

LOOKING BEYOND:
THE RN'S EXPERIENCE OF
CARING FOR OLDER
HOSPITALIZED PATIENTS

A Thesis Submitted to the College of
Graduate Studies and Research
In Partial Fulfillment of the Requirements
For the Degree of Master of Nursing
In the College of Nursing
University of Saskatchewan
Saskatoon

By

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ABSTRACT

Older patients comprise a large portion of patients in the acute care setting. Registered Nurses (RNs) are the main care providers in the hospital setting. RNs caring for older hospitalized patients are affected by many factors including workload pressures, issues related to the acute care environment and attitudes toward older patients. However, a literature review identified a limited number of studies exploring the RNs' experience of caring for older patients in the acute care setting. This study explored the RNs' experience of caring for older patients (age 65 and older) on an orthopedic unit in an acute care hospital. Saturation was reached with a purposive sample of nine RNs working on the orthopedic unit, including eight females and 1 male. Participants were interviewed using broad open-ended questions, followed by questions more specific to emerging themes. All interviews were audio-taped and transcribed verbatim. Data were analyzed using Glaser's (1992) grounded theory approach. Participants described the basic social problem as dealing with the complexity of older patients. The basic social process identified was the concept of "looking beyond". Looking beyond was described as looking at the big picture to find what lies outside the scope of the ordinary. Three sub-processes of looking beyond were identified as connecting, searching, and knowing. Connecting was described as getting to know patients as a person by taking time, respecting and understanding the individual. Searching was described as digging deeper, searching for the unknown by looking for clues and mining everywhere for information. Knowing was described as intuitively

knowing what is going to happen and what the older patient needs by pulling it all together and knowing what to expect. These dynamic sub-processes provided the RN with the relationship and information required to “look beyond” to manage the older patient’s complexity. The results of this study have implications for nursing practice, education and research. These findings may provide RNs with a process to manage the complex care of a large portion of our population.

ACKNOWLEDGMENTS

The phrase, “it takes a village” has been used to describe raising a child. After enduring the writing of this thesis, I have come to see the relevance of this statement with respect to this process as well! Although my name so boldly appears on the cover of this work, I could not have completed it without the support of so many others.

I wish to thank the Social Sciences and Humanities Research Council of Canada for their generous support. Receiving a Master’s scholarship was both an honor and a welcome financial relief. Thank you to my committee members Dr. Muriel Montbriand and Dr. Debra Morgan for their continued support and expertise. I also wish to thank my supervisor, Dr. Wendy Duggleby for her endless support, patience and encouragement. Her belief in my ability and her willingness to share her own struggles and experiences were more powerful than she will ever know.

Last but certainly not least, I wish to thank my family and friends for their endless support. To my friends who were always there with an encouraging word, thank you! To my parents, for their endless offerings of childcare and meals, thank you! To know that my family was well cared for gave me peace of mind. To my children and my husband (my computer support), I realize the sacrifice this study has been for you all, thank you! To know that you stood behind me and believed in me meant so much. Now when you ask me “how many more pages?” I am thrilled to say, “None!”

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CHAPTER ONE

INTRODUCTION

The Canadian population is aging. Future projections anticipate that by 2021, older adults (those 65 years and older) will make up 19% of the Canadian population, and 25% by the year 2041 (Health Canada, 2003). Canadian older adults have the highest rate of hospitalization next to infants, and are three times more likely than those aged 45-64 to be hospitalized (Health Canada, 2003). The hospitalization of older adults as a hazardous, complicated event is well documented in the literature (Brennan et al., 1991; Lefevre et al., 1992). Older patients are often victims of poor practice outcomes, resulting in unnecessary iatrogenic complications (Palmer, 1995). Considerable expertise is required to identify health concerns of older adults related to atypical disease presentation and age changes (Adelman, Greene, & Ory, 2000).

As the main care provider in the acute care setting, Registered Nurses (RNs) have a critical role caring for older hospitalized patients. This role has an effect on outcomes for older patients (Hamilton & Lyon, 1995; Jacelon, 1999). There is a limited amount of literature describing the experience of RNs caring for older patients in the acute care setting. Difficulties of managing acute healthcare needs of older people in the hospital setting have been described by RNs (Cheek & Gibson, 2003). However, no reported studies have focused on

how the RNs deal with difficulties and challenges in caring for hospitalized older adults. Understanding the RNs' experience of caring for older hospitalized patients is a timely and much needed area of study. Study results could serve as a foundation for education and further research.

Purpose of the Study

The purpose of this study is to gain a deeper understanding of the RNs' experience in caring for older patients on an orthopedic unit in a 200 bed acute care setting in a moderately sized mid-western Canadian city. The specific aims of the study include:

1. To identify social interactions and forces experienced by surgical nurses caring for older patients on an orthopedic unit.
2. To generate a theoretical analysis of the experience of caring for older patients.
3. To develop statements of relationships between concepts regarding the basic social processes of the experience.

These three aims addressed the following research questions:

1. What is it like to care for older patients in an acute care orthopedic unit?
2. What are the factors that influence the care of older patients in the orthopedic unit?

Relevant Literature

A review of the relevant research literature of caring for older adults in the acute care setting was conducted. Research focusing on the RNs'

experience of caring for older patients in the acute care setting is a relatively new area of study. The experience of caring for older patients in the acute care setting has been studied with orthopedic RNs caring for acutely confused elderly patients (Rogers & Gibson, 2002), and with nursing students (Fagerberg & Ekman, 1997).

Caring for Older Patients

Only one qualitative study investigating the RNs' experience of caring for acutely confused elderly orthopedic patients was identified in the literature (Rogers & Gibson, 2002). In their study, Rogers and Gibson explored the experience of 10 orthopedic RNs. Findings revealed that RNs identified acute confusion based on observations of patient behaviors, function, orientation, and the RNs' knowledge of factors that predispose patients to developing confusion. Once confusion was identified, RNs looked for possible causes. RNs used constant surveillance, elimination of underlying causes, reorientation strategies and caring interactions to manage the confusion. Acute confusion had a major effect on RNs, patients, room-mates and families. Caring for these patients also threatened RNs' safety, affected their self-esteem and created mental conflicts.

Rogers' and Gibson's (2002) study focused on the RNs' experience related to caring for older patients with acute confusion. The experience of caring for older patients with cognitive impairment and the experience of caring for older patients with various conditions may differ. Further investigation into

the experience of RNs caring for older hospitalized patients with a variety of conditions must be explored.

The experiences of 30 first year nursing students working with older patients in various settings were explored by Fagerberg & Ekman (1997). Using a transcendental phenomenological approach, the authors aimed to understand students' low interest in and negative attitudes toward caring for older patients. Two phenomena were identified: patients' helplessness and students' identification/non-identification of the uniqueness of individual patients. Students identified that they perceived patients as helpless in many situations related to hygiene, dressing, critical changes in health status, anxiety, depression, pain and approaching death. Students also described that they could relate to individual elderly patients.

These studies provide some insight into RNs' and students' experience of caring for older patients. They also identified factors affecting the RN caring for older hospitalized patients, such as workload issues, system wide issues, and attitudes toward older patients.

Workload

Workload issues affecting the RNs' ability to provide care for older patients in the acute care setting have been described in the literature (Cheek & Gibson, 2003; Eriksson & Saveman, 2002). Cheek and Gibson (2003) utilized critical incident technique interviews with 24 RNs and focus groups with other health care workers who worked with RNs to explore issues influencing RNs' ability to care for older hospitalized people. RNs described caring for older

patients as heavy work, physically and emotionally. Workload issues described by RNs included: lack of time to care, inability to conduct proper assessments, tension between encouraging independence and getting work done, and inadequate staffing levels to provide required care. RNs also described caseload issues such as high acuity levels and types of patients as adding to the intensity and difficulty of their workload. Staff shortages and lack of resources also affected RNs' ability to provide the needed care.

RNs working with cognitively impaired patients in the acute care setting also described workload issues affecting their ability to provide care (Eriksson & Saveman, 2002). The authors interviewed 12 RNs to describe their experiences of difficulties related to caring for patients with dementia in the acute care setting. Lack of time to get to know patients, to meet their needs, and to learn to interpret their different ways of communicating was identified as the biggest issue. RNs described that patients with dementia took too much of the RNs' time and intruded on the time they needed to do routine work on the ward. This caused irritation, frustration, and feelings of inadequacy, powerlessness, and failure among the RNs.

These studies describe the significant workload pressures affecting RNs working with older patients in the acute care setting. Only one study identified workload issues caring for older patients in general (Cheek & Gibson, 2003). The study identifying workload issues related to cognitive impairment narrowly focused on issues related to this group of older patients (Eriksson & Saveman, 2002). Further investigation into the workload issues affecting RNs as they

care for cognitively impaired and non-cognitively impaired older patients in acute care settings will increase understanding of their experience.

System

System wide issues affecting the RN caring for older patients in the acute care environment have been described in the literature (Cheek & Gibson, 2003; Eriksson & Saveman, 2002; Meyer, Bridges, & Spilsbury, 1999). Cheek and Gibson (2003) described difficulties related to the acute care environment. The environment/culture was described as problematic for managing elderly patients. RNs described the lack of continuity of care related to staff shortages and poor communication between sectors of the health care system. RNs also described the use of agency staff who did not have the knowledge of older patients and their needs. Another system concern was 'outliers.' 'Outliers' were described as older patients who required specialized care, but were sent to other units because the relevant ward was full. RNs felt these patients did not receive the care required, as the focus of the ward was different than what the older patient needed. RNs also suggested the acute care focus on acute illness and biomedical needs did not fit with the social and emotional needs of older patients. Taking a holistic view of the older patient was difficult in a system focused on curing the presenting illness and discharging as quickly as possible.

Eriksson and Saveman (2002) also described difficulties related to the organization of the acute care setting. Frequent transfers within the hospital and the involvement of numerous staff in the care of the older person increased

the patient's agitation, adding to the difficulty. RNs described lack of information and cooperation between different care agencies involved, lack of resources, cutbacks in staffing and bed numbers as system issues affecting their ability to provide care. RNs also described pressure from the broader system to care for more patients, spending less time with individual patients. All these issues added to the difficulty of caring for demented patients in the acute care setting.

Difficulties related to the acute care setting were identified as affecting the organization of care for older people in the accident and emergency department of an acute care hospital (Meyer et al., 1999). The authors utilized an action research methodology with an unidentified number of multi-disciplinary staff and 12 older patients to explore the organization of care for older people. Staff members described poor coordination between services as problematic with lengthy waits, conflict and tension between services. Staff also described how some services were not willing to take responsibility for the care of older patients. Lack of equipment, inappropriate skill mix, poor organization of nursing care, inadequate patient documentation, and lack of education were also described. Staff members described the low priority the broader organization gave to obtaining these needed resources to care for older patients. These difficulties affected the staff's ability to provide for the needs of older patients.

These studies highlighted the system wide issues that affect the RNs' and other staff members' experience of caring for older patients in the acute

care setting. Again, only one of these studies focused specifically on RNs caring for non-cognitively impaired older patients in the acute care setting. Older patients with cognitive difficulties have unique needs as compared with older patients in general. The experiences of RNs caring for older patients may differ from the experience of other interdisciplinary staff members. Therefore, further investigation into the system wide difficulties related to older patients is required.

RNs' Attitudes Towards Older People

Attitudes toward older people may affect the RNs' experience of providing care for older patients in the acute care setting. Jacelon (2002) found that staff attitudes affected the dignity and autonomy of hospitalized elders. Attitudes toward older adults have been the subject of much research with health care providers. However, there is a considerable lack of consistency in the findings examining attitudes toward older people.

Several studies have examined RNs' attitudes toward older patients in the acute care setting (Armstrong-Esther, Sandilands, & Miller, 1989; Courtney, Tong, & Walsh, 2000; Hope, 1994; Prevost, Wilson, & Gerber, 1991; Pursey & Luker, 1995; Salmon, 1993; Tierney, Lewis, & Vallis, 1998; Wilkes, LeMiere, & Walker, 1998). See Table 1.

Table 1: Literature exploring RN attitudes toward older patients

Author	Purpose	Sample	Method	Findings
Armstrong-Esther, Sandilands & Miller, 1989	To determine the attitudes of health care workers towards the elderly in acute care settings	50- RNs 20- nursing aides 4- degree nurses 8- volunteers	Quantitative Questionnaire Kogan's old people scale together with non-participant observation	Volunteers had most favorable attitudes, RNs & degree nurses had moderately positive scores, and nursing aides had most negative attitudes
Courtney, Tong, & Walsh, 2000	To determine RNs' knowledge of & attitudes toward older patients in rural & urban acute care settings	411 RNs	Quantitative cross-sectional design. Utilized Older Patients in Acute care Survey and Facts on Aging Quiz	Rural RNs had more knowledge than urban RNs. Urban RNs had more positive attitudes toward older patients than rural RNs. Rural RNs had more positive practices than urban RNs.
Hope, 1994	To examine RNs' attitudes towards older people in different care settings	73 RNs in acute care of elderly units 76 RNs in acute medical units	Non-experimental quantitative survey	Significant difference in attitudes with acute care of elderly RNs more positive than medical RNs; Significant relationship between post basic gerontological education and positive attitudes in Medical RNs.
Prevost, Wilson, & Gerber, 1991	To assess knowledge & attitudes of acute care nursing staff	162 RNs 69 –ICU 93- med-surgical	Non-experimental quantitative descriptive correlational study	ICU RNs had higher knowledge & more positive attitudes than medical-surgical RNs. Positive correlation with knowledge-attitudes

Continued on next page

Table 1 Continued

Author	Purpose	Sample	Method	Findings
Purseley & Luker, 1995	Describe differences between attitudes towards work with older people	49- RNs 136- health visitors 62- Student health visitors	Qualitative interviews	Results indicated attitudes toward older people were not as negative as attitudes about structural context of working with them.
Salmon, 1993	To identify if RNs' interactions with elderly patients varied in relation to their attitudes	27 RNs on psycho-geriatric units	Qualitative & quantitative comparison – observational & attitudinal scale	No correlation found, attitude measure failed to predict level or quality of interactions with older patients.
Tierney, Lewis, & Vallis, 1998	To assess & compare orthopedic RNs' knowledge & attitudes toward older people	161 RNs	Non-experimental quantitative comparison study (replication of Hope, 1994)	No significant association between knowledge or attitude scores and gender or age. Knowledge scores higher on unit with geriatrician involvement, not statistically significant.
Wilkes, LeMiere, & Walker, 1998	To determine RNs' attitude toward older people & to identify their knowledge base of older people	261 hospital RNs	Non-experimental descriptive, correlational comparative quantitative study	RNs had negative attitudes to older people. Age, clinical years of experience, ethnicity and highest nursing qualification did not have an effect on attitude. Significant gaps in RNs knowledge of older people.

Source: Author

Conflicting results are evident in the studies summarized in Table 1. Many have attempted to measure variables that may be associated with negative attitudes toward older people. Age, race, gender, education level, years of clinical experience and area of clinical practice have shown no consistent association in the relationship with attitudes toward older people (Hope, 1994; Tierney et al., 1998). Several studies have described conflicting results in the association between knowledge of older adults and the effect on attitudes (Courtney et al., 2000; Hope, 1994; Prevost et al., 1991; Tierney et al., 1998).

The workplace environment in which older patients were cared for was addressed in only one study looking at attitudes towards older patients (Pursey & Luker, 1995). Resources such as Geriatrician involvement was identified in only one study by Tierney and colleagues (1998). The environment in which older patients are cared for and available resources may affect attitudes and requires further exploration.

Identifying a direct link between attitudes and their effect on behavior has been controversial. Research consistently reveals the relationship between attitudes and actions to be problematic. A number of authors have pointed out that behavior cannot be predicted on the basis of attitudes alone (Pursey & Luker, 1995; Salmon, 1993; Wicker, 1969).

The majority of studies examining attitudes utilized a quantitative methodology. With the lack of consistency in study findings examining attitudes, researchers suggested the need for qualitative study in this complex

area (Purseley & Luker, 1995; Tierney et al., 1998). Qualitative studies such as the present one may assist in identifying information previously undiscovered by quantitative studies. Utilizing a grounded theory approach will assist in eliciting the issues and processes underlying the care of older adults in the acute care setting.

Summary

Review of the literature shows that the RNs' experience of caring for older patients is influenced by many factors. These factors include the difficulties of caring for older hospitalized adults, workload issues, system wide issues, and attitudes of RNs towards older people. These findings should alert the health care team to serious multi-faceted issues affecting caring for older patients in the acute care setting. The limited number of studies regarding the experience of RNs caring for older adults in the acute care setting is a serious gap in the current literature. Further qualitative study into the experience of RNs caring for older adults in the acute care setting may provide insight into the issues involved in providing high quality care.

CHAPTER TWO

METHODOLOGY

Research Design

Little is known about the RNs' experience of caring for older patients in the acute care setting. A qualitative, grounded theory approach developed by Glaser and Strauss (1967) and further delineated by Glaser (1992) was utilized to explore the experience of RNs caring for older patients. Grounded theory aims to discover underlying social forces that shape human behavior (Marcus & Liehr, 1998). Based on the symbolic interaction theory (Blumer, 1969), grounded theory explores the relationship between individuals and society, and involves an ongoing process of symbolic communication in which individuals create a social reality (Marcus & Liehr, 1998). Grounded theory is an important research method for nursing phenomena as it explores the richness and diversity of the human experience in a naturalistic setting (Streubert-Speziale & Rinaldi-Carpenter, 2003).

Caring for older patients has been linked to workload issues, system wide issues and attitudes. However, the lack of consistency in research findings has suggested that other factors may also play a role. Utilizing a grounded theory approach to identify social interactions and forces may provide insight, and allow for the exploration of other factors involved in caring for older patients.

Setting

The study was conducted on the orthopedic unit at a 200 bed acute care hospital in a moderately sized mid-western Canadian city. The hospital provides acute care services to the city as well as the central and northern regions of the province. This setting was chosen as older adults are typically seen on this unit. The orthopedic unit has 32 surgical beds with, on average, 2/3 of the patients age 65 and over. The average length of stay is 7-9 days. Frequent surgeries include total hip replacements, total knee replacements, and hip pinnings. Complications frequently seen in the age 65 and over age group include: confusion, congested heart failure, deep vein thrombosis, and infection. These older adults were the basis for the RNs' experience in this study.

Population

The orthopedic unit has a total of 23 RNs, 21 female and 2 male. The educational background of the 23 RNs varies. Five RNs have a degree in nursing, and the remaining 18 have a diploma in nursing. The RNs' length of experience on the unit ranges from 1 month to 35 years. The unit has a turnover rate of approximately 2-4 RNs per year. The orientation process is tailored to the individual needs of the RN, and varies in length from two weeks to one month. In addition to general hospital orientation, the unit has a clinical nurse educator who provides unit-specific orientation, ongoing assessment, and support to the RN staff.

Data Collection

A purposive theoretical sampling technique was used in this study. Theoretical sampling involves choosing individuals who can contribute to the evolving theory (Creswell, 1997). Inclusion criteria were: a) male or female RNs working full time or part time on the orthopedic unit, b) speaking English, and c) consenting to participate.

The researcher met with the manager of nursing for the orthopedic unit and the clinical nurse educator to describe the purpose of the study. The manager and clinical nurse educator contacted potential participants asking if they would be willing to participate. The researcher also made frequent visits to the unit making herself available to answer questions about the study's purpose. Posters and handouts outlining the study's purpose and researcher's contact information were posted in the staff conference room (Appendix A).

When a participant was identified as a potential study participant, the researcher met with the participant in person, or by phone, to explain the study's purpose. If participants agreed to participate, a written informed consent (Appendix B) was obtained at the first interview. Verbal consent was also obtained at subsequent interviews.

Participants were interviewed using broad open-ended questions, followed by questions adapted to each individual to clarify responses. Guiding questions were utilized during the interview (Appendix C). Interview questions such as the following were utilized to guide the study: What is it like to care for older patients in the orthopedic unit? How is this different than caring for

younger patients? How do you feel when you care for older patients? What helps you as you care for older patients? What do you feel hinders you as you provide care for older patients?

Using purposive sampling, a range of one to three face-to-face, tape-recorded interviews were conducted with participants at a location and time identified by each study participant. The number of interviews was determined by the emerging theory. All interviews occurred in a private hospital room. Four of the interviews took place on the participant's day off, 10 interviews occurred during the participants' meal break while working on the orthopedic unit. The first interview allowed participants to describe experiences of caring for older adults in the acute care setting. The demographic form was completed during the first interview (Appendix D). Information on this form included gender, years of nursing experience, years of orthopedic experience, nursing education, additional education in gerontology, and age. The purpose of the second and third interviews was to verify transcript information and clarify the meaning of emerging themes. Interviews lasted from 30 to 70 minutes. The researcher allowed time for debriefing and questions after the tape recorder was turned off following each interview.

Interviews were audio-taped and transcribed verbatim to facilitate analysis of the data. The transcription of the interview was returned to each study participant for approval to ensure that it adequately reflected the intention of the dialogue. Participants were also asked to sign a transcript release form (Appendix E).

Following each audio-taped interview, the researcher completed detailed field notes with observations made throughout the interview to augment the interview data. Field notes describe non-verbal communication, assumptions about what was being heard or observed and information about researcher perceptions during the interview (Streubert-Speziale & Rinaldi-Carpenter, 2003). Participants were interviewed until saturation occurred. Data saturation occurs when the information being shared with the researcher becomes repetitive and no new themes appear (Marcus & Liehr, 1998).

Data collection requires that the researcher make a conscious effort to put aside any preconceived beliefs about the phenomenon under study, so that data collected will not be contaminated by the researcher's personal biases and prejudices. Self-awareness of the researcher's personal pre-conceptions, values and beliefs is important. A journal was kept by the researcher to express personal feelings and reflections to heighten self-awareness. Peer debriefing with the thesis supervisor occurred weekly throughout the data collection and analysis to ensure self-awareness of potential bias.

As the researcher involved in this study, I have had 18 years of experience working with older patients. I have worked with older patients in nursing homes as a nursing assistant, and acute care settings as an RN and clinical nurse educator. Fourteen of those years have been in the acute care setting, specialized in geriatric assessment and treatment. The experiences I have gained working as a RN and clinical nurse educator have fostered a deep interest in caring for older patients in the acute care setting.

Ethical Considerations – Human Subjects

Ethical approval for this study was obtained from the University's Advisory Committee on Ethics in Behavior Sciences Research (Appendix F) and the Saskatoon Health Region Research Services Unit (Appendix G) prior to commencement of this research study. Participation in this study was voluntary. Any information that could identify a particular individual was altered to protect anonymity. Audio-tapes and transcripts will be stored in a secure place at the University of Saskatchewan for a period of 5 years, after which they will be destroyed. The process of maintaining confidentiality was explained to all participants. Written informed consent was obtained. A written explanation of the process of maintaining confidentiality was provided in the Consent to Participate (Appendix B). Consent for release of data/transcripts (Appendix E) was obtained from participants following their review of the transcript.

Data Analysis and Interpretation

Data was managed using Nudist 6 software. The constant-comparative technique was utilized to analyze data contained in the transcriptions of the audio-taped interviews (Glaser & Strauss, 1967). This approach allows for flexibility in guiding questions in subsequent interviews based on participants' descriptions of experiences in prior interviews (Burns & Grove, 2001). Data was examined line by line. Processes were identified and coded. Underlying patterns were conceptualized. Coding occurred at three levels: a) open coding, b) constant comparative coding, and c) theoretical coding as described by

Glaser (1992). According to Glaser (1992) open coding is the initial stage of constant comparative analysis. The researcher has no preconceived codes and remains completely open. Open coding is complete when the basic social process is identified. Constant comparative coding is the fundamental basis of the constant comparative method of analysis. The researcher codes incidents for categories and the theoretical codes that connect them. Theoretical coding yields conceptual relationships between categories. Theoretical codes are conceptual connectors. Using the constant comparative method of analysis, the researcher compared incident with incident, incident with category, and category with category or concept. Data analysis started with the first interview and continued simultaneously during data collection.

Selective sampling of the literature occurred throughout the final analysis (Glaser, 1992). According to Glaser, literature is integrated with the emerging theory to reconcile differences and show similarities in concepts and patterns. Memos were used to preserve ideas the researcher had throughout the data analysis regarding the emerging theory. Memos are described by Glaser (1992) as, “the theorizing write-up of ideas as they emerge, while coding for categories, their properties and their theoretical codes” (p.108). Theoretical sorting of these memos is the final step in generating theory and the key to formulating theory presentation.

Trustworthiness of Data

Trustworthiness of the data is the responsibility of the researcher. Scientific rigor in qualitative research is judged by creditability, auditability,

fittingness, and confirmability (Marcus & Liehr, 1998). These concepts served as a framework to guide the trustworthiness of the data analysis. Creditability refers to the truth of findings as judged by both the participants and others in the discipline (Marcus & Liehr, 1998). To establish creditability, audiotapes were transcribed verbatim and the participant's language was used in coding, categorizing, and theory writing. Once the data was collected and transcribed, study participants were given the opportunity to scrutinize their transcripts, to ensure the written word reflected their intentions. To ensure creditability, the emerging theory was presented to two new participants and one previously interviewed participant in the form of confirmation interviews. The emerging theory was also presented to experts in the area informally and at an international conference.

Auditability refers to the accountability as judged by the adequacy of information which leads the reader through the analysis from raw data to the interpretation of findings (Marcus & Liehr, 1998). Auditability was established by keeping all raw data, field notes, and memos detailing the thought processes involved in the analysis. An audit trail was maintained to assist in illustrating thought processes that resulted in the conclusions drawn from the data for future examination.

Fittingness indicates the faithfulness to everyday reality for the participants, described in detail to allow others in the discipline to evaluate the importance for themselves (Marcus & Liehr, 1998). Fittingness was ensured by grounding theoretical observations in the data, and by cross coding and

categorizing of data. Confirmability is achieved when the criteria of credibility, auditability, and fittingness are met (Marcus & Liehr, 1998).

CHAPTER THREE

FINDINGS

Sample Characteristics

Saturation was reached with 9 participants in a total of 14 interviews. Of the 14 interviews, 3 were confirmation interviews. During confirmation interviews, study findings were presented to participants to ensure creditability of the data. Twenty-three RNs work part time and full time on this unit. Nine consented to participate in the study. Two declined because they were too busy, or not interested in participating in a research study. The number of interviews with individual participants ranged from 1 to 3 interviews. Three of the participants were interviewed twice, five participants were interviewed only once, and one participant was interviewed three times to clarify interpretation of the data.

Demographic Characteristics

Eight of the study participants were female, 1 was male. The age of the participants ranged from 22-48 years (mean 37.5). Experience as a RN ranged from 1.5 months to 28 years (mean 14.5 years). The length of experience on the orthopedic unit ranged from 1.5 months to 14 years (mean 4.7 years). Two of the participants had degrees in nursing, and seven participants had nursing diplomas. Only one participant stated that they had taken some additional

continuing education in Gerontology. All participants were English speaking and Caucasian. All of the participants interviewed were in either part or full time permanent positions on the orthopedic unit.

Dealing with Complexity: Looking Beyond

The process of open coding resulted in the identification of a basic social problem and a basic social process. From the analysis of transcribed interview data, the basic social problem was dealing with complexity, and the basic social process was “looking beyond”.

Dealing with Complexity

Participants described dealing with complexity as managing the multiple and integrated issues of older patients (Appendix H). One participant stated, “the care [of older patients] is more complex because of all the systems that are involved, they have more issues in all systems.” Social issues, living arrangements and support systems were often important issues for older patients. Participants stated these issues were generally not big concerns for younger, less complex patients. Dealing with complexity was described as the significant difference between caring for older patients and caring for younger patients. Participants described complexity within this age population in terms of medical issues, social issues and communication difficulties.

Medical Issues

Participants discussed a variety of medical issues affecting older patients including; increased complications, multi-system involvement and slower

recovery times. All of these issues contributed to the complexity involved in the older patient's care. "They [older patients] have multiple health problems and stuff so you have more complications...." Another participant described, "It is more of a challenge [caring for older patients], because you are dealing with someone who is multi-factorial...you are not only dealing with the fracture, but you are dealing with all their other conditions at the same time." As one participant stated, "Every system is just so integrated, you can't look at one without looking at the other." Another participant described, "It is total body systems with the elderly. With the younger person...if they've got a fractured ankle, well that is what you focus on, with the elderly it seems like it is everything."

Social Issues

Participants noted that it wasn't just the medical or physical issues that affected the complexity of managing the care of older patients. "There are family complexes, social issues, and religious issues...." One participant described, "their [older patient's] children are the ones who make some decisions for them, so you are dealing a lot with family...." When describing discharge planning, another participant stated, "it is not just a simple discharge like it is for a younger person. You [RN] have to involve the family quite often and see how much support they [older patient] have...."

Communication Difficulties

Participants described communication difficulties and confusion as affecting the complexity of care. One participant stated, “Sometimes there are cognitive reasons ...you [RN] have to look at different ways of communicating with them [older patients].” Another participant described, “Generally, they [older patients] all have some sort of disability whether it is sight, or hearing...so that is a huge part in relating to them differently.” As one participant described, “A lot of our elderly patients have got hearing deficits which sometimes make it difficult ‘cause you are not sure you know how much information they have picked up.” Participants also discussed that older patients are not forthcoming with personal information. Detailed medical and social histories were often difficult to obtain. One participant stated, “just from their generation, they [older patients] are not as open about that stuff [medical histories]....”

Looking Beyond

Participants dealt with the issues of complexity by the basic social process of looking beyond. Looking beyond was described by participants as a constant process of looking at the big picture to find what lies outside the scope of the ordinary (Appendix I). Participants described looking beyond as a different way to approach caring for the older patient.

Participants described how the process of looking beyond differentiated caring for complex older patients from less complex younger patients. As one participant stated, “It’s looking beyond medical labels, like you might put a medical label on someone, but you have to look at the person...there are a lot

of other things happening.” Another participant described, “It [caring for older patients] is a much broader spectrum than just a fractured hip on a medical patient, you [RN] had to look at family dynamics, often a religious dynamic and lifestyle and previous lifestyle....”

Issues identified by looking at the big picture all became important factors in the assessment and treatment of the older patient. One participant described, “If you just look at the bare issues and you are not looking at all the other ones, they’ll [older patients] just slip through the cracks and not get the care they need.” Other participants stated, “it’s [the issue] not always obvious... [when working with older patients],” and “we are always looking at the bigger picture.”

Participants described the ability to advocate on behalf of older patients as an outcome of looking beyond. One participant described, “Older people sometimes can’t speak up for themselves...or they are afraid to speak up for themselves....” Another participant described, “you know what the patient needs and what they are doing, but having them [other team members]...take it seriously or be aware of those problems is challenging, getting the right care for the patient.”

When asked what would happen if they did not look beyond, one participant described, “You [RN] might miss something that might end up costing the system more because they [older patients] have to re-hospitalize as well as the trauma to that person.” Another participant stated, “You [RNs] can miss something critical and then you know, when something flares up you are

wondering ‘what the heck is going on?’” With the complexity involved, one participant described, “You really have to watch that their [the older patient’s] whole course doesn’t deteriorate.”

Using constant comparative coding followed by theoretical coding, three sub-processes of looking beyond were identified. These sub-processes were connecting, searching, and knowing. When dealing with complexity, participants connected by taking time, understanding the individual, and respecting them. Then they searched by looking for clues and mining everywhere for information. The third sub-process knowing, occurred by pulling all the information together and knowing what to expect. These sub-processes were dynamic, occurring rapidly within one or two interactions. Although these sub-processes occurred initially in order, participants went back and forth between them depending on the need. Looking beyond and its sub-processes provided the RN with the relationship and information required to look broadly to manage the older patient’s complexity. These sub-processes were in constant interaction with the patient / family unit. The entire process of looking beyond occurred within an environment affecting the process. See Figure 1.

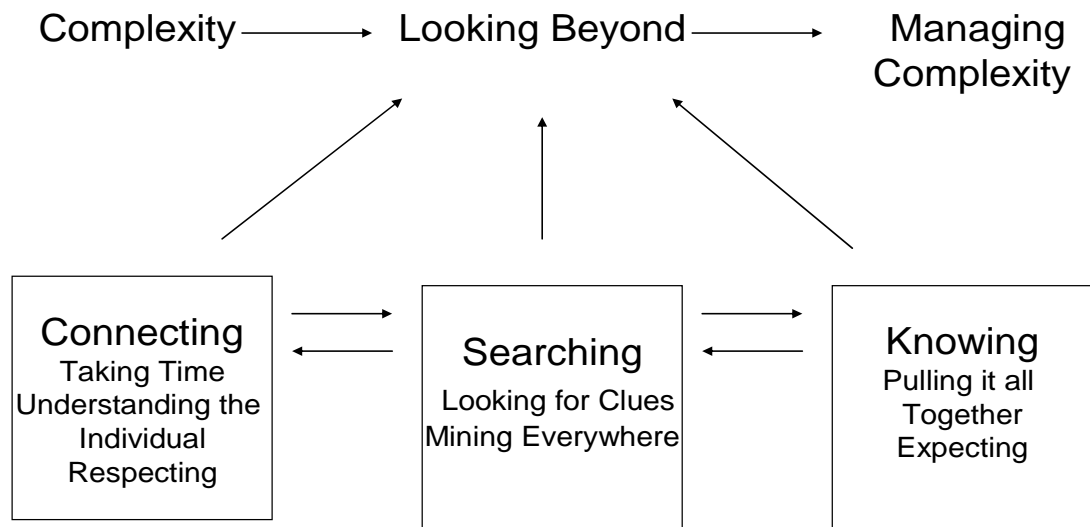


Figure 1: Process of Looking Beyond

Connecting

The first sub-process of looking beyond was connecting. Participants described the need to connect with their older patients. They described connecting as getting to know their patients as a person, by taking time, understanding the individual and respecting them (Appendix J). As one participant stated, “The most important thing involved [in caring for older patients] is looking at every person as an individual...it’s not just the left total knee in room #1...it’s you know, they are a person.” Another participant described, “You [RN] get to know them [the older patient], it goes beyond the, ‘you’re here, you’re fixed, now you’re out’, you get kind of involved and get a little personal even.” When describing this caring connection, one participant

stated, “That is one thing that enhances their [older patients’] recovery in their rehabilitation, is that connection, and the fact that it is not just a job for us [RNs], and that we are actually in there and we actually care about these people.” The ways in which the participants described connecting with their patients were by taking time, understanding the individual, and respecting.

Taking Time. Participants discussed taking time with their patients as one way of connecting. Taking time was described by participants as taking time to talk with the patient, listening to them, being interested in them (Appendix K). Participants described how important it was to take time with older patients. One participant stated, “It’s communicating and talking to them [older patients], being friendly, non-nurse, like talking to them as a friend...like being interested in them.” Listening was also identified as a key part of communicating and taking time. “You [RN] have to listen to everything they [the older patient] say and even if it is not important to them or you think it is not important, it is important because they have brought it up.” Another participant stated, “Take a little more time to let them [older patients] talk it out, because sometimes when they get into a story...if you let them go through that...you get ‘I had my heart attack in 1964,’ and you never knew that about them.”

Taking time helped participants know the older patient’s needs. One participant stated, “you are working with this patient and you know these things [what they need] because you are not just with them for 5 minutes, you can see these little things.” Taking time also influenced the cooperation of the older

patient. One participant stated, “he [the patient] might just take it [a pill] for you because you took the time to talk to him.”

Understanding the Individual. Participants discussed understanding the individual as another way of connecting with older patients. Understanding the individual was described by participants as looking at every person as an individual, picturing how they see things, and understanding how they think (Appendix L). Understanding the individual older patient helped participants connect with their patients through understanding where they were coming from. As one participant stated, “I look at them [older patient] as a father or grandfather and sort of remove them as the patient...give them that label, because otherwise they are just patients, they are just bed numbers, they are just a name.” Another described, “looking at every person as an individual and not trying to group them all together...just because you have 3 people in for the same surgery doesn’t mean they are going to respond in the same way as far as treatment or rehabilitation goes.”

Trying to understand the older patient’s viewpoint was important to understanding the individual and connecting. One participant stated, “I try and picture how they [older patients] see things, you know, how they perceive things, I try to be more sensitive to that.” While describing the effect of understanding the individual older patient, one participant stated, “what if that was my husband...and in the minute you empathize with the family, it is funny how you can change your mind quickly.”

Respecting. Respecting was identified as an important way of connecting with older patients. “If you [the nurse] don’t respect the patient, they might not respect you.” Participants described respecting as having respect for the older patient’s rights and freedom, maintaining their dignity, allowing them the ability to choose (Appendix M).

Participants described the vulnerability involved in coming into the hospital. One participant stated, “you [the patient] come into the facility and we [health care providers] take away almost all of your control, I mean, you have no say about anything.” Realizing this, participants described the effect of dignity and control on respecting the older patient. “I try and maintain their [older patient’s] dignity as much as possible.” Another stated, “it’s their [older patient’s] right to be able to choose.”

Connecting with older patients by taking time, understanding the individual and respecting, helped participants identify areas that still required more information to give them the ability to know what the older patient needed. Connecting provided the relationship between the participant, older patient and their family that was required to look broadly at the whole situation to assist in managing the complexity (See figure 1).

Searching

In order to look beyond, participants described the constant need to search for information. Participants described searching as digging deeper, searching for the unknown (Appendix N). The complexity involved in the older patient’s care made it difficult to clearly identify issues. One participant

described, “There is sometimes a medical issue that hasn’t surfaced yet and you [RN] have to kind of search for the unknown.” Participants recognized, “We ask the question ‘why?’ a lot.” Issues were often not easily visible, “you [RN] have to kind of dig a little deeper.” Another participant described, “You [RN] are looking at it in depth a little bit more when you’re looking at an elderly person.” The ways of searching described by participants were looking for clues and mining everywhere.

Looking for Clues. Participants described looking for clues as one way of searching. Looking for clues was described by participants as monitoring the older patient more closely in all areas, being a detective, looking for underlying issues (Appendix O). Participants described, “looking for clues... either verbally or visually, what you see, to try and prod out their [older patient’s] whole history.” Another stated, “Its like being a detective at times.”

Participants discussed that these clues were easy to miss if you weren’t perceptive to small changes in the older patient. Complications could potentially be avoided or minimized if caught early and appropriate interventions were provided. One participant stated, “You have to monitor more closely in all areas so their [older patient’s] condition doesn’t deteriorate.” Participants described how underlying issues complicated the process of looking for clues. One participant described, “It is not always just the orthopedic illness you [RN] are looking at, there is always something underlying that....” Participants also described how quickly the older patient’s condition could change, so continuous searching was critical. One participant stated, “you have to listen to them [older

patients]...do your head to toe assessment, you know once, sometimes twice and even three times a shift if you are concerned.”

Mining Everywhere. Participants described mining everywhere as one of the ways of searching for information with older patients. Mining everywhere was described by participants as researching, talking, gathering information from many sources (Appendix P). Participants described that because of the complexity of older patients, they had to look for clues in other areas beyond the older patient. Participants acknowledged that older patients were generally not forthcoming with information. Obtaining information from a variety of sources was required to get the complete picture of the older patient’s situation.

Participants described information obtained from the family, other team members and the patient’s chart. One participant stated, “I always ask if there is family there...because you have to mine everywhere you can for information.” In describing who can bring relevant information in, one participant stated,

Sometimes even the housekeeper will say, ‘do you know what they [older patient] told me?’ ...you were busy and you just missed that little clue that someone else had the time, while they were polishing their room, to pick up.

Another participant stated, “you [RNs] do a lot of thinking and researching, you refer to the chart a lot....”

Participants described information that was inaccurate at times; this highlighted the need for multiple sources of information. “The family may not live in the same location...and they may be in denial, and often times the elderly

are quite adept at covering up, they [the family] can be a resource, but not always reliable.”

By searching for information through looking for clues and mining everywhere, participants were able to identify information required to look broader at the situation to manage complexity. By connecting with the patient, participants had the ability to search for clues, which gave them the understanding to know what the older patient needed.

Knowing

Knowing was described by participants as the third sub-process of looking beyond. Participants described knowing as intuitively knowing what is going to happen and what the older patient needs (Appendix Q). Participants had difficulty identifying how they knew. They described how it was something they “just did”, but found it difficult to articulate how they did it.

One participant stated, “You [RN] know they [older patient] are brewing something and you know it’s just nurse’s instinct, by just watching the patient.” Another participant described experienced nurses who had the ability to look at a situation and know, “they [RNs] almost intuitively glance at a person and know what is going to happen.” As one participant stated, “You [RN] know without the patient asking when to do certain things, like when they need an icepack on their knee by just touching their knee.” Another participant described, “It’s [knowing] a sixth sense...it’s just seeing that patient and knowing.” The ways of knowing described by participants were, pulling it all together and expecting.

Pulling it all Together. Participants described the importance of pulling all information together as one of the ways of knowing. Pulling it all together was described as looking at the whole situation, figuring out what is important, focusing on the patient's main problem right now (Appendix R).

Not only did participants look broadly at issues, they also identified what was really happening. One participant described, "We [RNs] are always pulling all these little factors in, trying to explain 'why?'..." Another participant described, "We [RNs] have to look at the whole situation and figure out what is happening."

Pulling it all together involved identifying what was important at that moment. One participant described, "It's...the ability to be able to look at it all at once and pick out different areas, what's important." Another participant stated, "You have to focus on what is their [older patient's] main problem right now, and it's not always their fractured hip or their hip replacement."

Expecting. Expecting was described by participants as one of the ways of knowing with older patients. Participants described expecting as knowing what to expect by understanding what is normal for older patients as compared to younger patients, based on past experiences (Appendix S).

As one participant stated, "It's looking at the broader picture and putting it in a framework, and with the framework you [RN] are thinking that is sort of the normal and what you are expecting." Another participant described, "We [RNs] are always anticipating...we kind of know how they [older patient] are going to be...expect the worst...always looking for complications." When

describing working with older patients, one participant stated, “I [RN] gear my whole expectations down and I am more trial and error because they [older patients] are more sensitive to different things.”

The participants described that it was through experiences that they were able to anticipate and know what to expect. “You [RNs] know because usually these things happen.” One participant described, “With past experience you know what is an average amount...it is expected.” Another participant described, “Those things they don’t teach you in school, that sort of just comes with experience, you know that...it is day 3, that catheter can come out, or that IV can be turned down....” To be able to expect, the participants described requiring knowledge of the unique issues and needs of older patients, such as; differences between older and younger patients, and ethical issues and rights for this age group (See Appendix T). However, knowledge of these issues was not enough. The participants described that it was “the experiences...that was what really teaches.”

Participants described how knowing what the older patient needed by pulling it all together and knowing what to expect gave them the ability to look beyond the obvious. By connecting with the patient and searching for clues, participants were able to anticipate patient needs. These three sub-processes gave participants the ability to look beyond to manage the older patient’s complexity. (See figure 1).

Patient-Family Unit

Participants acknowledged the involvement of the family in the care of the older patient as extremely important. When describing the older patient and their family, one participant stated, "I don't think you can separate them [older patient and the family]." Another participant described, "With the elderly you [the RN] are working more with families than you do with just the adult population." In addition to the family being recognized as a source of information, the family was also seen as an entity with unique needs, requiring care of its own. One participant stated, "you can have a grandma that is so agitated...you can just see the pain on the family's faces, they just don't know what to do with this at all, they need lots of reassurance."

Context

Participants recognized that the process of looking beyond and its sub-processes occurred within an environmental context. This environment influenced the process of looking beyond. Areas described by participants as having the most influence were: working relationships, workload on the unit, and the acute care system.

Working Relationships

Participants discussed how working together with a large multi-disciplinary team supported them in the process of looking beyond. "This specific ward has a really good staff, that was what the other place lacked where I was before, that's why I left." Another participant stated, "You feel you've got the support of each other and are not isolated."

Participants also described difficulties in working with such a large group of team members. “The communication can be a little bit tighter....sometimes there is something lost in between what’s really meaning to happen...and what we were thinking was going to happen.” Participants also described situations where the support that was needed was not easy to obtain. “I get a bit frustrated...you call in the morning and they [the physician] can’t see them [older patients] until that night... or until the next day...I think there are some things that could probably be looked at sooner than they are.”

Workload

Participants acknowledged that looking beyond took time. Workload on the unit influenced the amount of time they had. One participant stated, “It’s a matter of having the time to deal with each of these [multi-system] issues.” When asked if the participants had the time to look beyond, one participant stated, “Not always, you have to make the time.” Another participant stated, “I don’t have the time to spend with these people [older patients], often times to really, you know, explore the nuances...this is an issue.”

Workload was described by some participants as problematic. One participant described, “The workloads are just too large, there is not enough help.” Another participant stated, “You [RN] just feel that you haven’t been able to do as much as you want to...there is just not enough of you to go around that day.” When describing the inability to provide the needed care, one participant stated, “I think deep down inside it does affect you, it tugs at your heart, I mean nursing is a calling, it’s not just a job.”

System

Participants described the organization of the broader acute care system as problematic for older patients. Physician structures supporting the specialization of care were seen to fragment the holistic care required. One participant stated, “The breakdown comes when...a medical problem presents...it is an orthopedic ward and not a medical ward...they [older patients] get lost...the issues do kind of get put on the back burner.” Another participant stated, “Sometimes there is tossing of the ball for responsibility around [between specialties] and it is very frustrating.”

Summary

Participants described the basic social problem as dealing with the complexity of older hospitalized patients. Numerous integrated issues made it difficult to manage the complexity of older patients. Participants described looking beyond as the basic social process used to manage this complexity. Looking beyond is a comprehensive process with three inter-related sub-processes (See Figure 1). The dynamic sub-processes connecting, searching, and knowing provided participants with the relationship and information required to look beyond to manage the older patient’s complexity. Family played an important role in the older adult’s hospitalization. Participants considered the patient and family inseparable, identifying them as the patient-family unit. The process of looking beyond occurred within a context with factors influencing upon it. Working relationships, workload and system wide issues were

identified as influencing the participants as they engaged in the process of looking beyond to manage the complexity of older patients.

CHAPTER FOUR

DISCUSSION

Based on the premise that the majority of patients in acute care hospitals are older adults, the purpose of this study was to understand the RNs' experience of caring for older hospitalized patients. No previous studies have focused on the RNs' experience of caring for older patients. The grounded theory methodology utilized identified the basic social problem of dealing with the complexity of older patients. The basic social process by which RNs dealt with the complexity was looking beyond. Looking beyond was described as a comprehensive process consisting of three inter-related sub-processes, all required to manage the multiple issues involved with older patients. The sub-processes were connecting, searching and knowing. By engaging in these sub-processes, the RN was able to see the broader picture to identify issues contributing to the older patient's complex situation. Looking beyond as a unique process to deal with the complexity of older patients has not been reported in the literature. Reported research studies were examined to identify similarities and differences with findings of the current study.

Dealing with Complexity

The basic social problem identified by participants was dealing with complexity. Participants described dealing with complexity as managing the

multiple integrated issues of older patients. Although the complexity of older patients has previously been acknowledged in the literature (Adelman et al., 2000), very little is known about dealing with the complexity of older patients. Only one study describing the complexity of managing the healthcare needs of the older person with an acute illness was found in the research literature (Cheek & Gibson, 2003). In this study, authors utilized a critical incident technique with 24 RNs and focus groups with health care workers to identify issues impacting on RNs' ability to care for older hospitalized people in Australia. The results of this study are similar to the present study. Both studies described the complexity of the issues and needs of older hospitalized patients. Therefore, dealing with complexity may be common to RNs working in other countries as well as Canada. Sample sizes of both studies were small. Further research is needed with larger samples to identify the scope of this problem.

With the multiple issues faced by many older patients, the problem of dealing with complexity is likely common. No reported studies have identified a method or process of how RNs deal with the complexity of older hospitalized patients. With the dearth of literature on the topic, it remains unknown whether some RNs are managing this complexity adequately. However, the literature describing complications and negative outcomes faced by older patients would likely suggest that complexity is not well managed (Brennan et al., 1991; Creditor, 1993; Leape et al., 1991; Palmer, 1995; Riedinger & Robbins, 1998; Rothschild, Bates, & Leape, 2000; St. Pierre, 1998).

Looking Beyond

Looking beyond was identified as the basic social process used by the participants of this study to deal with the complexity of older patients. Participants described looking beyond as looking at the big picture to find what lies outside the scope of the ordinary. Looking beyond has not been reported as a basic social process in any reported grounded theory research studies exploring working with older or other patient populations. No reported studies have identified a process to deal with the complexity of older patients. The results of the current study are unique, suggesting a strategy for RNs dealing with the complexity of older hospitalized patients.

Although the process of looking beyond was not identified in the literature, some similar concepts involved in the process have been described in earlier studies. Looking at the big picture has been identified in one previous study with older patients (Fagerberg & Kihlgren, 2001), and with other patient populations (Benner, Tanner, & Chesla, 1996; Radwin, 1995). Fagerberg and Kihlgren (2001) interviewed 20 RNs in acute care and other settings, to understand how RNs experienced the meaning of caring for elderly patients. RNs described having a comprehensive view. This comprehensive view was described as the need to know more about older patients' backgrounds and their lives.

Seeing the big picture was described by 130 RNs in a qualitative interpretive phenomenological study (Benner et al., 1996). They defined the big picture as "a sense of the future, recognizing anticipated trajectories, and

grasping a sense of future possibilities for the patient and the family” (p. 154). The big picture was also described as seeing what else is going on in the clinical situation, an expanded peripheral vision. Developing a bigger picture was also described in a previous qualitative study with RNs working in a variety of settings with patients of all age groups (Radwin, 1995). In this study the bigger picture was described as having knowledge of the patient in the hospital as well as a knowledge of the patient as a person outside of the hospital.

These studies suggest the importance of looking broadly to better understand the patient as a person in the full scope of their life. However, looking beyond described in the present study relates not only to knowledge of the patient as a person, but also a process that encompasses the entire situation surrounding the illness event. Looking beyond provides a broader process, describing how RNs can deal with the complexity of older patients. Looking at the big picture is only one aspect of looking beyond to manage the complexity involved in caring for older patients.

The strength of the process of looking beyond lies in the sub-processes involved. Connecting, searching and knowing are inter-related to provide the RN with the ability to look at the entire situation holistically to identify and manage the areas of complexity. No reported studies have described the sub-processes within looking beyond; connecting, searching and knowing. When these sub-processes were viewed as individual concepts, there were some similarities and differences with the literature. However, few of these studies explored working with older patients in the acute care setting specifically.

Sub-processes of Looking Beyond

Connecting

Participants of the present study described connecting as getting to know the older patient as a person, by taking time, understanding them as an individual, and respecting. Only one reported study identified connecting as an important part of caring for hospitalized elders (Jacelon, 2002). Using a grounded theory approach to identify the meaning of acute hospitalization for elders, connectedness was identified by elderly patients as a staff attitude that positively affected their dignity (Jacelon, 2002). Several other studies have described connecting as an important concept with RNs caring for various non-elderly patient populations (Doona, Chase, & Haggerty, 1999; Johnson & Hauser, 2001; Minick, Kee, Borkat, Cain, & Oparah-Iwobi, 1998; Morse, 1991).

Understanding the individual patient was identified as one of the ways of connecting in the present study. Understanding individual older patients has been identified in earlier literature (Fagerberg & Kihlgren, 2001). Fagerberg and Kihlgren described individualization and identification with the elderly patient. Individualization referred to the nurse's ability see the individual person, identifying and meeting their specific needs. Identification with the elderly was described as understanding the patient's life beyond the hospital experience.

Connecting as described in the current study is much broader in scope than the findings of the studies by Jacelon (2002) and Fagerberg and Kihlgren (2001). RNs connect not only by understanding the individual, but by taking time and having a respect for them. These actions then add to the overall

process of looking beyond by giving the RN the understanding to search for needed information and know what the individual older patient needs.

Connecting with the older patient and their family provides the relationship needed to assist the RN in managing the complexity of their situation. The full extent of the issues involved in the older patient's situation may not be known if the RN does not take time to get to know the patient and their specific concerns and needs.

Searching

Searching was described by participants in the present study as one of the sub-processes of looking beyond. Searching was described as digging deeper, searching for the unknown by looking for clues and mining everywhere for information. The concept of searching has not been identified in any qualitative studies looking at the experience of working with older patients, or any other patient populations.

Looking for underlying issues was identified as part of how RNs look for clues about the older patient's issues. Eliminating underlying causes was described in the literature in working with acutely confused elderly patients (Rogers & Gibson, 2002). The authors described how RNs attempted to reduce or eliminate possible causes of confusion by looking at a variety of underlying causes. This study has a link to the findings of the present study. However, searching for underlying causes is only one part of searching for unknown information with older patients.

The importance of obtaining collateral information as part of searching for the unknown was identified in the current study as well. Obtaining collateral information has also been identified in the earlier literature with RNs caring for older patients (Fagerberg & Kihlgren, 2001) and other patient populations (Hedberg & Satterlund Larsson, 2003). Similar to the current study, RNs described how they needed to get information from the patient's family in order to know about the patient's background and provide better care (Fagerberg & Kihlgren, 2001).

Collateral information was used by RNs when making clinical decisions regarding patients of all ages (Hedberg & Satterlund Larsson, 2003). Through inductive content analysis, 6 RNs were interviewed to describe how RNs made clinical practice decisions. Collateral information consisted of medical diagnoses, notes made by other colleagues, and discussions with other RNs. This collateral information focused more on the immediate resources available in the hospital setting. Looking more broadly to the family for collateral information may not be as important with non-elderly patients, or may be related to the differences in study methodologies and samples.

These studies indicate the need to obtain collateral information when working with older and other patients, and are similar to the findings of the present study. However, searching described in the current study is again, a sub-process of a larger process. By connecting with the older patient and their family the RN gets to know the patient as an individual. This provides the RN with a better understanding of the types of clues to search for, and where to

look for that information. The RN then has an understanding of the unique needs and issues of the older patient.

Knowing

Participants described knowing, a sub-process of looking beyond, as intuitively knowing what is going to happen and what the older patient needs. The ways of knowing described by participants were pulling it all together, and knowing what to expect through past experiences.

Two earlier studies identified similar concepts to the sub-process of knowing (Benner, 1984; Parke, 1998). Benner studied RNs working with patients of all ages, and Parke studied RNs working with older patients specifically. Parke (1998) identified intuitive perception as an important factor in the recognition of pain with cognitively impaired older adults in a long-term care facility. Six RNs were interviewed using clinical story telling. Findings revealed that with intuitive perception RNs had the ability to recognize subtle changes and to associate these changes with previous clinical situations. Intuitive perception developed from having relationships and past experiences with many different cognitively impaired older adults in pain. This intuitive perception was rooted in the exposure to multiple clinical experiences.

An intuitive grasp was described in a study of 1200 RNs aimed at uncovering the knowledge embedded in clinical nursing practice (Benner, 1984). This intuitive grasp relied on the perceptual capacity based on prior experiences. RNs knew what to expect through previous experiences with many similar patients. By grasping each situation as a whole, RNs had a

holistic understanding of the situation, rather than looking at everything independently, and then putting it together. This concept is similar to the intuition and ability to pull it all together, as described by participants in the present study.

The studies by Parke (1998) and Benner (1984) identify some of the concepts involved in the sub-process of knowing. However, knowing as described in the current study is again, only one sub-process in the larger process of looking beyond. Knowing is the last sub-process of looking beyond. Once the RN has connected to know the individual, and searched for needed information, the RN is able to pull all the information together, knowing what to expect. By knowing what to expect, the RN is prepared for a usual illness course or presentation of the older patient. The RN knows what is normal and what is not, and is able to anticipate needs. When the older patient does not present as expected, the RN can connect to know more about the older person, their issues, and search for other information to identify why things are not as expected. Thus, knowing together with connecting and searching gives the RN the ability to look beyond to manage the complexity involved.

Patient-Family Unit

The process of looking beyond involves the patient-family unit. Therefore, the two could not be separated. Family involvement was identified as important in caring for older patients. The participants recognized family members as an information source, and an entity with needs of its own. The family has been described as an information source in other studies by RNs

working with patients of various ages (Astedt-Kurki, Tammentie, & Paunonen-Ilmonen, 2001; Minick & Harvey, 2003; Tanner, Benner, Chesla, & Gordon, 1993). Caring for the family of older hospitalized patients was not identified by RNs in the research literature.

Family members provide a broad range of support to older adults. The type of support ranges from: advice, emotional support, shopping, transportation, to full time personal care giving and management of chronic conditions (Farran, 2002; Gaugler, Kane, & Kane, 2002). Family members know the older adult, and hold valuable information that may benefit the health care team. Communicating with the health care team is the most common need expressed by family members (Li, Stewart, Imle, Archbold, & Felver, 2000; Rose, Bowman, & Kresevic, 2000; Rutledge, Donaldson, & Pravikoff, 2000; Teno, Casey, Welch, & Edgman-Levitan, 2001).

Involving family members in the care of older hospitalized patients was seen by participants as important to the process of looking beyond. Older patients cannot always communicate or identify the breadth of information required to manage their multifaceted health issues. The family or support system is often very helpful. Ways to involve the older patient's family members and to care for their needs must be investigated.

Context

Participants described the influence of the environment in which the process of looking beyond occurred. The context in which RNs care for older hospitalized patients may have a powerful influence on the type of care that is

provided. The context issues identified by participants in the current study were working relationships, workload, and broader system issues. These issues are similar to those identified in earlier literature. The only major difference being attitudes towards older patients was identified previously, but not in the present study.

Working Relationships

Participants indicated the importance of the support offered by working in a large interdisciplinary team. The process of looking beyond was enhanced when the RN was supported by team members from different disciplines. No reported research described the importance or the role of the interdisciplinary team when working with older hospitalized patients. Interdisciplinary teams offer a holistic approach, supporting the RN in managing the complexity of the older patient. Team members are skilled in distinct disciplines, each viewing the older adult's situation with a unique perspective. When these unique perspectives are brought together, the older person can be seen as a complete whole. When interdisciplinary teams communicate well, understanding the different perspectives of each member, individual perspectives can be challenged and broadened. Different issues influencing the elder's situation can be viewed and handled with a broader scope, thus enhancing the process of looking beyond.

Participants also described the difficulties that can occur when working with a large team. Communication can be difficult when many people are involved. Getting information to and from everyone can be a challenge.

Finding a time when everyone can get together can be complicated. Many different perspectives also provide opportunity for discrepancy and disagreement between team members regarding the reality of the situation and desired goals and outcomes for the older patient.

Workload

Participants of the present study described how looking beyond took time, and how workload issues (such as having too much to do and not enough time) affected the time they had to spend. Workload issues related to lack of time when working with older hospitalized patients were found in the literature (Cheek & Gibson, 2003; Eriksson & Saveman, 2002).

Cheek and Gibson (2003) described lack of time to provide care for older people and insufficient staffing levels as problematic. The authors interviewed 24 RNs' to identify the issues impacting on their ability to care for older hospitalized people. These issues made it difficult for RNs caring for older hospitalized people. Similarly, RNs reported a lack of time to treat dementia patients satisfactorily in the acute care environment (Eriksson & Saveman, 2002). The RNs stated they felt powerless because they did not have the time to meet the patient's needs. Although the RNs felt they had given so much of themselves, they still felt as though they had not been able to do enough.

Caring for older hospitalized patients takes a considerable amount of time, especially when the care is focused on increasing function and independence. Given the high acuity levels of patients in the acute care setting, the goal of decreasing length of stays, and current staffing levels, one may

question if RNs have the time it takes to look beyond. The answer may be, “Do they have the time to not look beyond?” The process of looking beyond takes time. However, the time spent is well needed in sorting through the complexity involved. When the time is not taken to examine the complexity of the issues involved, all factors may not be clearly identified and included in the management of health issues and plans for care. The older patient is at risk for complications or unrealistic goals for care and discharge. These patients may be re-admitted to hospital with an issue that could have been handled during the first admission, had it been identified and viewed as important at the time. It could be argued that a process such as looking beyond may actually reduce hospital time for older patients overall. In the short term, the process could possibly increase the time staff spend and length of stay. However, it may then reduce the need for readmission by managing the complex issues up front, setting up supports to manage the older patient’s needs in the community setting.

System Issues

Participants in the present study also identified how structures supporting the specialization of care fragmented the holistic care required by older patients. The literature holds some similarity to these findings (Cheek & Gibson, 2003; Meyer et al., 1999).

The acute care environment and culture was identified as problematic for managing elderly patients (Cheek & Gibson, 2003). RNs described the focus on acute illness and medical needs as detrimental to the social and emotional

needs of older patients. It was difficult to take a holistic view of the older patient while the emphasis was on discharging the patient as quickly as possible.

Similarities with the present study and the literature regarding the broader acute care system have been identified. Poor coordination of services and waiting for various specialties to see patients were identified through an action research methodology with staff and older patients in the accident and emergency area of an acute care setting (Meyer et al., 1999). The findings of this study are similar to the present study where poor coordination between orthopedic and medical specialties resulted in patients waiting to be seen.

Factors affecting the provision of acute care to older adults such as organization policies, philosophies, resources, and informal care practices must not be overlooked. RNs caring for older patients do not work in isolation; many factors influence them. Providing care for hospitalized elders requires not only knowledgeable staff, but health care system principles, processes, and structures supporting continual learning that transfers into practice (Hart, Birkas, Lachmann, & Saunders, 2002). A system wide adoption of the process of looking beyond may provide RNs with the support needed to incorporate the process to guide the care of older patients. The influence of the environment on the RN cannot be underestimated.

RNs' Attitudes Towards Older People

Attitudes toward older people was described as having a role in the RNs' experience of providing care to older hospitalized adults (Jacelon, 2002).

Participants of the present study did not identify negative attitudes as a factor in

the description of their experience of working with older adults. This difference may be contributed to study methodology. Many participants described positive feelings towards working with older patients. Possibly these participants had positive attitudes towards older patients and therefore did not bring negative attitudes into their descriptions. Possibly attitudes are not as important of a factor as previously thought. Conflicting results in the literature on attitudes provides no clear explanation of their influence (See Table 1). This present study may support the thought that attitudes do not have a critical influence on care provided to older hospitalized patients.

Summary

Review of earlier literature examining the concepts involved in the process of looking beyond yielded few studies specifically aimed at caring for older patients. Of the literature identified, studies have focused on hospitalized cognitively impaired elders, elders in other settings and patients of all ages. Minimal similarities exist with the findings of the current study. No studies have identified a process to manage the complexity of older hospitalized patients. Concepts described in the literature identify fragmented activities involved in caring for older patients. A holistic approach is required to manage the complex issues of older patients. The process of looking beyond provides a comprehensive and integrated method of managing the complexity of older patients. Looking beyond as identified by participants of this study is a much needed addition to the dearth of literature regarding the management of the complexity of older hospitalized patients.

It could be argued that the process of looking beyond is the very essence of nursing, and could be used to guide nursing practice in general. Many of the actions involved in the process could be used with a variety of patient populations in a variety of care environments. What makes the process of looking beyond so critical with older hospitalized patients is the high risk for complications and adverse effects that may result from the complexity of their health issues. Older patients have a higher risk of iatrogenic illness and functional decline because of age related physiologic changes and multiple comorbidities (Buckwalter, 1991; Creditor, 1993; Palmer, 1995; Rothschild et al., 2000). The acute care environment can also be a challenge, making it difficult for older patients to retain function needed to perform activities of daily living (St. Pierre, 1998). Younger patients do not appear to have the same level of risk for negative outcomes associated with hospitalization (Brennan et al., 1991).

Risks involved in the hospitalization of older adults require RNs to be astute to minute changes in health status, as well as the multiple issues influencing the elder's health situation. The process of looking beyond provides the RN with a method to look broadly at the older patient's circumstances. Looking beyond assists the RN through relating and connecting with the older patient and their family, searching for information, knowing what to expect, and what is needed.

Some arguments indicate that the skills and knowledge involved in caring for older patients are difficult to quantify as many actions are based on

intuition (Ford & McCormack, 2000). Looking beyond may provide RNs with a clear process to guide care actions required for caring for older hospitalized patients. This process may assist educators and RNs themselves by identifying nursing actions critical to providing comprehensive care to older hospitalized patients.

Many of the study participants described how previous experience was vital to understanding the process of looking beyond. Some participants felt that new graduates would not have the skills required to look beyond. A new nursing graduate was purposely sought out to explore their experience of caring for older adults, and the process of looking beyond. It was clear from the new graduate's comments that some of the concepts involved in process of looking beyond and its sub-processes were understood and taught during the nursing program related to older patients. The one difference identified was the amount of exposure to different clinical situations. The new graduate felt that the ability to know what to expect involved in the sub-process of knowing, may be challenging for new graduates as they did not yet have a wealth of experiences to draw on. The new graduate indicated that the only way to gain this skill was to be exposed to many different clinical situations with older patients. New nursing graduates can engage in the process of looking beyond. As with all areas of nursing practice, experience will only improve the skills involved.

Findings of this study add to understanding the experience of RNs caring for older hospitalized patients. Study findings also add to the understanding of the complexity of older patients. The process of looking beyond as identified by

participants is important as it provides a method to manage that complexity and ideally improve patient outcomes. Management of the complexity of older patients may be greatly improved through the use of looking beyond.

Limitations

Several limitations to this study may be due to the methodology, sample characteristics and context. As with any qualitative research design, the findings are specific to the participants in this study. The sample included orthopedic RNs working in a moderately sized urban hospital in mid western Canada. The participants were all Caucasian and English speaking. Cultural aspects associated with geographic location and language may have influenced the results of this study.

Another limitation related to the sample was that most of the RNs interviewed seemed to enjoy working with older patients. Of the 9 participants interviewed, 8 “didn’t mind”, or “really enjoyed” working with older patients. Only one participant stated they did not enjoy working with older patients, “there is no escaping” (working with older patients in the hospital). This participant also stated, “not that it’s that I have anything against elderly people, it’s just that you have to work so **** hard”. Interview discussions centered around the extra time and physical energy involved in caring for older patients. The sample was also limited to those who consented to participate in the study. Those who refused to participate may have had a differing view, and may have affected the study results.

Discrepancy exists among scholars regarding sample size and its effect on findings and trustworthiness of the data (Glaser, 2001; Morse, 1994).

According to Glaser, small numbers of participants in a study does not matter; saturation of concepts is what is important. Once saturation was reached with 9 participants, purposive sampling was discontinued.

Grounded theory uses an emic perspective in which the findings are based on the perceptions of the participants. The results were presented using the language of the participants, which is the language of health care providers. Because I am a health care provider myself, I approached the participants using the language they are comfortable with. Other studies from the perspectives of patients and families may find different processes and concepts because of this.

Context, described as the condition in which the concepts occur (Glaser, 1992), may also have been a limitation. Participants described the environment on the orthopedic unit as supportive, with various team members and resources. This may have influenced the study results. The context also included the participants' knowledge of the issues of working with this age population, and may also have influenced the results of this study. Therefore, the description of the experience of RNs working with older patients was within the context of a supportive team with RNs who had an understanding of the unique issues involved in caring for older patients.

CHAPTER FIVE

IMPLICATIONS FOR PRACTICE AND RESEARCH

With the nature of the aging process, the complexity of older hospitalized patients is a reality that may be unavoidable. The way participants in this research study dealt with the complexity of older hospitalized patients was by looking beyond. Therefore, the process to deal with complexity, as identified in this research study has implications for nursing practice, education, and research.

Implications for Practice

The process of looking beyond may benefit RNs directly caring for older hospitalized patients by providing a process to guide care plans and interventions, ultimately improving outcomes for older patients. The complexity of older patients identified in this study acknowledged the challenges RNs face caring for older hospitalized adults. Caring for older patients has been perceived as requiring little skill or knowledge (Akid, 2001). In Akid's study, 73% of the 375 physicians, RNs, and other health care providers described caring for older people as having low professional status. Caring for the elderly was described as "a baby-sitting service," "a waste of 3 years training", and "a dumping ground for nurses who couldn't do anything else." However, specialized knowledge and skills involved in caring for an older patient population are beginning to be recognized (Joy, Carter, & Smith, 2000). In

describing the processes of looking beyond, processes and skills required to care for older adults were identified.

A process such as looking beyond may also provide the necessary framework to guide care practices for RNs managing the complexity of older hospitalized patients. The framework outlines ways to look holistically at the older adult. When the RN is able to see all issues influencing the older patient's hospital course, a holistic approach can be used to manage each issue effectively. The process of looking beyond outlines the holistic approach needed to guide the understanding of managing the complexity of older patients. The health care system must support RNs as they look beyond. Reducing barriers caused by a specialty focused system and providing education will give the support needed to enhance this holistic process.

Implications for Education

The findings of this research study may also have implications for undergraduate and continuing nursing education. Educators may benefit from understanding the process of looking beyond by utilizing the conceptual process to articulate the unique skills and actions needed to care for older patients. This process could better prepare RNs to care for the aging population. Informing students and staff of the complexity involved in caring for older patients along with a process of how to best deal with that complexity may be beneficial. Undergraduate programs and continuing nursing education programs could also provide students and RNs with the much needed skill in this area.

Implications for Research

The grounded theory developed from this research is important as it adds to the theory base for designing future studies related to caring for older patients in the acute care setting. By using grounded theory methodology, emerging theories were identified, but not formally tested. The theory is suggested, not proven (Glaser, 1992). The process of looking beyond and its sub-processes must be formally tested to increase understanding of how to deal with the complexity of hospitalized elders.

Further investigation is required to understand the process of looking beyond and its sub-processes with older hospitalized patients. Studies involving RNs working with children, young, middle aged, and older adults who are hospitalized must be included to fully appreciate the unique experiences of RNs caring for older patients. Inquiry into the benefit of the overall process as a method to guide the management of the complexity of older patients should be explored. The sub-processes of looking beyond also require further study. Do all sub-processes of looking beyond have equal importance? Do all three sub-processes need to be present for the process to occur? Although three sub-processes were identified in the current study, there may be others. The effect of the environment on the RN and the process of looking beyond also requires investigation. Resources and structures that assist RNs in the process of looking beyond must also be identified.

Complexity of older patients and the issues surrounding dealing with this complexity requires further exploration. Are all older hospitalized patients

complex? Do all RNs consider managing complexity of older patients a concern? Does the process of looking beyond still have implication for older patients with less complex issues? Research studies investigating these questions regarding the complexity of older patients are needed.

The family was identified as important to the process of looking beyond. Investigation into the differences between the importance of family with older and younger patient populations must be explored to increase the understanding of the role of the family in the care of older patients. In addition, methods to include and care for families require exploration.

Lastly, investigation into managing the complexity of older patients with participants from other disciplines other than RNs should also be explored. Care givers (licensed and non-licensed), and other members of the interdisciplinary team such as; physical, occupational, and recreational therapists, social workers, dietitians, physicians, and pharmacists should be considered. The effectiveness of utilizing the process of looking beyond with older patients and these team members is an area for further inquiry.

Conclusion

As the population continues to age and interact with the acute care environment, it is imperative that RNs are able to meet the needs of this large age group. It is essential that older patients in the acute care setting receive optimal care from nursing staff that efficiently manage their needs. This may be accomplished by looking beyond as described by study participants. These study findings are unique as they begin to fill the current void in the literature

regarding RNs ability to manage the complex care of older hospitalized patients. The basic social problem of dealing with complexity acknowledges the unique challenges faced by RNs providing care to older patients. As the main consumers of health services, older patients have complex needs requiring knowledgeable and skilled RNs to manage their care. Older patients do not fit well into a model of health care aimed at service delivery toward to the younger patient. RNs must have the ability and the resources to manage complex care of older patients. Dealing more efficiently with this complexity may affect the outcomes of hospitalization for older patients.

The grounded theory developed from this research provides a foundation for designing future studies for RNs working with complex older adults in the acute care setting. Although the findings of this study raise many research questions, they also provide a foundation for education and practice strategies for RNs. Care practices of RNs working with this age group must be adapted to meet the needs of this population group efficiently and effectively in order to prevent crisis with the expected increase of numbers in this older age group.

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APPENDIX A

Research Poster / Handout

Caring for Older Patients...What comes to Mind?



Registered Nurses on the Orthopedic Unit at SCH are invited to participate in the qualitative research study entitled:

***“The Registered Nurses’ Experience Of Caring For Older Patients
On An Acute Care Orthopedic Unit”***

Purpose of the study:

- To gain a deeper understanding of the RN's experience of caring for older patients
- Identify issues surrounding caring for older patients in the hospital setting
- This information will help us find ways to give the best care possible

For more information, or if you are interested in participating, contact
Gaylene Molnar, Graduate Student, College of Nursing
Phone number 655-8264
(Thesis supervisor – Dr. Wendy Duggleby, 966-6237)
Or
Joan Santoro, Clinical Nurse Educator, 655-8311

Why should I take time out of my busy life to be interviewed for this study?!

- Older adults are the fastest growing age group in Canada
- The majority of patients on ortho are older adults
- The literature identifies that caring for older hospitalized patients involves many factors including:
 - Difficulties involved in caring for older patients
 - Unique needs of this patient population
 - Poor outcomes and complications experienced by older adults in the hospital environment
 - Negative attitudes of care providers towards older patients
 - Ageist practices by health care providers

**Given all these factors, there are no reported studies exploring the nurses' experience of caring for older patients in the acute care setting!
Who better to ask about the complexity of caring for this patient population than those who work directly with them!**

- Taking the time to be interviewed will help to shed light on the factors that influence the care of older patients and also identify the resources that assist in the care of older patients on ortho.
- The results of this study will assist in the care delivery you provide on this unit! I will make every attempt to have the results of this study published to help fill the gap in the literature regarding this huge and timely area of study.

Please consider taking the time to talk with me, the results may positively impact the way you provide care for older patients on this unit!

APPENDIX B

Consent Form - Research Participants

Title of Study: The Experience of Caring For Older Patients on an Acute Orthopedic Unit

Supervisor: Professor Wendy Duggleby
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107 Wiggins
University of Saskatchewan
Saskatoon, SK S7N 5E5

Researcher: Gaylene L. Molnar
Master of Nursing Student
College of Nursing
107 Wiggins
University of Saskatchewan
Saskatoon, SK S7N 5E5

Office of Research Services
University of Saskatchewan
Telephone (306) 966-4053

You are invited to participate in a study entitled, "The Experience of Caring for Older Patients on an Acute Orthopedic Unit". Please read this form carefully, and feel free to ask questions you might have.

I _____ agree to participate in the study entitled " The Experience of Caring for Older Patients on an Acute Orthopedic Unit" conducted by Gaylene Molnar, a Registered Nurse in the Master of Nursing Program, College of Nursing, at the University of Saskatchewan, Saskatoon, SK.

Concerns about the hospitalization of older adult are documented in the literature. The purpose of this study is to get a better understanding of the experience for the registered nurse in caring for older patients in the hospital setting. A better understanding of the elements involved in caring for older patients can help in identifying what may enhance the effectiveness of this care. Benefits of this area of study may affect the study participants directly.

I understand the researcher will be interviewing me at a time and location of my choice and that the interview will be audio-taped. The interview will take between 30-60 minutes to complete. I understand that the audio taped interview will be typed out and that I will receive a copy of the transcript to review to make sure it reflects what I wanted to say in the interview.

I understand that I am free to withdraw from the study for any reason, at any time, without penalty of any sort. If I decide to withdraw, any information I have given the researcher will be removed from the study and destroyed. I understand that I may refuse to answer individual interview questions. I understand that any information I give the researcher will be kept confidential. Any information I give that may be a key identifier of me will be altered to protect my anonymity. The researcher will make sure that any audio-tapes and transcripts will be stored in a secure place at the University of Saskatchewan for a period of five years and then will be destroyed.

I understand that the information collected in this research will be used as part of a Master's thesis in nursing and will not identify me by name. I understand that the findings of this research study will be distributed to the orthopedic unit and other areas within the Saskatoon Health Region. The findings may also be used in publications and conference presentations.

If I have any questions or concerns before, during, or after my participation in this research, I can contact the researchers at the numbers provided above. I understand that this study has been approved on ethical grounds by the University of Saskatchewan Behavioral Sciences Research Ethics Board on (insert date). Any questions regarding my rights as a participant may be addressed to that committee through the Office of Research Services (966-2084).

I have read and understand the description provided above; I have been provided with an opportunity to ask questions and my questions have been answered satisfactorily. I consent to participate in the study described above, understanding that I may withdraw this consent at any time. A copy of this consent form has been given to me for my records.

(Participant Signature)

(Date)

(Researcher Signature)

(Date)

APPENDIX C

Guiding Interview Questions

Thank you for taking the time to talk with me about the work you do with older patients on your unit. I may take some notes while you are talking so I can make sure I understand everything you are telling me. Do you have any questions before we get started?

- What is it like to care for older patients in your orthopedic unit?
- How is this different than caring for younger patients?
- How do you feel when you care for older patients?
- How is this different than caring for younger patients?
- What helps you as you care for older patients?
- What hinders you as you provide care for older patients?

APPENDIX D

Demographic Information – Participants

Date _____

Gender _____

Years of Nursing experience _____

Years worked on orthopedic unit _____

Nursing Education _____

Age _____

Additional education in gerontology _____

APPENDIX F

U of S Ethics Approval



UNIVERSITY OF SASKATCHEWAN BEHAVIOURAL RESEARCH ETHICS BOARD

<http://www.usask.ca/research/ethics.shtml>

NAME: Wendy Duggleby (Gaylene Molnar)
College of Nursing


BSC#: 03-1099

DATE: August 12, 2003

The University of Saskatchewan Behavioural Research Ethics Board has reviewed the revisions to the Application for Ethics Approval for your study "The Registered Nurse's Experience of Caring For Older Patients on an Acute Care Orthopedic Unit" (03-1099).

1. Your study has been APPROVED.
2. Any significant changes to your proposed method, or your consent and recruitment procedures should be reported to the Chair for Committee consideration in advance of its implementation.
3. The term of this approval is for 5 years.
4. This approval is valid for five years on the condition that a status report form is submitted annually to the Chair of the Committee. This certificate will automatically be invalidated if a status report form is not received within one month of the anniversary date. Please refer to the website for further instructions: <http://www.usask.ca/research/behavrsc.shtml>


I wish you a successful and informative study.


Dr. David Hay, Acting Chair
University of Saskatchewan
Behavioural Research Ethics Board

DH/ck

APPENDIX G

SHR Approval

	<p>Research Services Unit Strategic Health Information & Planning Services (SHIPS) Joanne Franko, Manager Box 16, Royal University Hospital 103 Hospital Drive Saskatoon, SK S7N 0W8 Phone: 306.655.6796 Fax: 306.655.6489</p>
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DATE: August 28, 2003

TO: Wendy Duggleby (Gaylene Molnar)

FROM: Joanne Franko
Manager, Research Services Unit

RE: Research Project Ethics Committee (EC)#: 2003-1099
Project Name: The Registered Nurses' Experience of Caring for Older Patients on an Acute Care Orthopedic Unit

Saskatoon District Health is pleased to provide you with operational approval of the above-mentioned research project.

Please advise me when the data collection phase of the research project is completed. I would also appreciate receiving a copy of the final report for this research project. As well, any publications or presentations that result from this research should include a statement acknowledging the assistance of Saskatoon District Health.

I would like to wish you every success with your project and encourage you to contact me if I can assist you with it.

If you have any questions, please contact my office at 655-6796.

Yours truly,

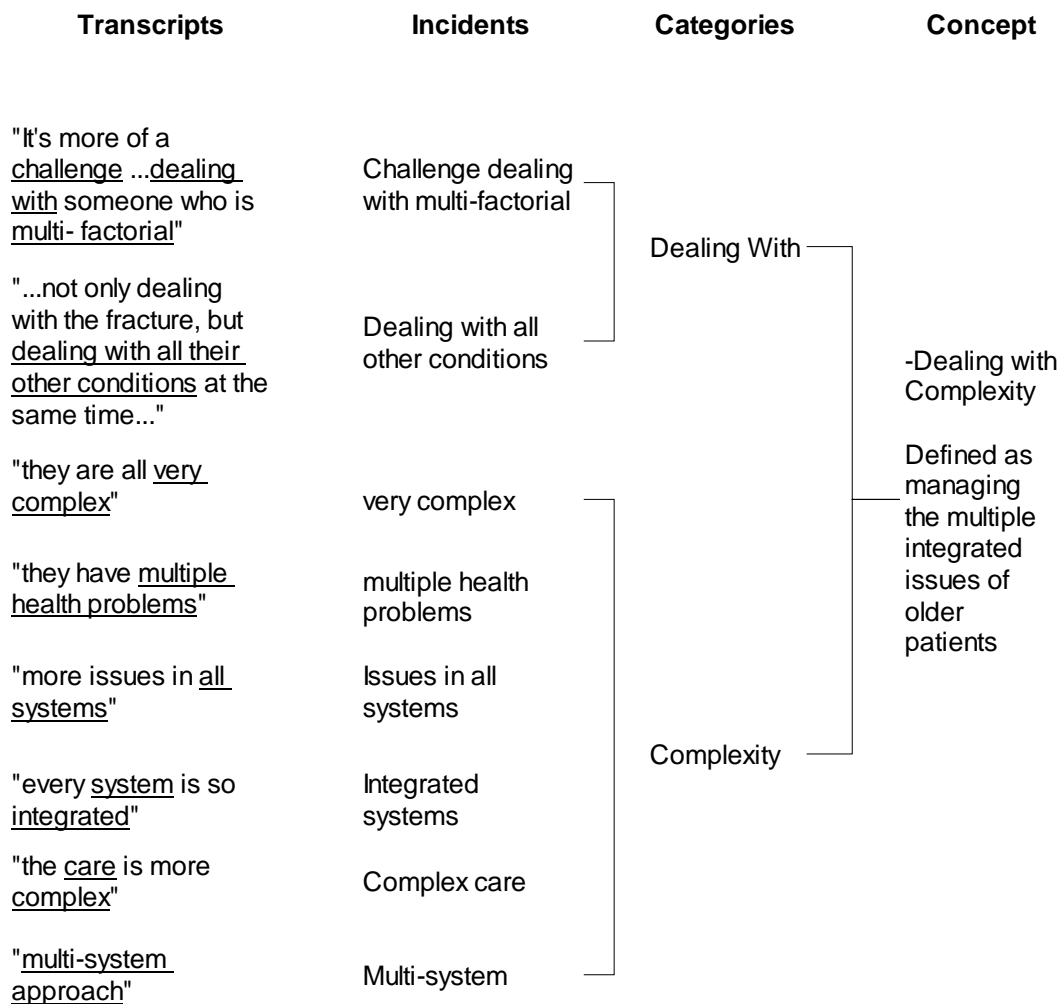


Joanne Franko, M.Sc.
Manager, Research Services Unit

cc: Carol Melymick, MON, 6100 - RUH

APPENDIX H

Concept Definition – Dealing with Complexity



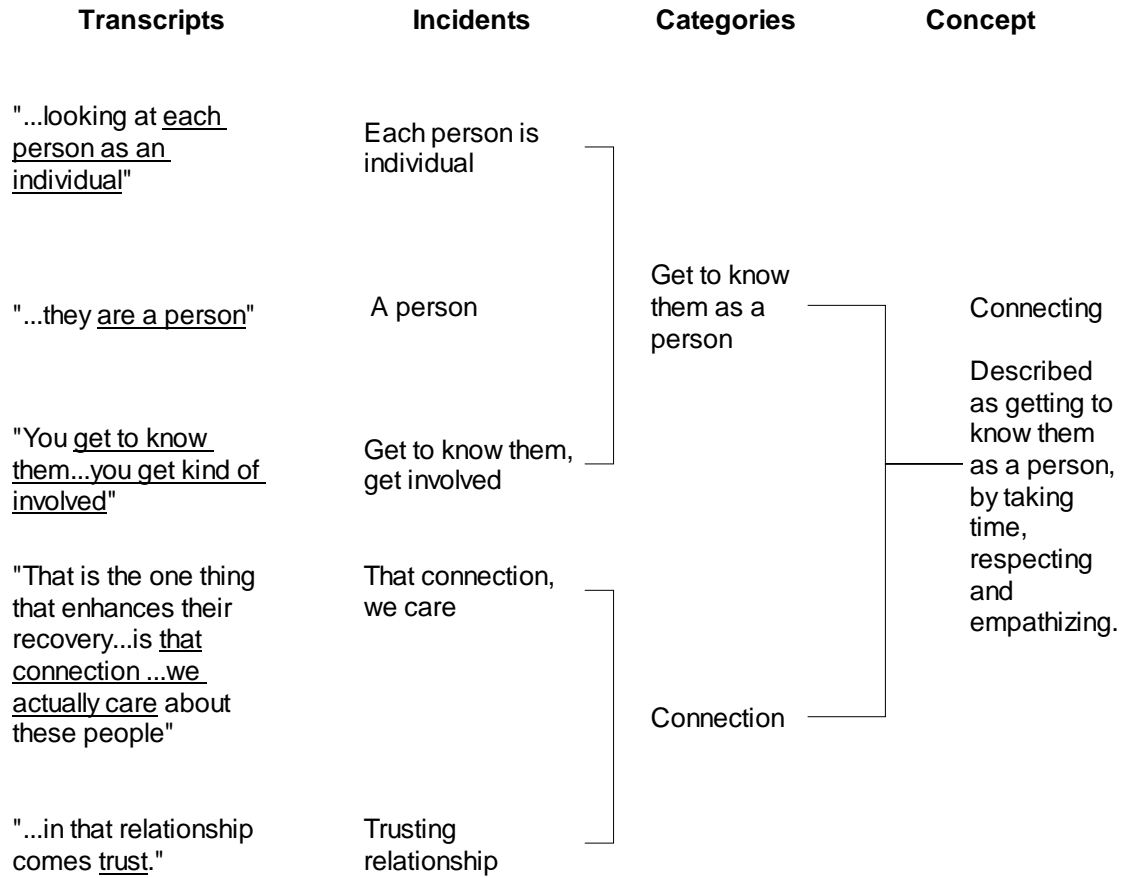
APPENDIX I

Concept Definition – Looking Beyond

Transcripts	Incidents	Categories	Concept
"... <u>looking beyond</u> medical labels"	Looking beyond	Looking	-Looking Beyond Described as looking at the big picture to find what lies outside the scope of the ordinary
"... <u>look at the person</u> ...there are a lot of other things happening"	Look at the person		
"...really have <u>to watch</u> that their whole course doesn't deteriorate"	Really have to watch		
"We <u>look beyond</u> ...we do a thinking and talking"	Look beyond		
"...it's <u>not always obvious</u> ..."	Not obvious		
"... <u>looking at it</u> from a multi-system, multi-disciplinary approach."	Looking at it	broad/ indepth	
"...a much <u>broader spectrum</u> than just a fractured hip on a medical patient..."	Broader spectrum		
"If you <u>just looked</u> at the <u>bare issue</u> and you are <u>not looking at all the other ones</u> ..."	Not looking at all issues		
"... <u>looking at the bigger picture</u> "	Looking at the big picture		

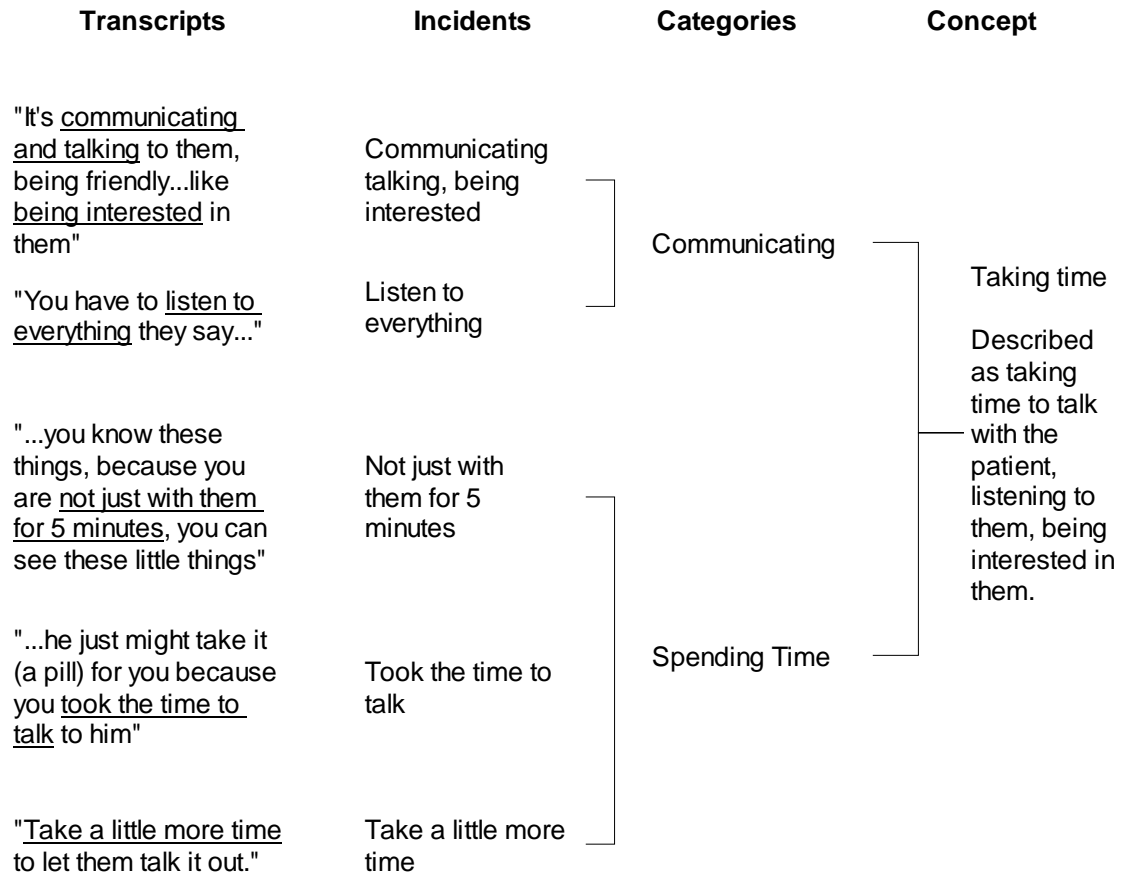
APPENDIX J

Concept Definition – Connecting



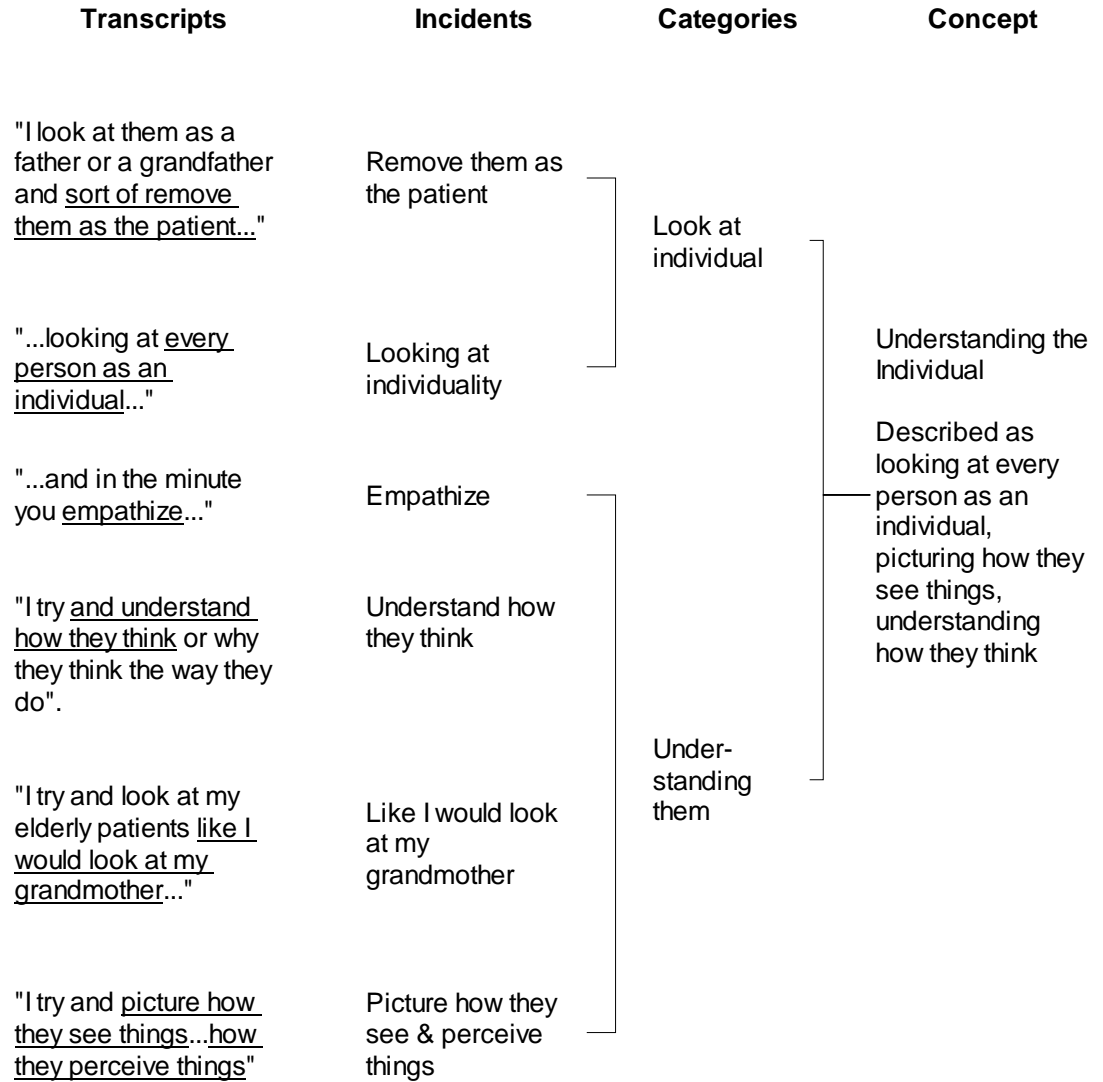
APPENDIX K

Concept Definition – Taking Time



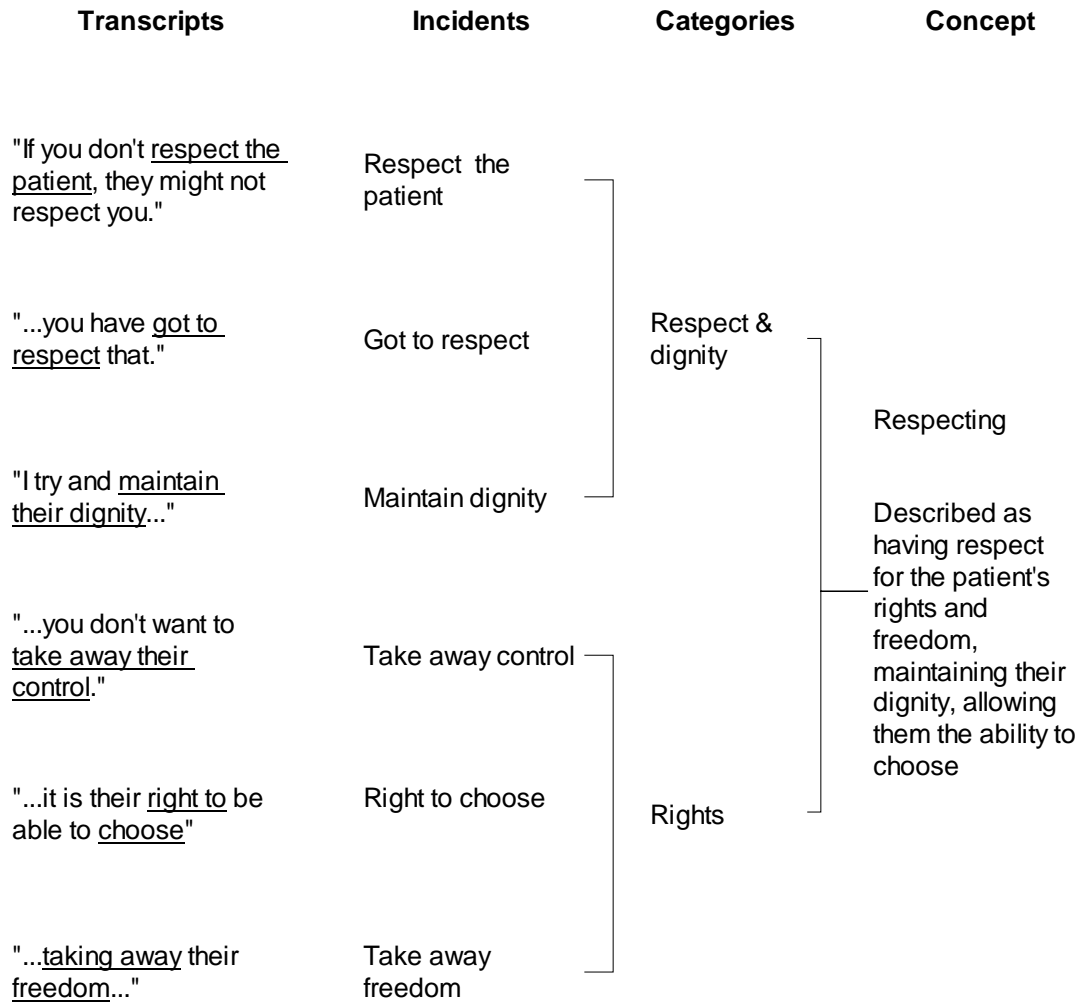
APPENDIX L

Concept Definition – Understanding the Individual



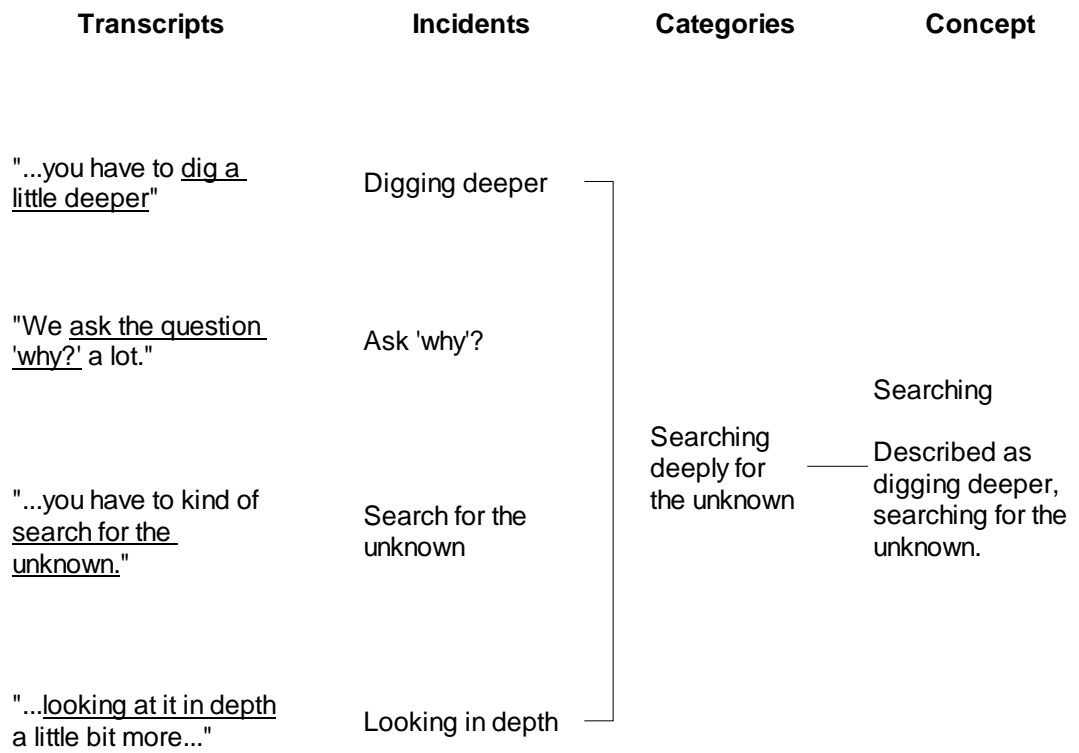
APPENDIX M

Concept Definition – Respecting



APPENDIX N

Concept Definition – Searching



Appendix O

Concept Definition – Looking For Clues

Transcripts	Incidents	Categories	Concept
" <u>looking for clues</u> ...either verbally or visually...to try and prod out their whole history"	Looking for clues	Looking closely for clues	Looking for clues Described as monitoring more closely in all areas, being a detective, looking for underlying issues.
"It's like <u>being a detective</u> at times."	Being a detective		
" <u>do your head to toe assessment</u> ...twice, even 3 times a shift..."	Do assessment even 3 times per shift		
"You have to <u>monitor more closely</u> in all areas..."	Monitor more closely		
"...when you have a patient who is out of normal...but really have <u>no real symptoms that you could catch</u> ."	no symptoms to catch	Missing clues	
"...you might <u>miss that little clue</u> ."	Miss a clue		
"It is not always just the orthopedic illness you are looking at, there is <u>always something underlying</u> that..."	Something underlying		

APPENDIX P

Concept Definition – Mining Everywhere

Transcripts	Incidents	Categories	Concept
<p>"..you have to <u>mine everywhere you can for information.</u>"</p>	<p>Mining everywhere for information</p>	<p>Mining for information</p>	<p>Mining everywhere</p> <p>Described as researching, talking, gathering information from many sources.</p>
<p>"...you do a lot of <u>thinking and researching, you refer to the chart</u> a lot, and <u>talking to families.</u>"</p>	<p>Thinking, researching, referring to chart, talk to family</p>		
<p>"...the <u>family</u>...can be a resource, but <u>not always reliable.</u>"</p>	<p>Family not always reliable</p>	<p>Family and team know the patient</p>	
<p>"the family plays a <u>big part in saying 'this isn't normal'...</u>"</p>	<p>Family knows what's normal</p>		
<p>"<u>the team</u> is surrounding you, they probably <u>know more about the client</u>"</p>	<p>Team knows client</p>		
<p>"...you missed that little clue, and <u>someone else had the time...to pick up</u>"</p>	<p>Someone else found clue</p>		

APPENDIX Q

Concept Definition – Knowing

Transcripts	Incidents	Categories	Concept
"It's a 6th sense... <u>seeing</u> that patient and <u>knowing</u> ."	Seeing and knowing	Knowing what they need/what will happen	Knowing Described as intuitively knowing what is going to happen and what the older patient needs
"You just <u>know what they need</u> ."	Know what they need		
"You <u>know without the patient asking</u> ..."	Know without them asking		
" <u>You know</u> they are brewing something...it's just <u>nurse's instinct</u> ... <u>just watching the patient</u> "	You know by just watching, nurse's instinct		
"... <u>intuitively glance at a person and know</u> what is going to happen."	Intuitively glance and know		

APPENDIX R

Concept Definition – Pulling It All Together

Transcripts	Incidents	Categories	Concept
"... <u>pulling all these little factors in</u> , trying to explain why?..."	Pulling all factors in	Pulling it all together, figuring out what it important	Described as looking at the whole situation, figuring out what is important, focusing on the patient's main problem right now
"... <u>problem solving</u> and being able to <u>look at the broader picture</u> ."	Looking broadly & problem solving		
"... <u>look at the whole situation</u> and <u>figure out what is happening</u> ."	Looking at the whole, figuring out what's happening		
"... <u>focus on their main problem right now</u> ..."	Focus on main problem right now		
"...to be able to look at it all at once and <u>pick out</u> different areas, <u>what's important</u> ."	Pick out what's important		

APPENDIX S

Concept Definition – Expecting

Transcripts	Incidents	Categories	Concept
"We are always <u>anticipating...</u> "	Anticipating	Expecting what's normal and what's not	<p style="text-align: center;">Expecting</p> <p>Described as anticipating what is normal for older patients as compared to younger patients, based on past experiences.</p>
"... <u>looking at the broader picture</u> , and putting it in a framework... <u>thinking that is sort of normal</u> and what you are <u>expecting.</u> "	Looking, thinking, expecting what is normal		
" <u>.Knowing what's different</u> about the older person compared to the younger person"	Knowing what's different		
"...you know because <u>usually these things happen</u> "	Usually these things happen		
"... <u>with past experience you know what is an average amount...it is expected.</u> "	Know what is expected based on past experiences		
"..I <u>gear my whole expectations down</u> and I am more trial and error because they are more sensitive."	Gear my whole expectations down		

APPENDIX T

Required Knowledge

Knowledge Area	Quotes
Differences between older and younger patients	<p>“Everything is compromised slightly, everything is just a little bit different.”</p> <p>“It’s not just looking after an older person, lot’s of different things come into play.”</p> <p>“So called normal values are different.”</p> <p>“Each patient is more time consuming in that they are weaker...they are moving a lot slower, plus they’re frail, so your total care is a lot slower.”</p>
Ethical Issues and Rights: the right to live at risk, the right to refuse treatment, and the right to a thorough investigation and treatment	<p>“It is an awful feeling to think that they are going to go home and have that happen (fall again) but I don’t know what we can do...it’s their right to be able to choose.”</p> <p>“To decide whether they can live at risk, it’s such a big thing, and they do have that right.”</p> <p>“I think it is a shortcoming for geriatric patients, as soon as you enter a hospital, if you have come from a nursing home...we are far more aggressive than we should be...even if the patient is DNR...should you be intubating and giving oxygen?... how invasive do you get?”</p> <p>“You are physically tying someone to their bed, I mean, you know you are totally taking away their freedom...it is like taking away their rights.”</p>