Beyond ‘person-centred’ care: a new vision for gerontological nursing

Mike R. Nolan PhD, MA, MSc, RN
Professor of Gerontological Nursing, Department of Community, Ageing, Rehabilitation, Education and Research (CARER), School of Nursing and Midwifery, The University of Sheffield, Northern General Hospital, Sheffield, UK

Sue Davies PhD, MSc, BSc, RGN, RUV
Senior Lecturer in Gerontological Nursing, School of Nursing and Midwifery, The University of Sheffield, Sheffield, UK

Jayne Brown M. MedSci, DipEd, RGN
Lecturer, School of Nursing and Midwifery, The University of Sheffield, Sheffield, UK

John Keady PhD, RMN
Senior Lecturer in Nursing Research, Faculty of Health, University of Wales, Gwyneedd, UK

Janet Nolan MEd, BA, RGN, RUV
Lecturer, School of Nursing and Midwifery, The University of Sheffield, Rotherham, UK

Submitted for publication: 28 October 2003
Accepted for publication: 19 December 2003

Correspondence:
Professor M.R. Nolan
The University of Sheffield
Department of Community, Ageing, Rehabilitation, Education and Research (CARER)
School of Nursing and Midwifery
Samuel Fox House
Northern General Hospital
Herries Road, Sheffield S5 7AU
UK
Telephone: 0144 226 6849
E-mail: m.r.nolan@sheffield.ac.uk

International Journal of Older People Nursing in association with Journal of Clinical Nursing 13, 3a, 45–53

Beyond ‘person-centred’ care: a new vision for gerontological nursing
Currently considerable emphasis is placed on the promotion of person-centred care, which has become a watchword for good practice. This paper takes a constructively critical look at some of the assumptions underpinning person-centredness, and suggests that a relationship-centred approach to care might be more appropriate. A framework describing the potential dimensions of relationship-centred care is provided, and implications for further development are considered.

Key words: person-centred care, relationship-centred care, senses framework

The greatest challenge facing our health and social care system is to get services right for older people. Philp (2003, p. 24)

Nurses working with older people have always experienced difficulties in articulating the knowledge, skills and expertise underpinning their practice and their impact on patient care. McCormack (2001, p. 290)

Introduction
The launch of a new plan for the National Health Service (NHS) in the UK (Department of Health, 2000) marked the most radical series of reforms to the NHS since its formation in 1948. The far-reaching changes that were envisaged recognized that services needed to be more responsive to future health challenges, particularly those posed by the growing numbers of older people. Fuelled by increasing concerns that older people are not receiving the quality of care that they required (HAS, 1998), a key aim of the plan is to eliminate ageism and to create a culture in which any form of discrimination based on the age of an individual becomes ‘unacceptable’. A year later the National Service Framework (NSF) for Older People (Department of Health, 2001) was announced, which for the first time set national standards of care for older people in the UK. Two principles lie at the heart of the NSF: the promotion of ‘person-centred care’; and
the rooting out of age discrimination in the NHS, with these two aims being inextricably linked. This paper argues that person-centred care, as defined in the NSF, is not the panacea that it is held up to be. Indeed, we will suggest that it may well perpetuate, rather than eliminate, poor standards of care for older people. An alternative vision based on relationship-centred care (Tresolini et al., 1994) will be presented, together with a framework, ‘The Senses Framework’ (Nolan, 1997; Davies et al., 1999; Nolan et al., 2001, 2002), which it is suggested can be used as the foundation for enhancing the care older people receive from both health and social services.

**Person-centred care**

Person-centred care is an oft quoted but ill-defined concept that has nevertheless exerted a considerable influence on the policy, practice and academic literatures, particularly in nursing (see McCormack, 2004). Indeed, following a consideration of global trends in ‘gerontic’ nursing, Nay et al. (2000) concluded that notions of ‘client-centredness’ would become the watchword for quality care in the twenty-first century. ‘Patient’, ‘client’ or ‘person-centred’ care reflect the emergence of new approaches to work with older people in a range of care environments, including long-term care (Henderson & Vesper, 1995), rehabilitation (Nolan et al., 1997), learning disability (Williams & Grant, 1998), and dementia care (Kitwood, 1997). It is probably in the latter area, following the pioneering work of Tom Kitwood and colleagues at the Bradford Dementia Centre (Kitwood, 1988, 1989, 1990, 1993, 1997; Kitwood & Bredin, 1992a,b; Kitwood & Benson, 1995) that person-centred care has been fully articulated, and there can be little doubt that Kitwood’s ideas have provided a new sense of direction and purpose for practitioners. However, even within dementia care, some have begun to doubt if person-centred care can actually be achieved, and to question whether it is simply an evangelical ideal (Packer, 2000).

Williams and Grant (1998) contend that person-centred care mandates that practitioners know what it is like to live ‘a certain kind of life’, and that this requires that they have knowledge of people as individuals. This is consistent with the vision of person-centred care promoted in the NSF, where it is defined as care that ‘respects others as individuals and is organized around their needs’ (Department of Health, 2001). This focus on individuality reflects wider trends within health and social care which emphasize the importance of promoting the independence and autonomy of older people, which together with notions of greater user involvement, have become major policy drivers (Hanford et al., 1999). As McCormack (2001) concludes, it is the application of consumerism to health care, and the promotion of a philosophy that treats people as individuals that has resulted in the emergence of the ‘contemporary speak’ of person-centred care. Notions of independence and autonomy also infuse related concepts such as ‘successful ageing’ (Scheidt et al., 1999), which underpin the ‘heroic’ model of the ageing process which depicts ageing as a primarily positive experience. This heroic model provides a counter balance to the deficit model in which ageing is viewed mainly in terms of decline (Reed et al., 2003). However, as Reed et al. (2003) point out, neither the ‘deficit’ nor the ‘heroic’ model adequately capture the experiences of most older people. Others too have been sharply critical of an heroic approach to ageing, particularly one which emphasizes individual autonomy (Kitwood, 1997; Kivnick & Murray, 1997; Scheidt et al., 1999). Indeed, from an ethical standpoint, Evans (1999, p. 13) contends that autonomy is ‘incapable of underpinning any shared societal responsibility for the health of all its members, including the least advantaged’. While autonomy might well be a central notion in health care ethics (MacDonald, 2002), particularly within the nursing literature (McCormack, 2001), a concept of autonomy based on individualism and independence becomes ‘untenable’ in the context of health care for older people, particularly in a hospital setting (McCormack, 2001).

If this is the case, then it would appear that a strategy for fundamental reform, and the promotion of national care standards for older people, that have at their heart a definition of person-centred care that focuses on meeting individual need, may well be misguided. In presenting an alternative vision we will use Mulrooney’s (1997) analysis of person and relationship-centred care to suggest that there are more appropriate foundations for enhancing the care of older people than autonomy and individualism. Mulrooney (1997) suggests that there are three prerequisites that largely determine the quality of care older people receive. These are that caregivers: (i) respect personhood, (ii) value interdependence and (iii) invest in caregiving as a choice.

**Respecting personhood**

While we have argued that a vision of person-centred care, which privileges individual need is inadequate, we would agree that respect for personhood is nevertheless essential. Much depends here on how we view what it means to be a person. There are several complex metaphysical and existential arguments underlying the notion of personhood that we do not have the space to rehearse here (but see Kitwood, 1997 for an accessible introduction, and McCormack, 2004). However, after considering these positions carefully, Kitwood (1997, p. 8) defines personhood as the ‘standing
Valuing interdependence

Several authors contend that the relative failure of modern day health care to address the needs of people with chronic illness has arisen, in no small measure, from the promotion of an individualistic view of the world in which independence has become ‘lionized’ (Kivnick & Murray, 1997) and interdependence and communitarian values neglected (Clark, 1995; Evans, 1999; Mintz & Marosy, 2000). However, if personhood is best understood in the context of relationships (see above), it is important to recognize that the best relationships are reciprocal (MacDonald, 2002; Ronning, 2002). Such relationships are created and sustained in situations where all parties appreciate the need to achieve an appropriate balance between independence, dependence and interdependence (Ronning, 2002), and therefore valuing interdependence becomes a central concern (Clark, 2002). Such considerations apply equally to nurse–patient relationships, which constitute the ‘essence’ of new nursing (McCormack, 2001, 2004). As McCormack (2001) contends, it is important that the values that both patients and nurses bring to an encounter are made explicit, and are used to underpin a process of negotiation that results in mutual recognition of each other’s beliefs. On this basis a reciprocal relationship develops in which ‘both parties grow as a result’. For this to happen it is essential that practitioners account for and value the ‘multiple voices’ within caregiving relationships (Pryor, 2000; Clark, 2002).

The importance of creating a positive nurse–patient relationship has recently been more fully acknowledged (Bright, 1997; Fagermoen, 1997; Jones et al., 1997; McCormack, 2001, 2004). However, we firmly believe that it is not just relationships with patients and their families that are essential (Nolan et al., 2003), and the way that nurses relate to the other professions involved in the delivery of care also requires careful consideration. It has been suggested that the majority of problematic situations that arise when caring for older people do so because of differences of opinion between colleagues who feel that their opinions and values are not listened to or acknowledged (Forsgärde et al., 2002). In reflecting on the way forward for gerontological nursing in the twenty-first century, Whall (1999) argued that nursing has been too self-absorbed for the last 20 years and that, to develop, nurses need to pay greater attention to their ‘external’ relationships, especially with other disciplines. She suggests that if a more meaningful dialogue is to occur then certain conditions have to be met, foremost amongst which is the need to make explicit ‘the underlying assumptions or premises that each participant holds and the beliefs and meanings that they bring to the situation’. Just as with the arguments advanced above with respect to the nurse–patient relationship, interactions between differing disciplines are only likely to thrive when partnerships based on ‘mutual respect and self-determination’ are created so that reciprocal, complementary and symmetrical relationships result. Person-centred care, which focuses on ‘individuals’ and their needs, or person-centred nursing, that focuses on the nurse–patient relationship (McCormack, 2004) is unlikely to promote such relationships. Rather there is a need to create a ‘milieu’ in which all participants are meaningfully involved, and which reflects the existence of multiple environments of care (Pryor, 2000). This is rarely the case in modern day health care, with its focus on responding to acute conditions (Nolan et al., 1997).

It was recognition of the deficiencies in current systems of health care delivery that prompted the emergence of ‘relationship-centred care’ (Tresolini et al., 1994).

The emergence of relationship-centred care

During the early 1990s there was ‘intense national debate’ in the US about the future of health care. This was prompted by growing disenchantment with existing arrangements amongst both practitioners and patients who recognized the relative failure of the American health care system to address the needs of a diverse, multicultural society in which the major demands arise as a result of chronic illnesses (Tresolini et al., 1994). In order to advance this debate a Task Force was established to consider a differing approach to health care
based upon the interdependence of psychological, social and biological factors. The aim was to promote the closer integration of such concepts into the educational preparation of all those working within the health care system. As a result of these deliberations, the Task Force proposed a new model for health care delivery that they termed ‘relationship-centred care’, which reflected the ‘importance of interactions amongst people as the foundation of any therapeutic or healing activity’ (Tresolini et al., 1994, p. 22).

Such relationships exist at several levels including those between patients, their families, staff from all disciplines, and the wider community. The interactions between these groups constitute the ‘defining force’ in health care, as they are the medium for exchanging the information, feelings and concerns needed for a better understanding of the meaning of illness. As the Task Force noted, every participant in a health care encounter ‘interprets and constructs a subjective world, and these worlds are modified by the dialogue between them. Both are changed in the process… (and) from an inseparable unit of interdependent subjects’. We would suggest that such a vision of health care is likely to prove far more useful than one based on notions of person-centred care.

The Task Force went on to suggest the basis for an educational system that would promote relationship-centred care but recognized that the concept was emerging, rather than fully formed, and that further work was needed to ‘explicate the dimensions of a relationship-centred approach to care’. This is something to which we will turn our attention shortly. However, prior to that there is a need to consider Mulrooney’s (1997) third prerequisite for good care for older people – investing in caregiving as a choice.

**Investing in caregiving as a choice**

Mulrooney’s (1997) third prerequisite is based upon the premise that individuals providing care to older people, whether family members or paid carers, are unlikely to ensure care of the highest quality unless they have a positive predisposition towards such care. This is a major concern for gerontological nursing where issues of motivation, recruitment and retention of staff are currently priority areas. A recent major review of gerontological nursing in the UK concluded that ‘the goal of ensuring high quality nursing care for all older people in the NHS remains elusive’, and noted that the persistence of negative attitudes towards work with older people as being of ‘great concern’ (Standing Nursing Midwifery Advisory Committee, 2001). Work with older people is often perceived to be of low status and to be less attractive, exciting and important than nursing in acute or rehabilitative contexts (Standing Nursing Midwifery Advisory Committee, 2001). Similar conclusions have been reached in other countries such as Australia, where student nurses view work with older people as being unchallenging, untechnical and unrewarding, with only 1% of those in training identifying gerontological nursing as their preferred career option (Happell, 2002). Furthermore, it seems that negative dispositions towards gerontological nursing are heightened throughout nurse training, with it increasingly being seen as boring, unstimulating and frustrating (Happell & Brooker, 2001). Likewise, in Hong Kong, Herdman’s (2002) study indicated that the percentage of students who would actively choose to work with older people decreased as they neared qualification. However, Herdman (2002) asserts that the reasons for this are complex and are not necessarily the result of negative attitudes towards older people *per se*. Rather she suggests that the conditions of work, such as a lack of resources and a poor physical environment, exert a negative influence. However, the most telling reason that nurses do not choose to work with older people is because they believe that such work will not enhance their clinical skills and career prospects, when compared with areas such as accident and emergency or surgery, which are seen to provide the experiences necessary for a solid career platform.

Others have reached similar conclusions, noting that even when student nurses have positive intentions to work with older people they soon learn that gerontological nursing is seen as ‘uninteresting’ by peers (McKinlay & Cowan, 2003). These authors suggest that there is a need to highlight the potential sources of job satisfaction in gerontological nursing if it is to attract and retain staff.

However, the belief that working with older people provides little stimulation and challenge is not confined to nursing. Following a review of the literature Lee et al. (2003) argue that such a perception exists in virtually all professions within the health and social care fields. Their own study with clinical psychologists demonstrated that trainees feel that they have little of value to offer older people and that such beliefs betray both ageist attitudes and trainees’ own fears of ageing and death. These authors argue that there has to be a concerted effort to promote work with older people if newly qualified staff are to be attracted to the area.

On the basis of recent studies it would seem that there is a need for considerable remedial action if gerontological nursing is to become a more attractive career prospect. Interestingly there is evidence to suggest that efforts should not be directed at students’ attitudes towards older people *per se*, but rather to counter the view that gerontological nursing provides little challenge and represents a poor career option. Certainly our own recent study, the largest ever conducted in the UK, concerning students’ views and experiences...
of gerontological nursing (Nolan et al., 2002), would support such a position. We discovered that students hold initially positive views of work with older people but that these are significantly influenced by their prior experience with older people, their experiences whilst undergoing training, and the attitudes of qualified staff. If students had positive prior experience of work with older people, enjoyed their placements as a student, and believed that they could ‘make a difference’, then they were far more likely to want to go and work in gerontological nursing when they qualified. The belief that nurses could ‘make a difference’ and have a positive impact on the lives of older people was a primary motivation. However, much turned on how ‘making a difference’ was construed. When this was defined largely in terms of cure or physical improvement then gerontological nursing was viewed less positively. Conversely, when there was an appreciation of more subtle and less overt forms of ‘improvement’ or benefit then students were far more likely to see the therapeutic potential and reward of working with older people. However, all too often students were exposed to environments of care where they struggled to see what ‘difference’ nursing made and where work with older people was portrayed as having little to offer.

In many ways the problem is a perennial one and is indicative both of the dominant biomedical view of ageing (Reed et al., 2003), and the pervasive influence of notions such as autonomy and independence. Against such a background nurses have ‘always experienced difficulties in articulating the knowledge, skills and expertise underpinning their practice and their impact on patient care’ (McCormack, 2001, p. 248). Over two decades ago, Wells (1980, p. 129) reached a similar conclusion when she argued that ‘the central problem in all nursing…conclusion when she argued that ‘the central problem in…’ (McCormack, 2001, p. 248).

We would suggest that ‘relationship-centred care’ potentially provides such a perspective but would agree that there is a need to ‘further explicate’ (Tresolini et al., 1994) what we mean by relationship-centred care so that we can identify the conditions in which positive caring relationships can be created and sustained. If, as McCormack (2001) asserts, the essence of nursing ‘lies in the nature of the nurse–patient relationship’, then, as he suggests, we have to understand the ‘rules’ guiding such relationships. This means turning attention to the types of ‘supportive social conditions’ (MacDonald, 2002) or to the ‘milieu of care’ (Pryor, 2000) needed to promote genuinely empowering and reciprocal caring relationships. We would agree with Brechin (1998) that good care is best understood in terms of the inter-relationships between those giving and receiving care, and that there is a need to identify the ‘fundamental similarities’ that characterize such inter-relationships. It is here that we believe that the ‘Senses Framework’ (Nolan, 1997; Davies et al., 1999; Nolan et al., 2001, 2002) has much to offer.

The ‘Senses Framework’

The ‘Senses Framework’ (Nolan, 1997; Davies et al., 1999; Nolan et al., 2001, 2002) captures the subjective and perceptual dimensions of caring relationships and reflects both the interpersonal processes involved and the intrapersonal experiences of giving and receiving care. The ‘Framework’ is underpinned by the belief that all parties involved in caring (the older person, family carers, and paid or voluntary carers) should experience relationships that promote a sense of:

- security – to feel safe within relationships;
- belonging – to feel ‘part’ of things;
- continuity – to experience links and consistency;
- purpose – to have a personally valuable goal or goals;
- achievement – to make progress towards a desired goal or goals;
- significance – to feel that ‘you’ matter.
The essence of the Senses Framework is that all participants need to experience these senses if good care is to result. Therefore, it is not just the nurse and patient who are ‘in relation’ (McCormack, 2004). Although initially developed as a means of providing a rationale for care within longer term institutional settings (Nolan, 1997), the Framework has since been the subject of extensive empirical testing, which has highlighted its value in understanding good quality caring relationships in acute hospital settings for older people (see Davies et al., 1999). It is now apparent that although what creates a sense of security, belonging, continuity, purpose, achievement and significance will vary across differing groups and caring contexts, such ‘senses’ are nevertheless prerequisites for relationships that are satisfying for all parties involved.

Following empirical work (Davies et al., 1999), and an extensive consideration of the relevant literatures in relation to older people, which involved an initial overview of some 22 000 references and a more detailed reading of approximately 2000, Nolan et al. (2001) summarized the ‘senses’ as in Table 1.

Subsequently the ‘Senses Framework’ has been subjected to detailed empirical study involving interactive focus groups

Table 1. The Six Senses in the Context of Caring Relationships

<table>
<thead>
<tr>
<th>Sense of Security</th>
<th>Sense of Continuity</th>
<th>Sense of Purpose</th>
<th>Sense of Achievement</th>
<th>Sense of Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>For older people:</strong> Attention to essential physiological and psychological needs, to feel safe and free from threat, harm, pain and discomfort. To receive competent and sensitive care.</td>
<td><strong>For older people:</strong> Recognition and value of personal biography; skilful use of knowledge of the past to help contextualize present and future. Seamless, consistent care delivered within an established relationship by known people.</td>
<td><strong>For older people:</strong> Opportunities to engage in purposeful activity facilitating the constructive passage of time, to be able to identify and pursue goals and challenges, to exercise discretionary choice.</td>
<td><strong>For older people:</strong> Opportunities to meet meaningful and valued goals, to feel satisfied with one’s efforts, to make a recognized and valued contribution, to make progress towards therapeutic goals as appropriate.</td>
<td><strong>For older people:</strong> To feel recognized and valued as a person of worth, that one’s actions and existence are of importance, that you ‘matter’</td>
</tr>
<tr>
<td><strong>For staff:</strong> To feel free from physical threat, rebuke or censure. To have secure conditions of employment. To have the emotional demands of work recognized and to work within a supportive but challenging culture.</td>
<td><strong>For staff:</strong> Positive experience of work with older people from an early stage of career, exposure to good role models and environments of care. Expectations and standards of care communicated clearly and consistently.</td>
<td><strong>For staff:</strong> To have a sense of therapeutic direction, a clear set of goals to which to aspire.</td>
<td><strong>For staff:</strong> To be able to provide competent standards of care, whether delivered by self or others, to ensure that personal standards of care are maintained by others, to maintain involvement in care across care environments as desired/appropriate.</td>
<td><strong>For staff:</strong> To feel that gerontological practice is valued and important, that your work and efforts ‘matter’</td>
</tr>
<tr>
<td><strong>For family carers:</strong> To feel confident in knowledge and ability to provide good care (to do caring well – Schumacher et al., 1998) without detriment to personal well-being. To have adequate support networks and timely help when required. To be able to relinquish care when appropriate.</td>
<td><strong>For family carers:</strong> To maintain shared pleasures/pursuits with the care recipient. To be able to provide competent standards of care, whether delivered by self or others, to ensure that personal standards of care are maintained by others, to maintain involvement in care across care environments as desired/appropriate.</td>
<td><strong>For family carers:</strong> To maintain dignity and integrity, well-being and ‘personhood’ of the care recipient, to pursue (re)constructive/reciprocal goals and challenges, to exercise discretionary choice.</td>
<td><strong>For family carers:</strong> To be able to maintain/improve valued relationships, to be able to confide in trusted individuals to feel that you are not ‘in this alone’</td>
<td><strong>For family carers:</strong> To feel that you have provided the best possible care, to know you have ‘done your best’, to meet challenges successfully, to develop new skills and abilities</td>
</tr>
<tr>
<td><strong>For family carers:</strong> To feel recognized and valued as a person of worth, that one’s actions and existence are of importance, that you ‘matter’</td>
<td><strong>Family carers:</strong> To feel that one’s caring efforts are valued and appreciated, to experience an enhanced sense of self.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

From Nolan et al. (2001, p. 175).
and workshops with practitioners, carers and older people to determine if the senses capture those elements of relationships that participants considered important. In particular, participants were asked to consider whether the ‘senses’ resonated with their own experiences and ‘spoke’ to them in a language that they understood and related to. In total, 196 people took part in these various activities comprising older people, family carers, a diverse multidisciplinary set of professionals, and paid but unqualified care assistants in both institutional and community settings (see Nolan et al., 2002 for a detailed account).

The senses were seen as highly relevant to the care of older people by all groups. However, for staff in particular, it was apparent that they helped to provide a sense of direction as reflected in comments such as:

- the senses could help us to celebrate success;
- they can help us to define best care;
- they make the seemingly insignificant significant;
- I feel a connectedness to these;
- I can identify with this (Senses Framework) as it relates closely to my practice;
- they highlight what gets lost in evidence-based care.

It was apparent from the workshops that the senses provided a means of highlighting important, but often taken-for-granted, aspects of care that participants felt were often lost in debates about evidence-based care. Practitioners believed that the senses were implicit within their existing philosophy of care but that the Framework helped to make them more explicit.

Significantly, in those workshops involving professionals, much of the discussion focussed around the value of the senses for staff themselves, with participants believing that they could provide a means of overcoming the prevalent ‘NHS blame culture’ by helping staff to ‘feel good about what we do’.

Overall, participants at all the workshops saw the need for a new vision and direction for work with older people, which provided a greater sense of therapeutic potential and more subtle and appropriate indicators of ‘success’. While it was recognized that a change of culture among staff was required, several participants felt that if staff were valued and supported themselves they would be better able to value and support older people. There was much talk of the need for strong and visionary leadership and of a supportive culture, which celebrated success rather than concentrating on failure, and which recognized mistakes as learning opportunities rather than seeking to apportion blame. Several ways in which such a culture could be achieved were suggested during the workshops. However, the key was seen to be vision and leadership, and the ‘senses’ were acknowledged as providing a way of realizing a ‘vision’ of care in which ‘fundamental’ elements were valued and accorded status (Standing Nursing Midwifery Advisory Committee, 2001). Furthermore, the relevance of the senses for several stakeholder groups was endorsed, as was their potential to promote a better shared understanding. For example, having applied the senses to their own situation participants, especially staff, felt better able to relate the senses to older people and their carers.

However, it was with the student nurses that the most detailed data were collected. On the basis of both large-scale surveys (Nolan et al., 2002) and in-depth case studies we were able to identify the characteristics of what we term ‘impoverished’ and ‘enriched’ environments of care for older people (Brown, 2002). Environments can be impoverished in two main ways, one relating primarily to the physical environment, the other to the more subtle and difficult to address, staff attitudes and care practices to which students are exposed. One of the main conclusions of the Advancing Gerontological Education in Nursing (AGEIN) Project (Nolan et al., 2002) was that a major determinant of students’ future decisions to work with older people, or not, was the nature and quality of their clinical experience, both within rostered placements and during extra curricular work as care assistants. Occasionally during the former, and frequently during the latter, students were exposed to ‘impoverished’ environments in which staff shortages, outdated equipment, and lack of time for anything other than physical care often served to reinforce students’ perceptions that gerontological nursing had little to offer as a future career. Importantly, in such environments, students themselves were not valued and supported. They were not made to feel that they ‘belonged’, there was little continuity of care, and a pervasive feeling of a general lack of purpose and direction. Students certainly did not feel ‘significant’ in such environments and believed that there was little that they could do to change this. Crucially, they frequently picked up similar messages in respect of older people, as the actions of more permanent staff often demonstrated that older people themselves were not seen as significant, and that the staff did not believe that what they did was accorded value and status. In such environments nobody, least of all older people themselves, experienced the ‘senses’.

Conversely, if students were exposed to ‘enriched’ environments of care where staff actively worked to create the ‘senses’ for both older people and for students, then experiences were altogether more positive. Moreover, in such environments, staff experienced the senses for themselves, and it is in capturing the need for all parties to feel secure, that they belong, to experience continuity, and to perceive a
sense of purpose and achievement that the senses have the most to offer. As such they provide a means of understanding the interdependency that characterize the best caring environments. Such an understanding is essential to promote a new vision of gerontological nursing in which older people themselves, and the staff who provide care, really believe that they ‘matter’.

Conclusion

Fundamentally if therapeutic nursing is dependent on the individual relationship between a nurse and a patient, then attempting to base therapeutic nursing practice on an individualistic concept of autonomy can be seen to be flawed. McCormack (2001, p. 248)

While we would agree entirely with the sentiments expressed in the latter half of the above quotation, we would like to suggest that therapeutic nursing is not best depicted as being ‘dependent on the individual (our emphasis) relationship between a nurse and a patient’ (McCormack, 2004) but rather on a network of relationships. As with others (Clark, 2002; MacDonald, 2002), we believe that therapeutic care requires that we establish a shared understanding and, as Zgola (1999) has noted, to do this we have to use the same language and concepts. This is more important in relation to vulnerable older people.

Elsewhere it has been argued that any framework for work with older people needs to be able to take account of individual subjective interpretations of experience but also to provide a shared set of concepts, which are seen as relevant and meaningful by disparate groups of people both giving and receiving care (Nolan et al., 2001). We believe that the Senses Framework has such potential. To date the relevance and usefulness of the senses have been explored with several key groups (including older people, family carers, qualified and unqualified staff and student nurses) and they have received strong support. Herein lies our challenging agenda for the future, not only for gerontological nursing, but all those who seek to meet the needs of vulnerable older people and to enhance their quality of life. However, there is a need for further work to determine more fully what the senses mean and how they can be achieved for differing groups in differing caring contexts.

References


This document is a scanned copy of a printed document. No warranty is given about the accuracy of the copy. Users should refer to the original published version of the material.
This document is a scanned copy of a printed document. No warranty is given about
the accuracy of the copy. Users should refer to the original published version of the
material.