusion of CAM modalities from clinical

assessments. Education and awareness opens dialogue, facilitating discussion and ultimately aiding in careplanning. This CAM movement is being supported both nationally and internationally, with 64 per sent of medical schools in the USA alone including CAM in their curricula (Lorenzi, 1999).

For personal reasons it has also been suggested that increasing one's education into CAM practices may have the potential to support those working in the conventional medical system, in their own health and well-being. Research supports the notion that informed individuals are more likely to engage in alternative and complementary practices themselves, thus garnering personal benefits (van der Riet & Levett-Jones, 2011). It has further been suggested that appropriate referrals to CAM practitioners may decrease the demands on the current medical system. At a minimum, education directs attention to areas of need within the current system of service delivery and guides initiatives and future resources to better address the needs of older adults.

Factors to Consider when Making Best Fit Decisions

As umbrella terms for multiple interventions, alternative and complementary therapies encompass a significantly diverse grouping of practices, with significant variance in methods for service delivery, and an even greater array of individual practitioners – some of whom combine methods. With so many options, finding the best fit for each individual is no small feat and unfortunately, it is up to the consumer to be informed with regard to personal treatment decisions and in evaluating the quality of treatment being received. Some vital points of consideration to govern recommendations and ultimately support the patient in their decision-making include:

What are the goals?

Not all CAM therapies are created equal, nor do they all offer the same or similar results. Recognizing the goals of older adults as they seek and engage in CAM interventions narrows the scope of available alternatives. Outcome goals – what benefits they are seeking, what changes they are hoping for – are equally important to the process goals – with what frequency and intensity are treatments sought? Is

there a recovery time associated with them? How rapidly will the changes be noted? Knowing the client's goals, symptoms and preferences goes a long way to matching the patient with an appropriate intervention. "Making a decision based on the facts is a better idea than using a therapy simply because of something you have seen in an advertisement or on a Web site or because someone has told you that it worked for them" (National Center for Complementary and Alternative Medicine, 2013, http://nccam.nih.gov/health/decisions/consideringcam.htm).

What type of CAM intervention is most appropriate?

A common attitude among CAM users equates *natural* interventions with *safe* interventions, however the responses to each treatment varies by individual: their presenting physical and mental health symptoms, the presence of co-morbidities, additional treatments they are receiving, beliefs and attitudes about CAM and conventional medicine, etc. Also important is the ability of the individual to engage with the particular method. For example, an older adult with limited mobility and high fragility being referred to yoga is an inappropriate fit. Consideration must also be taken into the individual's ability to follow-up with homework/recommendations from the CAM provider. Also note that some CAM strategies represent long-term lifestyle changes, while others serve as more short-term interventions. Cost and accessibility may also be limiting factors, as not every CAM intervention is covered under health care or insurance plans.

What are the risks?

While advertising emphasizes the lack of side effects with CAM interventions, very little research to prove this claim actually exists. This applies to the side effects on the population in general, as well as with older adults. How the therapy is used, the administration of the interventions, and the presence of evaluative tools – throughout the course of the older adult's engagement with CAM – influence the possible risks (Ibid.). This begs query into the intensity and frequency of engagement: At what intensity should these interventions be administered to account for such factors as increasing fragility, loss of mobility, susceptibility to injury, and decreased recovery times following interventions?

Behrman and Tebb (2009) take it one step further and ask: "are seniors being swindled and deceived into believing that alternative and complementary therapies are assisting them in maintaining and achieving their health goals" (p. 132), or rather do practitioners adhere to evidence-based practice which negates the placebo effect or simple folklore? It is true that when CAMs are perceived to represent more of a personal decision than a medical one, they are more likely to be omitted from a medical history and older adults are more likely to be unaware of the potential for interaction between a complementary medicine and a prescribed medication (van der Riet & Levett-Jones, 2011). Findings from one study indicate that nearly 3 million older adults are at risk for potential adverse interactions involving prescription medications and herbs or high-dose vitamin supplements alone (Cheung, *et al.*, 2007). Also concerning are the findings that CAM use may lead to delays in seeking medical interventions among ageing adults. It should be noted that most CAM practitioners lack medical knowledge and that these therapies are not equated with medical interventions; educated communication between practitioners and conventional clinicians is needed.

Finding the Right Practitioner

The number of practitioners accepting new clients often exceeds the demands generated by the ageing population, providing an opportunity to find not only best fit among the chosen therapy(s), but also best fit among the service providers. Worth mention is the lack of standardized administration among some CAM strategies, a lack of regulating bodies among others, and varying standards for education and professional conduct (National Center for Complementary and Alternative Medicine, 2013). While some CAM practitioners study for years and are backed by an accredited institution, others are not, and again this falls into the category of 'buyer beware'. Areas of expertise also differ among individuals, and finding one with knowledge of geriatrics is imperative. Of course, personal choice is also a consideration: Do you like and trust them?

Conclusion

There is an increasing body of literature to support the use of complementary and alternative therapies. More recently, research has

begun to explore the practice implications for use among an ageing population. However, significant gaps exist in the information available; studies typically lack a clinical component, co-morbidities are likely to be excluded from research trials, outcome measures are not documented throughout the treatment process, nor are they standardized among same-field practitioners, and the term "older adult" represents a highly diverse population of elderly people. Educating ourselves into CAM serves to facilitate in the care planning for the older adults in our care, and ensures a best fit between individuals and the treatments with which they are engaged.

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Lessons Learned in Cross-Cultural Nursing Education: Implications for Gerontological Practice

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ABSTRACT

With an increasing focus on the development of cultural competence within nursing education, there is a need to capture teaching and nursing experiences from abroad. The teaching and practice experiences of the authors traversed a number of cultural settings – the Middle East, west Central Africa, Asia, and South East Asia. The following article provides a summary of these teaching experiences under five identified themes: (1) need for adaptability, (2) sensitivity towards culture and ways of knowing, (3) importance of communication and language, (4) the role of family, and (5) the richness of cross-cultural teaching. Findings from the literature are discussed in context of the authors' experiential narratives within each theme. Finally, implications for gerontological nursing are discussed in the absence of literature on cross-cultural nursing for geriatric populations.

Key words: Cross-cultural education, Experiences, Gerontological nursing

In the last couple of decades, there has been increasing importance placed upon nurse educators helping students to gain "cultural competence". The emphasis placed upon nurses understanding how to relate to patients from various cultures relates to the recognition that

western countries have citizens from many parts of the world who have different values and beliefs from the dominant culture. It also stems from the recognition that when western nurses show understanding and respect for the cultural beliefs of those from other regions in the world, trust is built between patients and nurses, which may result in better health care outcomes.

However, cultural competence towards others is often described within the context of western home countries. What happens when individuals from western home countries travel to other countries to provide health care or health education? As we (the authors) have provided education to nursing students and nurses in a number of countries, such as Qatar, Thailand, Laos, Cameroon and India, we wanted to situate our experiences with those of educators in the literature. In what ways did our experiences differ from other nurse educators who have taught abroad and in what ways are they similar? And, because the global population is rapidly ageing (United Nations, 2013), what are the implications for gerontological practice? Within this paper, we provide a brief overview of the literature regarding nurses' experiences providing care/education to individuals in foreign countries. We then discuss the lessons we have learned from teaching in cross-cultural settings, but do so within the context of what is already addressed within the literature. Within the discussion on lessons learned, we will use our initials (CZ, AML or SPH) to refer to which author experienced particular situations. We then offer implications for gerontological nursing practice.

Literature Review

In order to ascertain the cross-cultural teaching experiences of nurse educators, we accessed the Cumulative Index of Nursing and Allied Health Literature (CINAHL) database. We utilized the search terms "nurse educators" and "cross-cultural" from present to 2000. This search yielded over 900 articles. A good number of articles were omitted because they did not pertain to cross-cultural nursing education; many of these articles addressed how to assess for or promote cultural competence in nursing students within the dominant country (e.g. Liu, *et al.*, 2008; Mahara, *et al.*, 2011; Perng & Watson, 2012; Virdun, *et al.*, 2013), or they discussed cross-cultural experiences

of nursing students, either within their own country or in others (e.g. Allen, *et al.,* 2013; Greatrex-White, 2007; Larson, *et al.*, 2010).

When we distilled the articles down to ones that specifically addressed cross-cultural experiences of nurse educators in other countries, our search yielded 8 articles. In general, these articles discussed either short-term teaching in countries such as Zambia, Viet Nam, and Ethiopia, but there also were a couple that addressed teaching in other countries (e.g. Japan) for extended contracts, such as 2 to 5 years. Overall, nurse educators spoke of the tremendous personal and professional benefits derived from educating nurses/nursing students in foreign countries, but they also addressed the hardships, such as loneliness, feeling marginalized (Furuta, *et al.*, 2003) and being uncertain of what their students actually learned from them. While most of the articles concentrated on the experiences of the nurse educators, in one article, the author focused on how Japanese graduate nursing students assessed her cross-cultural teaching (Cox, 2010). Further specifics of the literature search will be embedded within the next section, when we discuss what we have learned as nurse educators.

Lessons Learned

As nurse educators, all three of us (authors) would attest to the tremendous value in teaching overseas. Currently, one of us (CZ) is still teaching overseas in Doha, Qatar. In the following sections, we will discuss our cross-cultural experiences under five major themes: (1) the importance of adaptability, (2) sensitivity towards the culture and ways of understanding and working, (3) teaching in terms of communication and language, (4) importance of family, and (5) the richness of teaching cross-culturally. Our experiences will be compared and contrasted with findings from the literature.

Need for Adaptability

As we have found from personal experience, along with resounding support from the literature, cross-cultural teaching requires adaptability in a number of ways (Pron, *et al.,* 2008; Williams, 2008). First, if teaching outdoors, or within bamboo buildings, the educator has to adapt to the heat and humidity. Particularly if the

educator has come from a country which is experiencing a cold winter at that time, the adjustment to heat and humidity can sap energy and concentration. As part of the environmental conditions, electricity/power may or may not be available. This will infringe upon what teaching props are available to the educator. Increasingly, educators in westernized countries rely on power points, video clips and other visual aids that enhance presentation, but structural factors, such as electricity, may impede upon the utility of these teaching tools. Even if teaching sessions occur within buildings that have electricity, the power may not always be reliable (Williams, 2008).

Similarly, when SPH taught in India, there was electricity within the nursing residence where she was teaching, but the electricity did not work consistently, so overheads could not be used. Similarly, she was informed that she should not use her laptop. Basic means of instruction were, therefore, not available. While educators from westernized countries will utilize electronic visual images to enhance experiential learning in developed countries, these may not work in other places. This can result in educators feeling like the strength of their message is lessened without the usual accompanying visual aids. In situations such as these, educators need to consciously seek out how learners in the host country best learn, and improvise with these strategies. For example, when Williams (2008) was leading a grief and loss programme for teachers and guardians (for orphans) in Zambia, she tapped into storytelling, role playing and experience sharing – learning methods that are preferred in Zambia.

Sensitivity towards the culture and ways of understanding and working

Nurse educators that come to other countries are guests and as such, they need to respect the culture of the country. Within the literature review, all of the nurse educators reported on the importance of learning about the culture before going to the country and noted that despite ardent attempts to prepare, nurse educators can never be totally prepared for the new culture (Furuta *et al.,* 2003; Melby, *et al.*, 2008). Educators thus need to prepare, but also recognize that they will never be so fully prepared so as not to experience some measure of shock.

Part of respecting culture involves the sensitivity to show consideration for the way in which health care is delivered; when a practice that is not western is utilized is safe, it is not opposed. There is, however, a fine line between respecting customs in health care and knowing when to respectfully challenge existing practices and teach new ways of delivering care. For instance, when Kater (2000) was teaching health care methodologies to Ethiopian nurses in Addis Ababa, she became acutely aware of how traditional medicine and folklore are used to explain disease. Some residents of Ethiopia believed that diarrhea was caused by worms underneath the gums, running or jumping, or frogs in the stomach. While Kater (2000) offered education to combat these beliefs, she also needed to show respect to the nurses, ask about their beliefs (even when viewed as folklore) and allow the nurses to make some decisions related to teaching. Similarly, when AML worked in a Cambodian refugee camp, the Cambodian nurses would gently hit the arm of the patient repeatedly before injecting the medication (into the deltoid muscle). Some North American nurses that came to work in the refugee camp would express annoyance at this technique. However, there was some basis for what was done. Gently hitting the deltoid muscle resulted in the patient relaxing the tense muscle, and as such, the injection hurt less. This did not harm the patient and therefore, was not discouraged. Another practice in this refugee camp, placing chewed tobacco into an open wound, was foreign to nurses coming from westernized countries. And yet there was also a physiological basis for this action; the nicotine from the chewed tobacco caused vasoconstriction, leading to less bleeding from the site. Unfortunately, the chewed tobacco in an open wound was also a potential and likely source of infection. As such, this practice was discouraged. Even when teaching is offered regarding why a practice should not be utilized, it should be offered with sensitivity towards the nurses, as well as an openness to understand the rationale of the indigenous nurses, and a willingness to explain an alternative method of achieving the desired outcome, without jeopardizing the safety of the patient.

It can be more difficult to challenge ways in which health care is delivered, however, when those ways are embedded within faith. For instance, when CZ was teaching health assessment, she saw first-hand

the influence of gender and faith (Islam) on nursing education and practice. Because of principles of faith, exposing self to others (hair, arms, legs, torso) and contact with members of the opposite gender are restricted. This has implications on how nurses learn. The university in which she teaches has established a Standardized Patients programme, whereby trained, paid actors come into the lab to serve as patients. This ensures that male nurses do not care for female patients. Faculty members, at times, have had discussions on how to handle incidents where female nursing students have refused to care for male patients. Although as educators they were reticent to allow female student nurses to refuse to care for patients based upon gender, they recognized that it is difficult to ask students to go against social and religious beliefs and traditions.

Perhaps even more challenging is when nurse educators teach concepts that are integral to nursing in westernized countries, but may be less emphasized in other countries. For instance, when CZ was teaching community health nursing Qatar, she was uncertain of how to embed concepts such social justice, equity and empowerment. She was instructing 17 female students who did not understand what these concepts meant. It is not that they had not experienced or witnessed injustice, inequity or disempowerment, but they had not yet learned these terms in English, so could not identify such experiences. When CZ offered an example of a situation where there was blatant inequity, one student immediately responded, "I know this!" and began to explain why she knew this. She then stated of the people experiencing injustice, "They don't deserve to suffer!" For CZ, this was a powerful moment of learning! While the students did not understand what the English words meant, when explained by illustrations, they immediately recognized the concepts and could give examples of situations of social injustice. Further, they identified ways through which these practices can be rectified.

What happens, however, when concepts of equity and fairness are not demonstrated (in terms of western standards) by the culture in which the nurse educator is teaching? For example, Melby and colleagues (2008) interviewed 8 western expatriate nurse educators who taught within several countries in Eastern Asia. The educators spoke of the challenges they experienced when students engaged in

behaviours that were not equitable or fair within western education, such as plagiarism (which is viewed as acceptable within some Asian countries). The educators could not change these behaviours; they had to direct their energies towards finding meaning and purpose in their teaching, rather than in modifying their student actions

Communication and Language

In many cross-cultural situations, English is not the dominant language of the nurse learners. Sometimes, these individuals will know some English, but it may be limited. Translators may therefore be necessary. Even when there are English translators, teaching needs to be tailored to vocabulary that the translator can understand in order for the message to be accurate and clear. Not only does this take deliberate effort on the part of educators, but this also takes extra delivery time (educator to give a couple of points and then turn to the translator to indicate that he or she can then pass on the message; the translator may pause to consider how to express these points and then may ask clarification from the educator; after the translator delivers the points, the translator then indicates to the educator that he or she can resume again). Some cross-cultural nurse educators iterate the need for strong interpreters and even those who are certified (Cox, 2011; Cox & Yamaguchi, 2010).

In some cross-cultural situations, students and instructors are familiar with English and in fact, have been taught in English. However, the nuances of language and expression may still be different. For instance, when SPH taught in India, she used the term "dressing" to refer to a covering over a wound. To the large audience, "dressing" referred to putting one's clothes on. Similarly, words such as "incontinence", which are common within western healthcare situations, were met with blank looks. The nurses did not understand, despite having taken their education in English.

Understanding that English is often not the dominant language in cross-cultural education, teaching needs to be adapted not only for language, but also for the amount of time. This forces the cross-cultural educator to consider, "What is really most important in my message? What do I want to make absolutely sure that the students understand?"

Importance of Family

In teaching in various countries and continents, we have been impressed and moved by the importance of family in other cultures. In some cultures, when nurses attend to and intervene with patients, they are automatically involved with family members. Family members are in close proximity to the patient and indeed, may not leave their loved one's bedside. Cross-cultural educators, whether in clinical situations or in the classroom, need to "make room" – literally and metaphorically for the family members when individuals are in hospital.

When Pron and colleagues (2008) taught nursing students in Viet Nam, they found that family members provided basic care to their hospitalized loved ones, including bathing, feeding and providing bedding. Family members often stayed in hospital with their relative. SPH experienced a similar situation in Laos. Family members were expected to bring food for their loved one in hospital, as well as sheets from home to cover the bed their family member occupied. A family member would stay with the patient while he or she was in hospital, often setting up a camp outside the main hospital gate.

The Richness of Teaching Cross-culturally

In all of the reports of nurse educators we located in the literature, the value and richness of cross-cultural teaching was emphasized. As nurse educators, this endorsement of cross-cultural teaching resonates with us. Not only does it demand more of us in terms of creativity to mechanically teach differently (i.e., not rely upon power points, overhead slides, etc.), but educators need to work harder to impart concepts that may not be readily understood within their guest culture (cultures within which we were guests). Further, we needed to learn about cultures where beliefs, traditions and ways of being were totally foreign to us! This enriched us greatly, recognizing that *our* way of understanding is not the *only* way and that nurses from other countries, although holding to very different belief systems, are more like us than different from us! And, in coming back to Canada, we are able to share with our students varied ways of understanding social situations, healthcare situations, and strategies for improvising when some of the "props" of education or healthcare are missing.

Implications for Gerontological Nursing

In light of the ageing population worldwide, not just in western countries, we find it concerning that of the articles perused, none involved cross-cultural education of nurses or nursing students in the care of older adults. However, our experiences mirror that of the literature. Of the three of us, only one (SPH) taught cross-culturally about nursing older adults. The lack of literature evidence about teaching gerontological nursing cross-culturally reinforces its importance to us.

Importance of Educating Nurses in other Countries about Older Adult Care

It is crucial, we believe, that when nurse educators teach in other countries, that they present information that is specific to older adults. Because in the past, some individuals did not live to older age in developing countries, gerontological nursing may not have been a priority. However, it is well known that most developing countries are "ageing", not just westernized countries (United Nations, 2013). It is not sufficient that health care information about adults in general be applied to older adults, as the effects of ageing result in changes to physiological processes that impact how care is provided. For example, older adults may have an infection, and yet not register a temperature due to changes in thermoregulation (Miller, 2012). Another physiological change that occurs with normal ageing is the change in distribution, metabolism and excretion of medications. As such, older adults require less medication than their younger counterparts; if they receive the same dosages as adults 20–30 years younger, they could build up toxic levels of the medication in their bodies and become delirious (Miller, 2012).

In addition to the above physiological changes associated with ageing, many older adults experience arthritis and chronic pain. This can cause significant problems in managing the daily affairs of living. While older adults in westernized countries may have trouble getting out of the bathtub, standing up from the toilet seat and managing stairs, there generally are some aids that can be put into place. These aids are often not available for ageing adults in developing countries. For instance, SPH has taught in several South East Asian countries. There, squat toilets are frequently used. When teaching nurses about

basic assessment for incontinence, such as bladder retraining, the issue of squat toilets came up. How does an older adult who has used a squat toilet all of her life manage when she has suffered a stroke or has bad arthritis (Hirst, 2013)?

Needs of Older Adults in Other Countries

Some older adults in other countries are facing extreme and even unfathomable situations, not only in terms of poverty, but also in relation to the AIDS crisis. For instance, some older women in Africa are caring for their grandchildren because one or more children have died from AIDS. These women confront overwhelming grief (Williams, 2008) in the midst of trying to provide for their grandchildren at a time in their lives when their own health may be failing. Nurses working in AIDS-ridden countries need education on how to best help these older individuals care for themselves so that they can continue to care for their grandchildren.

Conclusion

While there is relatively little literature documenting the experiences of nurse educators teaching in cross-cultural situations, it is clear that such experiences are challenging, yet enriching. With the changing global demographics (towards an ageing population), we propose that cross-cultural education needs to focus on the care of older adults. Nurse educators teaching cross-culturally can not only pass on valuable information to nurses in other cultures, but can also return to their westernized countries to impart the wisdom received from the guest countries.

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The Influence of Chronological and Professional Age in the Appraisal of Critical Incidents by Emergency Room Nurses: Implications for Nursing Education

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ABSTRACT

The work of nurses in the emergency room is fraught with urgent and dire situations. While these situations are an expected aspect of work within this setting, it is not unusual for nurses to be greatly impacted by these events that are often referred to as critical incidents. Experiencing critical incidents may lead to distress, anxiety and even Post Traumatic Stress Disorder in nurses and other professionals. However, what constitutes a critical incident within the literature is not clear. Using a hermeneutic approach, this study addresses how emergency room nurses appraise critical incidents. What constitutes a critical incident for these nurses is described. As a secondary finding, the influence of age – both of the patients and the nurses – is examined within the appraisal of critical incidents.

Key words: Critical incidents, Emergency room nurses, Age

The influence of chronological and professional age in the appraisal of critical incidents by emergency room nurses: Implications for nursing education Emergency room nurses regularly face serious and critical situations with patients. These situations can cause great

stress and distress within these nurses and lead to absenteeism, staff turnover, emotional pain and sometimes Post Traumatic Stress Disorder. Work circumstances that cause great emotional turmoil are referred to as critical incidents. Within the literature, however, *how* to define critical incidents and *what* incidents are considered to be critical varies. Definitions explicating the criticality of incidents usually cite the type of patient situation, the performance of the professional, as well as the professional's reactions. While it is acknowledged that the nurse's appraisal of the situation can determine criticality, this factor is often not recognized within definitions. Additionally, we suggest that the influence of the age of the professional (both chronological and professional) and the patient is rarely discussed. Within this paper, we assert how nurses perceive the criticality of incidents is crucial, and that age plays an important role in the appraisal of critical incidents by emergency room nurses. We base our discussion on a study conducted by the first author. We will briefly review the literature addressing critical incidents within nursing and then outline the particulars of the study conducted by the first author. We will then explicate how age influences the appraisal of critical incidents by emergency room nurses and suggest implications for nurses and health care professionals.

Literature Review

Critical incidents are defined in various manners within the literature. Generally, critical incidents are considered to contain one or more of the following components: the event itself, the meaning a nurse ascribes to the incident, the professional's performance, and the professional's reaction to the event (Burns and Rosenberg, 2001; Caine & Ter-Bagdasarian, 2003). For instance, Niesse, *et al.* (2011) and Thomas and Mackway-Jones (2008) provided definitions that stated a critical incident was an adverse event that produced actual or potentially damaging consequences or near misses to the patient. A critical incident can also be defined in relation to the performance of a professional. As such, some studies examined the performance of professionals that can lead to undesirable outcomes that jeopardize the safety of patients (Buckley, *et al.,* 1997; Cooper, *et al.*, 1978). As an example, the concept of performance-based errors in critical incidents has been significantly explored by the anesthesiology discipline (Cooper, *et al.*, 1984; Craig and Wilson, 1981; Manser, 2011).

Additionally, a critical incident may be defined as the professional's reaction to an event. In 1983, Mitchell defined a critical incident as "any situation faced by emergency personnel that causes them to experience unusually strong emotional reactions which have the potential to interfere with their ability to function either at the scene or later" (1983, p.36). Within this definition, a critical incident can be considered as any event that has the ability to generate powerful, uncontrollable emotions leading to a distressed state (Clark and Friedman, 1992; Halpern, *et al.*, 2011; Pups, *et al.*, 1997). Finally, an incident may be regarded critical when the nurse deems it as such. Interestingly, definitions of critical incidents often do not include the nurse's appraisal of the event. These points will be further explicated shortly.

Our Study Method

With an understanding that much of the research conducted on critical incidents does not explore how emergency room nurses actually experience and make sense of critical incidents, the first author (SD) decided to talk to emergency nurses about how they experience and process critical incidents. The philosophical herme-neutics of Gadamer (1989) was chosen to guide this research, as this approach would provide the ability to delve into how nurses experience and interpret critical incidents. The hope was that through talking directly with emergency nurses about their experiences of critical incidents, further insight into the nature and definition of these events could be gleaned.

Ethical permission for this study was sought and obtained from the local university and health board. Participants were recruited through the use of posters placed within emergency departments in two major metropolitan hospitals in western Canada. Inclusion extended to any male or female nurse of all ethnicities registered with the College and Association of Registered Nurses of Alberta (CARNA) and who worked in the identified emergency departments. Four emergency nurses participated and were interviewed by the first author. Each participant was interviewed once between one and one and a half hours in length and the conversations were audio taped. The length of time the nurses had practiced ranged from 5–20+ years.

Additionally, the first author of the study included herself as a research participant, owing to her 4 years of experience within the emergency room as a nurse, and with the underlying goal of transforming her use of the word "I" into connection with others (the research participants) (Chambers, 2004).

All of the recorded conversations were transcribed verbatim into text, which permitted the data to be revisited on several occasions. The goal of the analysis was to uncover new or alternate understandings through each nurse's experiences and within the text. While the importance of the appraisal of the criticality of the incident was viewed as most salient, the influence of age upon the assessment was also noticed as a secondary finding. We will briefly address how the nurses viewed critical incidents, and then will move to the appraisal of the event, including the effect of age on the appraisal.

Findings

The nurses interviewed spoke at length about their experiences with critical incidents. At times, the emotions expressed were strong and almost visceral. The following themes emerged.

Painful Nature of Critical Incidents

First, the nurses spoke about the painful nature of critical incidents. Indeed, they spoke of how reminders of specific incidents could immediately evoke tears, even months after the incident. One nurse spoke of being at a conference several months after accompanying a seizing pediatric patient being transported by air ambulance to a hospital. Neurology in the pediatric patient was one topic for discussion at the conference. Upon hearing this, the nurse's memories came rushing back and tears flooded his eyes. He once again agonized over questions such as: "did I do everything I could; was it my fault?"

Stereotypes

Secondly, nurses spoke about the stereotypes of critical incidents. When asked by the first author about what constituted a critical incident, they often initially responded with "a code", or an incident where many individuals were involved. One nurse stated:

... at the time to me it was a critical incident but kind of on the spectrum of what can happen, it almost feels like more people need to be involved when it is a critical incident and if it is just you and the patient, that is not necessarily critical, that is just your problem, and I think maybe there is *a stereotype around critical incidents in that it's messy, a code*...(italics ours).

In light of the stereotyping about what constituted critical incidents, the nurses interviewed remarked that they were at risk for being stigmatized. If they responded emotionally to a critical incident and cried, they might be considered by their colleagues as unfit to be an emergency room nurse. As the nurse above commented, if the incident does not fit the stereotype, other nurses might think "that it is just your problem". This results in nurses failing to seek help when they are traumatized by incidents that are critical *to them*. One nurse noted,

If a nurse was not able to deal with their emotions I think that person could get a *reputation as... weak* or maybe not invited back to the next critical incident or is not somebody you would want around. I think everybody is probably *allowed one, one strike on* the incident that really gets them, but if it was something like the individual over and over again couldn't cope with it, I think you would just feel like they needed to move on... (italics ours).

As mentioned by this nurse, nurses may be allowed one time where they can reveal how deeply affected they are by particular events in the work setting. However, if they cry or demonstrate more often than once that they are emotionally impacted, they may be viewed as unfit to work in the emergency room.

Appraisal Ascribed to Critical Incidents

The third finding, and indeed the most prominent one, was the importance of the meaning nurses ascribed to particular incidents. When they could in some way relate to the patients involved, or their relatives, the impact of the event was greater:

... I have seen the patient's husband at least 5 times in the lineup for visiting her on other visits. I always smiled at him because he looked like *my old English teacher, so I have that kind of a connection* and so I

would always smile at him and he probably had no idea who I was, but I was thinking, what a nice man, coming to support his wife... (italics ours).

When this nurse was caring for the wife of the man she depicted above, she described how the man's wife showed serious signs of deterioration when she assisted the patient into a standing position. This patient needed to be transferred to a section of the emergency room that provided closer monitoring. The impact of this event, particularly the grief in seeing this woman, was very evident. Tears streamed down the nurse's face as she spoke about the connection she felt to this patient and her husband, as well as the self-doubts about whether or not she had missed some piece of vital information regarding the patient.

The ability to relate to patients, or patient situations, triggered the emotional response in nurses. It was the activation of an emotional response that seemed to make incidents more difficult, and factor into their assessment that these situations were critical. As one nurse eloquently remarked,

... actually, for me and by looking through the career (at critical incidents), it's never been like this (a big trauma or cardiac arrest), it has always been a call with a bit more *emotion t*o it (italics ours). *The influence of age upon the assessment of criticality of incidents* Embedded within the above situations, as well as in other critical incidents illustrated by the nurses, is the influence of age upon the ascription of the criticality of the incidents. Interestingly, the nurses themselves, in pondering what makes critical incidents critical, often reflected slowly upon their answers, and only upon reflection would mention the role of age in assigning criticality. However, only when describing the age of patients did they overtly recognize the influence of age upon their assessment of critical incidents. Within the discussion below, we highlight how the age of patients, and the chronological and professional ages of the nurses factored into their assessments of criticality.

The Patient's Age

Almost unanimously, the nurses spoke of incidents being considered critical if children were involved. As previously mentioned, one nurse described how he immediately teared up months after an incident of transporting a seizing child via air ambulance. Another nurse, depicting a similar scenario of arriving on scene via air ambulance to a child in cardiac arrest and the subsequent death of this child, described how she agonized over the situation and scrutinized each detail to see if she and her colleagues could have done anything differently. Being young and very ill automatically was categorized by nurses as being critical. This secondary finding was similar to other studies where nurses rated the death or abuse of a child as being the most critical of events (Burns and Harm, 1993; O'Connor and Jeavons, 2003) they faced in emergency room nursing. In contrast, the death of an older adult was rarely mentioned. One nurse did suggest that critical incidents could involve an older adult, and juxta-posed the elderly gentleman with a gang member. She stated,

...I guess there is a variety of degrees of levels of critical incidents. It could be... and I guess... because probably everyone has a different idea of what is critical and like critical could be a gang member getting shot... or *some little old man found down in a house that needs CPR*...(italics ours).

It was unusual to find older adults situated within the examples of critical incidents. Also, although we are making an inference, one aspect of the degree of criticality in the event described by the nurse could involve the solitude within which the older man experienced the cardiac arrest. The idea of being "found down in a house" and needing CPR could suggest that this individual lived alone and perhaps, died alone. As the fear of dying alone is common (Hall, *et al.*, 2010), this nurse may have determined that the incident was critical based upon the nature of the death – being isolated from others – rather than the age.

The Nurse's Professional Age

How young the nurse was within critical care nursing had an impact on how he or she determined the criticality of the incident, as well as the ability to put events behind him or her. For instance, nurses

labeled particular incidents critical when they were new within emergency nursing that they would not determine critical after years of practice. One nurse nicely illustrated how advancing professional age (being in emergency nursing for longer periods of time) impacted his ability to lessen the impact of the work events.

> …when *I first started my profession* I would wake up in the middle of the night, dreaming that I forgot to do something and gasp…

> …*now it's been like 12 years that I have been in critical care* so I have this… this thing that I am able to switch to help me deal with the emotions (italics ours).

Having worked in emergency nursing for over a decade, this nurse was able to metaphorically use "this thing that I am able to switch" in order to turn off the emotions and impact. Another nurse, spoke about how experience, working as an emergency nurse for almost 10 years, impacted her appraisal of what could be considered critical.

> If you were to have this conversation in *my first year of emergency nursing*, I probably would have told you that my last critical incident was when my patient had a seizure (laughing) because to me at that *time that was a critical incident and it was horrific and I had never seen it before. So almost 10 years in, a seizure probably would not register as anything* (italics ours).

The Nurse's Chronological Age

From the interviews with the emergency room nurses, it was clear that the older they became (chronologically), changed how they viewed the criticality of incidents. The nurses stated that particular patient incidents took on the critical component because they could relate the patient to someone in their life. With age, and subsequently, increased life experiences outside the work setting, situations within the emergency room became more personal. For example, in the quotation below, a nurse noted that her transition into parenthood influences how she deals with pediatric emergencies; these situations have become more difficult. From her comment, it appears that she was an emergency room nurse before having children. The impact of

her aging chronologically and developmentally (becoming a parent) has made the care of children within her work harder.

> ... I would say global things in my life would affect how I see a critical event. For instance *since having children, pediatric cases are harder. Or, if you can link that patient to anybody in your life for some reason because it is a similar appearance or age or that sort of a thing.* If it fits with somebody in your life then yes, it makes it harder (italics ours).

When considering the juxtaposition of chronological aging (getting older) with professional aging (working longer within the emergency room), an interesting relationship becomes evident. On the one hand, developing more skill, knowledge and expertise helps nurses gain a greater sense of control in the midst of difficult situations, and hence, incidents that may have emotionally rattled them early in their emergency room career no longer do so. Conversely, however, by being exposed to life situations outside of the emergency room (having friends with cancer, having children, etc.), they develop greater sensitivity about how challenging these circumstances can be, and thus, relate to these situations on a deeper emotional level. As such, when younger, similar situations at work did not affect them as acutely as they do now.

Nursing Implications

We propose that there are important implications for nursing education regarding how nurses appraise critical incidents in general, and more specifically, how they factor age into their appraisal.

Appraisal of Critical Incidents

It was clear from this study that how nurses appraise critical incidents – that is, the personal meaning they attach to the incidents – is the most significant factor in how they are impacted by difficult events within their work. The nurses mentioned that they viewed critical incidents as different from the media stereotypes and that critical incidents were *critical* because they could in some way relate to the situation. By being able to connect with the patient, or having experienced similar events, or knowing of friends and family that had experienced comparable situations, they attached meaning to the

situation, became emotionally involved, and thus felt deeply vulnerable. However, their vulnerability was compounded because of the stigma of revealing what they felt. We suggest that nurse educators within students' academic programmes need to teach undergraduate students about the need to monitor their stress reactions within their nursing work. In particular, nursing students need to be taught that it is appropriate to seek professional help if the emotional response to a critical incident lingers on much beyond the event. As part of this teaching, it is useful to normalize that all individuals, and thus all nurses, have trigger points; that is, all nurses have areas of sensitivity based upon their life experiences. As such, nursing students can be counselled to work in areas that are less likely to trigger vulnerability, if they feel that they still wrestle with previous circumstances. Similarly, nurse educators in acute care, as well as nurse managers, should be sensitized to the importance of talking to staff after difficult events and supporting staff in taking the time and help they need.

Addressing Influence of Age Upon Appraisal of Incident Criticality

Although the importance of ageing upon the appraisal of critical incidents is a secondary finding, and indeed may appear subtle, the relative exclusion of older adults in the descriptions of critical incidents is noteworthy to us. We recognize that the exclusion of older adults in many of the descriptions about critical incidents was not intentional or deliberate. We also are cognizant of the strong note of caring in the voices and words of the research participants. However, when critical incidents are linked strongly with children, or younger adults, we wonder about the influence of media messages upon specific populations, such as older adults, or marginalized populations such as the homeless. Thus, will nurses be less in tune with how critical incidents impact not only older adults, but family members of older adults? Will they think that the death of an elderly parent should not be too hard on older spouses or adult children because death of old age is to be expected (Lane, *et al.*, 2013)? How do we sensitize health care professionals about the impact of critical incidents upon older adults and their family members, irrespective of age? Perhaps one way to challenge this commonly accepted belief is to address ageism within nursing education, as well as through in-services in acute care settings.

We also advocate that nursing students, as well as nurses already working in the profession, are educated about the influence of both chronological and professional age upon their practice. While growing more seasoned within nursing – particularly emergency room nursing – may shield nurses from the traumatic effect of some events, growing older and thus experiencing more of life's challenges may also enhance their sensitivity and vulnerability to some situations faced within the emergency room. Students and nurses can be counselled that age – both professional and chronological – has an impact on how they perceive work events and appraise them. In this way, they may be less surprised or troubled when strong emotional reactions occur, particularly when they did not feel these emotions to similar situations in the past.

Study Limitations

There are several limitations in this study. A small sample size was utilized in the research and may hinder the ability to generalize the findings amongst all emergency nurses. Similarly, as only 2 emergency departments in a large urban centre were selected for data collection sites, it is possible that the experiences of nurses in these departments do not reflect the experiences of emergency departments in smaller, rural areas. Additionally, since emergency nurses were interviewed, the findings may not be generalizable to all nurses or to other professions working with critical incidents such as EMS, fire fighters, and the police force.

Conclusion

While emergency situations are justifiably expected within emergency rooms, how they will impact nurses is not always clear cut. Understanding that how nurses appraise the criticality of incidents (in particular, the meaning they attach to patient events) will influence how they respond emotionally and what kind of supports they require following traumatic situations. Further, understanding that age – both that of the patient and the professional – impacts how nurses view critical incidents, is useful information for educating current and future nurses, as well as providing counsel after critical incidents.

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