

## Chapter 1

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# Principles of Gerontological Nursing

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### Box 1.1 What matters to me: older person

'A good nurse to me is someone who knows what they are doing and can do it in a way that shows they care, care about me that is. They should speak to me with respect and not simplify information because I am eighty years old. I will ask when I don't understand.' (Ronald Newman, 81)

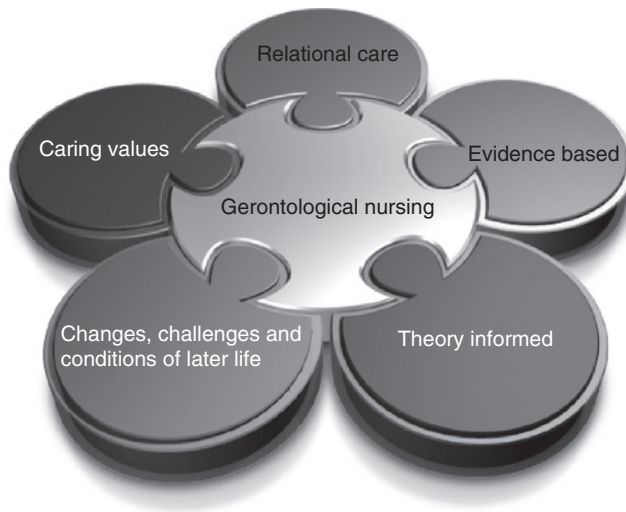
## Introduction

Improvements in health and social care have contributed to demographic ageing around the world. This means that nurses who work with adults will increasingly be working with older people (people over retirement age, most often aged 60 years or more). The fastest growing group of the older population is the oldest old, i.e. those who are 80 years old or more. Globally in 2000, the oldest old numbered 70 million and their numbers are projected to increase to more than five times that over the next 50 years (Huber 2005). Adding years to life is a great achievement, particularly when this is accompanied by a good level of health and well being. For many people, however, longevity brings with it an array of challenges, some age related, others condition specific which impact on their lives and those close to them. Increased susceptibility to health problems and the cumulative effect of relatively minor problems coupled with a decreased recovery capacity explains the high demands for healthcare by this group. In addition to changes in states of physical and mental health, social determinants of health such as poverty and social isolation can compound an individual's problems. The susceptibility of older people to declining health and the global increase in numbers of people living into late old age make compelling reasons to mobilise nursing efforts and for us all to prioritise investment in the development of gerontological practices.

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**Figure 1.1** Essential connections for gerontological nursing practice.

Nurses are uniquely positioned to promote health in later life and to influence care outcomes and experiences for older people and their families. To do this effectively nurses need to draw on the best available evidence and adopt approaches to practice informed by health and medical sciences. Practice will also be influenced by conceptual and cultural understandings and reflect what is possible in the particular nursing situation. This book does not set out to be a definitive practice textbook *per se* – our intention is to explore the connections between practice, the value base of practice, emergent theory and the continually evolving evidence base which collectively informs how nurses can and do work with older people.

This foundational chapter will orientate readers to three fundamentally important and related issues which shape contemporary thinking about evidence informed nursing with older people:

- (1) the meaning of gerontological nursing and its relationship to the evidence base;
- (2) the importance of shaping evidence implementation through a culturally appropriate value base;
- (3) the evidence informed management of common geriatric syndromes and health conditions.

Taking this unified view allows individual nurses to make essential connections to inform practice (Figure 1.1).

The introductory discussion is pivotal to understanding the contribution that nurses can and do make to the health and well being of older people. Importantly, we will introduce current debates and emergent ideas about the constituents of nursing practice at its best. The core premise is that nursing at its best occurs when practitioners make connections between the value base, evidence, underlying theory and gerontological practice know-how in the unique moment of care.

## **Meaning and scope of gerontological nursing**

Over recent decades it is possible to trace debates in the literature as to whether nursing older people is a specialism or a component of general adult nursing. Kagan (2009) is critical of this preoccupation, contending that to progress we must focus on the promotion of gerontological principles when nursing people who for reasons of chronological age, illness, injury or genetic disposition manifest needs associated with later life. The Nursing and Midwifery Council of the UK now recognises that nursing older people is a specialism that requires highly skilled nurses who can respond to the complexity of health and social care needs of older people (Nursing and Midwifery Council 2009, p. 6). In addition to recognising the prerequisite skills that practitioners require to nurse older people, McCormack and Ford argued a decade ago that it is essential for nurses to be able to describe the contribution they make to older people's health and healthcare. If they fail to do so then it is likely that the trend, in some countries, to replace registered nurses with cheaper vocationally qualified support workers will continue (McCormack & Ford 1999).

We take the view that nurses who become expert in working with older people draw on knowledge from applied gerontology, geriatric medicine and generic nursing skills alongside knowledge of the older person, their family and life circumstances.

By describing nurses whose practice is guided by an explicit value base and informed by clinical and applied gerontological knowledge as 'gerontological' nurses, a distinction can be made between nurses with expertise, and those with a more general understanding of adult nursing. We believe this distinction is an important one to make as it signals the need for preparation specific to understanding clinical and psychosocial aspects coupled with an appreciation of the aspirations and felt needs of older people. We also concur with Kagan (2009) that all adult nurses should be equipped to apply gerontological principles within their practice.

Approaches to preparing nurses to work with older people vary and are influenced by views about underlying competencies and essential skills sets. Such views inevitably change with development of knowledge and theory and are reflective of national health-care policies, priorities and service configurations. In the UK for example, recent health policies have promoted respectful and dignified care. These affective dimensions and the relationships within care are reflected in gerontological nursing competencies set out by the national agency for healthcare education in Scotland (NHS Education Scotland 2003). American and European alliances, whilst acknowledging the importance of these dimensions, highlight more clinically orientated perspectives including the differentiation of normal ageing from illness and disease processes, and assessment for syndromes and constellations of symptoms that may be manifestations of other underlying health problems (American Association of Colleges of Nursing 2004; Milisen *et al.* 2004). Such regional differences reflect local interpretations of nursing roles and functions in relation to older people rather than genuine differences in the underlying knowledge and skills sets which inform practice. In reality nurses need knowledge derived from clinical subjects and social sciences including the arts and humanities, so they can understand both what to do in a technical clinical sense and to convey their caring in ways that are safe and compassionate. There is an emerging consensus in the international literature that the scope of nursing older people embraces:

- health promoting aspects that enable people to optimise health, well-being and independence in later life;
- curative and rehabilitative dimensions that focus on functional or psychological recovery from illness or injury;
- facilitating self-care and enabling effective management of long-term conditions;
- providing care for those who become frail or with limited and/or declining self-care capacity;
- palliative and end-of-life care.

An important consideration for all countries is the attention afforded by pre-registration nursing courses in terms of preparing nurses to meet the varied and complex needs of an ageing population. Given the broad scope of gerontological nursing, working with older people offers ample opportunities for registered nurses to specialise in selective aspects of later life care. A challenge for the profession is to steer a transformative path to ensure a positive future for nursing older people and move away from negative legacies associated with ageist service mindsets and a general lack of investment in this area of health-care (Hayes & Webster 2008).

We suggest that reframing thinking around the concept of gerontological practice contributes in several ways to the development of a positive mindset, which could facilitate progress (Kelly *et al.* 2005). Gerontological practice is a multi-professional and multi-agency endeavour, and although our discussions focus on nursing, it is with an appreciation that the clinical, theoretical, conceptual and ethical roots of much of our practice are shared and collaboratively developed with other health and social care disciplines.

The definition of this area of nursing presented in Box 1.2 reflects the previously listed scope of gerontological nursing. The definition was generated inductively through a social participatory programme of research undertaken over a 6-year period within Scotland (Kelly *et al.* 2005). The definition was formulated collaboratively with nurses from across Scotland working in a spectrum of specialist settings with older people, including acute hospital wards, rehabilitation units, long stay facilities, care homes, community and primary care (Tolson *et al.* 2006). Hence it has applicability across UK care environments and potentially beyond. An additional feature of the definition is that older people were also involved in its preparation. Critique and feedback on the original definition agreed in 2001 was invited from 11 gerontological nursing communities of practice over a period of 5 years ([www.geronurse.com](http://www.geronurse.com); Tolson *et al.* 2007, 2008) and it is noteworthy that the only requested amendment was made in 2004 when the concept of person-centred care was substituted with relationship-centred approaches. This suggests that the definition captures the contemporary meaning of gerontological nursing for practitioners and older people within Scotland and we also believe that it is in tune with international descriptions. Participants who collaborated in the development of this definition recognised that to realise their vision, a nurse would require in-depth, evidence informed gerontological nursing knowledge, skills and experience together with commitment to an explicit value base shared with members of their local multidisciplinary team. For some this definition represented an important stage in demonstrating professional identity, improving status and conveying their growing confidence in a new era of nursing with older people.

## Box 1.2 Defining gerontological nursing

Gerontological nursing contributes to and often leads the interdisciplinary and multi-agency care of older people. It may be practised in a variety of settings although it is most likely to be developed within services dedicated to the care of older people.

It is a relationship-centred approach that promotes healthy ageing and the achievement of well-being in the older person and their family carers, enabling them to adapt to the older person's health and life changes and to face ongoing life challenges. See [www.geronurse.com](http://www.geronurse.com)

Our definition (Box 1.2) highlights that gerontological nursing is relevant within any setting where older people receive healthcare and that it is not the exclusive domain of units dedicated to the care of older people. Importantly, the definition acknowledges the potential leading role played by gerontological nurses working as part of a multi-professional care team. Interestingly, most nurses who practise gerontological nursing do not use this term in their job title, preferring descriptions which are more meaningful to the public.

That said, an agreed definition and clarity about the principles of gerontological nursing are useful in that they enable nurses to describe their contribution or potential contribution to the healthcare of older people. Furthermore, it is an important step towards understanding the core gerontological knowledge and skills that underpin safe practice. This in turn should determine how we prepare practitioners to work with older people, either as a component of their general adult nursing role or as specialists with increased knowledge. Now that we have defined the area of practice and delineated the range of knowledge necessary to equip practitioners we can begin to examine the adequacy of our practice know-how, the underlying evidence base. Following this we can make theoretical connections to develop and advance practice. In this way we can demonstrate aspects of practice that are informed by evidence to be of demonstrable or perceived benefit to older people and reconsider aspects that are of questionable benefit. We will consider the issue of evidence, information use and appraisal within practice more closely in Chapter 2.

For now let it suffice to say that it is only by drawing on a credible inclusive evidence base that we can begin to understand how to optimise outcomes for older people and realise the potential of gerontological nursing. Griffiths (2008) suggests that by focusing on outcome indicators with older people, nurses have an opportunity to move beyond traditional approaches of identifying the problems and needs of older people. Rather, Griffiths (*ibid.*) argues that we should begin by identifying the desired outcomes of healthcare with the person and from this position recognise the nursing contribution to their care, plan and deliver appropriate nursing interventions. Heath and Phair (2009a) also advocate outcomes frameworks, which focus on older people's abilities, aspirations, health and well-being. To do so, they argue, values activities such as listening and being compassionate which research has shown are important to older people (Way *et al.* 2008). Furthermore, given that our definition of gerontological nursing (Box 1.2) recognises the importance of family carers it would be inconsistent to ignore them in our consideration of care outcomes.

If we accept the above arguments, we need ways to orientate our thinking towards person and family carer experiences, their expectations of care in addition to responding to the individual's presenting clinical symptoms and life changes.

Additionally, it would be inappropriate to restrict the nursing view of outcomes for the management of clinical symptoms to narrow measures based upon treatment efficacy alone; this has been the tendency of evidence based medicine (Jutel 2008). A more relevant approach for nursing is to take a broader view to accommodate the practical benefits experienced by patients and their close family members. Schulz *et al.*'s (2002) review of intervention studies specific to the caregivers of people with dementia provides a useful basis for a more relevant and inclusive description of clinical significance. They identify four core concepts that are clinically significant: symptomatology, quality of life, social significance and social validity. Intuitively these constructs have relevance to both the family carer and older people and to conditions other than dementia, including the spectrum of geriatric conditions and syndromes. Table 1.1 provides an overview of clinical significance based on the analysis of Schulz *et al.* (2002) using as exemplars two common geriatric conditions (urinary incontinence and hearing loss) to demonstrate the nursing contribution and outcomes within healthcare.

We will return to clinical conditions and features in the latter part of this chapter, but first we will turn our attention to the values underpinning practice and connections between these and the evidence base.

## Linking evidence with beliefs about caring

Evidence based practice has in many ways become the mantra of contemporary healthcare policy and practice (Rycroft-Malone 2006). However, debates continue within nursing as to what constitutes meaningful evidence. Jutel (2008) is highly critical of the narrow scientific preoccupation of evidence based medicine and advocates that nurses should engage in information appraisal that goes beyond traditional evidence based tools which are subservient to evidence hierarchies.

We agree with this stance and acknowledge the view that evidence is contextually bound and socially constructed (Dopson *et al.* 2002). Philosophically, this means that the way nurses understand and relate to evidence is a function not only of the evidence itself but the interplay of how nurses think about practice and their beliefs about the constituents of good care. This may or may not embrace contemporaneous research. In a postal survey of registered nurses' understanding and interpretation of evidence based practice, Rolfe *et al.* (2008) found that nurses cited three influences on their practice: their own past experiences (69%), patient preferences (63%) and local evidence based guidelines (49%). This suggests that the way nurses make decisions and judgements in practice is a function of much more than their awareness of what may be recommended within care guidance. We have confirmed, within the Scottish Gerontological Nursing Practice Project, that when evidence is presented in ways that explicitly align with nurses' underlying beliefs about practice and caring, then they are more likely to adopt and sustain evidence based change (Tolson *et al.* 2008).

Many authors contend that caring is the core essence of nursing, describing it in terms of conveying a sense of concern, a desire to protect and ameliorate suffering in others.

**Table 1.1** Exemplifying the nursing contribution using Schulz's framework for clinical significance.

Clinical significance core concepts	Geriatric condition 1: urinary incontinence (UI)		Geriatric condition 2: hearing loss	
	Focus	Nursing contribution	Nursing contribution	Outcome
Symptomatology	Physical and mental health symptoms	Comprehensive assessment and determination of type of UI	Type of UI identified: targeted intervention applied	Person gains insight into level of hearing impairment crucial to adaptation
		Agreeing continence-promoting intervention with older person	Bladder rehabilitation not palliative containment	Rehabilitation options known
Quality of life	Perceptions of life quality which includes relationships with others	Support for self-management of urinary symptoms	Reduced urinary incontinence or cure	Timely referral
		Evaluate effects		
Social significance	Includes service utilisation and broader impacts on society, such as delaying institutionalisation	Measures of symptom distress and impact on quality of life	Reduced experience of symptom distress, reduced social isolation and improved quality of life	Optimal hearing aid benefit
		Appropriate use of specialist continence, urodynamic and urology services	Enables coping	Reduction in hearing hassles
Social validity		Support to appropriately manage urinary incontinence to prevent curtailment of life-enhancing activities	Improved self-esteem and participation	Improved relationship with communication partners
			Delays need for institutionalisation	Inappropriate consultations avoided
		Appropriate use of continence equipment	Appropriate use of continence equipment and participation	Reduction in level of hearing aid rejection
		Support to appropriately manage urinary incontinence to prevent curtailment of life-enhancing activities	Informed and sensitive response to age-related hearing loss	Improved self-esteem
			Augmentation of specialist audiological rehabilitation	Enhanced communication opportunities
				Improved levels of participation

Other authors, however, concede that caring is an elusive concept that defies definition, being a culturally and contextually bounded experience. Cronqvist *et al.* (2004) describe caring as a relational concept that involves caring about someone. For Cronqvist *et al.* the qualities that characterise caring include compassion, conscience and commitment, competence, sharing and mutual respect. Specific to expert gerontological nursing, McCormack and Ford (1999) propose five caring attributes: holistic knowledge and practice, saliency, knowing the patient, moral agency and skilled know-how. In an analytical exploration of the four core concepts of person-centred nursing in relation to nursing older people, McCormack (2004) describes:

- *being in relation* as concerned with relationships with people;
- *being in a social world* as highlighting the essential sociability of a person;
- *being in place* as the context in which personhood is articulated; and
- *being with self* is about being recognised, respected and trusted and its impact on our sense of who we are.

On a theoretical level it becomes clear that relationships are central to caring, and that to create a sense of care involves reciprocity founded on trust and demonstrable respect for the individual. This highlights the centrality of attitudinal dimensions and communication in nursing older people. In thinking about how to promote quality in our communications with people, Fredriksson and Eriksson (2003) advocate that we focus on what they describe as the caring conversation. This they explain is rooted in an appreciation that conversation occurs at a number of levels extending from being with (the ontological perspective), to a means of gaining knowledge (epistemological perspective), as a process which focuses on communication technique (methodological) and as an ethical encounter intended to do the person good. Recognition of the ethical dimensions of the caring conversation we believe to be pivotal to the relationships that nurses and others can form with older people and their family carers. This is reflected in the evidence surrounding perceptions of truth telling which we explore in Chapter 4.

## Rights based care

International rights movements have highlighted the principles of fairness, respect, equality, dignity and autonomy. For many readers these principles will resonate with their own core values. The United Nations adopted five principles for the care of older persons in 1991 concerning independence, participation, care, self-fulfilment and dignity (United Nations 1999). These principles, reflecting the rights of older people are considered to be globally relevant and form the basis of an international action plan agreed in Madrid in 2002 (United Nations 2002). Some of the rights are related to essential elements for survival such as access to food and water, whilst others extend to opportunities for social engagement and participation in community life. The intention is that countries will embrace these five dimensions and create appropriate policies and mechanisms to ensure that these rights are observed.

In terms of healthcare policy imperatives a number of important UK developments reflect principle based care rooted in a system of older people's rights. The Department



of Health in England produced a National Service Framework for Older People which introduced a set of national standards for the care of older people in England and Wales (Department of Health 2001). A major ambition of the National Service Framework was to root out age discrimination in health services and promote person-centred care. However, Nolan *et al.* (2004) have suggested that whilst this development was a major step forward some tensions have emerged from the narrow focus on the individual, which excludes the many supportive relationships within care. The importance of relationship-centred care, with a focus on the individual, will be further explored in Chapter 3.

A different stance to promoting principle based care of older people has been adopted in Australia. Rather than mandating standards of care, as in the English system, the Australian health ministry established an overarching framework for health services to use in their management of older people services (AHMAC 2004). Australian providers were duly expected to review their underlying principles and practices to ensure that they:

- adopted principles and practices that enable older people to access appropriate forms of care, support and treatment;
- optimise older people's health outcomes and functional independence;
- take the older person's wishes into account where possible;
- provide a supportive environment during decline and end of life (AHMAC 2004).

The importance of the involvement of family and significant others in care is enshrined within the Australian aged care standards of practice (Haesler *et al.* 2006). In regions of New Zealand, where this scheme has been partially adopted, the Treaty of Waitangi provides a framework to address cultural and inequality issues for older Maori people (Waikato District Health Board 2009).

An interesting feature of the Australian scheme is the emphasis placed on the evidence base. Principle 1 states that health treatment and care delivered to older people will be based on strong evidence (AHMAC 2004, p. 6). What is not explained in the document is the meaning or form of the evidence that might be considered strong.

As we move beyond rights based service frameworks to explore the value base espoused by specific disciplines such as nursing, the core concepts of human rights remain implicit. In many countries this can in part be attributed to legislative frameworks such as the European Convention on Human Rights and professional codes of practice (Nursing and Midwifery Council 2009).

## **The value base for gerontological nursing**

In many care environments, unit philosophies and value statements explaining the caring culture to staff and clients are displayed in public areas or distributed in written material. The intention of such statements is to demonstrate organisational commitment to shared values designed to promote good quality care. However, such overt displays of group ethics are no guarantee that individual practitioners believe or act in accordance with the declared value base. This situation was reflected in early findings from the Scottish Gerontological Nursing Practice Project as will be explained in Chapter 2. An initial step in building a sense of cohesion among participants of the newly formed community of

practice was to invite the group of 36 nurses working in different care environments to scrutinise the care philosophies in their own workplace (Tolson *et al.* 2005). In the majority of cases the origins of the workplace value statements were unknown and only a minority of the nurses could illustrate the influence that these values had on current practice. Nonetheless, the community of practice members were adamant that alignment of their personal values and that of their team would be a key determinant as to whether they would be willing to implement best practice care guidance (Tolson *et al.* 2005). It thus became a key activity for the community of practice to locate or develop an explicit set of values that resonated with their own and their team's values. These values would then be used as a lens through which to filter the care guidance (best practice statements) which the group were concurrently constructing (Tolson *et al.* 2006; Booth *et al.* 2007).

As with the definition shown in Box 1.2 refinement of these values is an ongoing process. Kelly *et al.* (2005) noted that the list of 10 values may appear an oversimplification of the philosophical foundations of practice. However, the project participants saw simplicity of expression as the key to the future utility of the values. The brief value statements were subsequently used as a filter through which to present the written care guidance and in doing so made an explicit connection between the nurses' shared beliefs and the evidence base (Booth *et al.* 2007). This strategy avoided a common pitfall in care guidance preparation, that of failing to reflect practitioners' beliefs.

McCormack (2004) describes the notion of authentic consciousness whereby principles for action or care embody the beliefs of both nurse and patient. As Dewing (2004) elaborates, it is the act of making values transparent which provides the basis upon which the negotiated relationship between the nurse and older person can develop. In the dynamic of a caring relationship then, an explicit value base enables the practitioner to view the evidence in new light. This is an essential beginning for trust and for working in partnership with older people and their families (Tolson *et al.* 2007).

The values set out in Box 1.3 were developed collaboratively by nurses involving older people, and the inductive approach used in the Scottish Gerontological Nursing Practice Project ensured that practitioners could express their values in familiar language. Kelly *et al.* (2005) acknowledge that although developed by and for nurses, these values have a generic quality and are arguably meaningful for the multi-professional gerontological practice team. Explication of the multi-professional practice value base is an important step to promoting consistent approaches to care. The achievement of conceptual and attitudinal clarity is critical to the delivery of optimal care and enrichment of the practice environment. However, as can be seen in the definitions of expert practice already reviewed, affective and moral considerations form only part of the totality of attributes required by gerontological nurses. Other key attributes are clinical and therapeutic aspects.

## **Key clinical features in later life care**

It is timely to revisit and reinforce the importance of some key features of clinical geriatric care. The term 'geriatric' is used here in its true sense, as pertaining to the healthcare needs of older people. Although it is often used in a derogatory manner, it must be acknowledged that it is a term which is used in leading contemporary medical research

### **Box 1.3 Practice values agreed within the Scottish Gerontological Nursing Study**

#### **Commitment to relationship-centred care**

Recognition that the older person is best understood in the context of their relationships with others and that while the focus of care is the individual, they are part of a network of complex relationships that may impact on the person's care processes and which should be acknowledged for the most successful care to be achieved. Promoting continuity of care that values the older person's unique past, present and future individuality and respects the person's role and contribution to family and wider society.

#### **Commitment to negotiating care decisions**

Recognising that the older person has the right to make informed choices, with assistance from family members if they wish. The older person's choices and priorities are respected and may include an element of risk.

#### **Promoting dignity and respect**

Promoting dignity and respect for the older person in all aspects of care, regardless of setting, including consideration for the person's privacy and confidentiality.

#### **Maximising potential**

Recognising that caring events are also therapeutic opportunities and developing attitudes, knowledge and skills to empower the older person to live a life that reflects their individuality and enables them to achieve their potential.

#### **Commitment to an enabling environment**

Promoting a positive work culture together with a supportive physical and organisational environment in order to create an enabling living or care environment that conveys a sense of hope and achievement for the older person.

#### **Establishing equity of access**

Striving to secure on behalf of all older people the same access to services as other age groups and challenging evidence of age discrimination.

#### **Commitment to developing innovative practice**

Adopting strategies to promote evidence based gerontological nursing, acknowledging the value of multiple forms of evidence including practice expertise. Recognising the importance of choosing to specialise in gerontological nursing as a prerequisite to successful advancements in practice.

#### **Consistency of vision**

Developing a shared care philosophy that clearly enunciates the value base of gerontological nursing and the standards of care older people and their families can expect.

**Commitment to team working**

Working as part of a team who recognise, seek out and respect each other's contribution and commitment to the care of the older person. Directing the collective effort towards attaining goals negotiated with the older person and their family according to their needs and wishes.

**The value of reciprocity**

Recognising the value of mutual respect between all parties involved in the giving and receiving of care and the dynamic nature of the interactions in which benefits for all are appreciated.

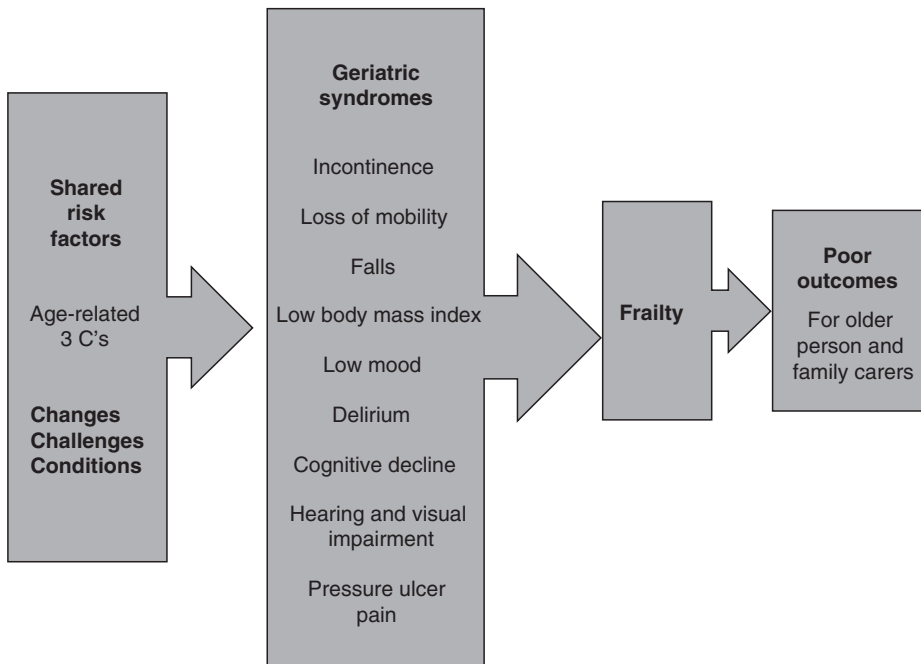
papers and associated literature. Knowledge contributed by different disciplines forms part of the overall knowledge base relating to older people's health and well-being. Nurses working in older people's specialist teams must therefore necessarily have a comprehensive knowledge of the presentation of changes in health status in later life, of contemporary holistic responses to such changes, and an appreciation of the contribution of colleagues from other disciplines. We would argue that nurses who work with older people in any setting require a working knowledge of such health changes in order to contribute to safe and effective care for older people. The key clinical features include the altered presentation of disease; multiple pathology; the concept of frailty; 'geriatric syndromes' (Anderson 1985; Inouye *et al.* 2007), also referred to as 'geriatric conditions' (Cigolle *et al.* 2007); and the 'domino effect' whereby a single event can trigger a knock-on series of events that lead to rapid deterioration or death of an older person (Isaacs 1981). These key features (Box 1.4) will form the basis of selected chapters, or they will be considered in each chapter, and their significance is now outlined.

The presentation of changed health status itself can be different in older people. Signs of illness are often atypical or 'altered' and this is mainly due to age-related changes in physiology. For example, pain may not always be a reliable indicator of myocardial infarction and fractured femur, and temperature may not be elevated in infection. Instead an older person in pain or with an infection may present with cognitive impairment, as in the development of delirium. The atypical presentation of a change in health status is often complicated by the presence of multiple pathology. Even when conditions are minor, they can have a cumulative effect on the older person's overall condition to the extent that the individual rapidly loses functional and cognitive capacity. For each separate medical condition the older person may require medication and the resulting polypharmacy may lead to toxic drug reactions and interactions, which in turn culminates in the loss of functional and cognitive capacity.

Geriatric syndromes (Inouye *et al.* 2007) and geriatric clinical conditions are commonly seen in older people, especially those who are frail, and where changes in health status do not fit into discrete disease categories. Common, serious and debilitating conditions such as delirium, falls, pain, urinary incontinence, low body mass index, hearing impairment, and immobility, where people describe themselves or are described by others as 'going off their legs', are examples of geriatric syndromes. The syndromes are indicative of a change in health status but frequently do not represent the specific disease condition or conditions which are causing that change. Furthermore, the organ systems affected, such as the

### Box 1.4 Key clinical features in later life care

- Altered disease presentation
- Multiple pathology
- Polypharmacy
- Frailty
- Geriatric conditions and syndromes
- Domino or cumulative effect



**Figure 1.2** Geriatric syndromes and link to poor care outcomes. (Adapted from Inouye *et al.* 2007 with permission.)

bladder in urinary tract infection, may be distinct and distant from the system involved in its presentation (the brain in delirium). When geriatric syndromes occur together, precipitated by multiple underlying conditions, the interrelationships are increased in complexity. Figure 1.2 shows the link between the shared risk factors which give rise to geriatric conditions and the link with frailty and, if unmanaged, poor outcomes of care.

Geriatric syndromes will play an ever more prominent role with the increasing numbers of very old people. Despite this, within the UK and USA, the policy focus is on the management of single disease long-term conditions such as diseases of the heart and lungs and diabetes. However, a large US prevalence study of geriatric conditions and their

effect on health and disability in older people living in their own homes found that some geriatric conditions were as common as chronic diseases, and strongly associated with disability (Cigolle *et al.* 2007). Whilst we would not argue against nurses playing a role in the care trajectories of long-term conditions, a failure to address the key features of geriatric care will result in inadequate and substandard care for potentially preventable disability for older people.

Frailty is currently a much debated concept and understandings of frailty vary. According to Campbell and Buckner (1997) it is a syndrome associated with underlying physiological and metabolic changes to the extent that minor alterations in a person's health status can cause increased disability or death. Another approach is an understanding of frailty as a collective of risk factors which might result in an increased state of vulnerability or even death (Ravaglia *et al.* 2008). Topinkova (2008) describes frailty as a 'geriatric condition' which belongs to the larger family of 'geriatric syndromes'. She cites a consensus of geriatricians working in Europe, Canada and America to the effect that frailty is a state of increased vulnerability to stressors, resulting from a decrease in physiological reserves and a degree of failure in multiple organ systems. Fried *et al.* (2004) describes frailty as a clinical syndrome characterised by multiple pathologies of weight loss, fatigue or weakness, low levels of physical activity, slow movement, abnormalities of balance and gait and with the added possibility of cognitive impairment. Frail individuals are particularly vulnerable to hospitalisation and medical procedures, sustaining falls and developing delirium, the latter resulting from age-associated changes in neuromuscular functioning and activity of endocrine and immune systems. It has been suggested that frailty can be reversed, by treating underlying conditions, under-nutrition and weakness. A recent definition of frailty from the nursing literature is provided by Heath and Phair (2009b):

*a weakened state of being in which a person's reserve capacity is reduced to an extent where health, functioning and wellbeing are compromised. In the Precursor Stage a range of indicators can identify people who are vulnerable to frailty. Advanced frailty threatens life. Complications of frailty occur when the care delivered fails to compensate for the impact of frailty...*

This definition is important for our book as prevention or compensatory care in relation to common clinical conditions will be addressed in the case study chapters.

Heath and Phair (2009b) suggest that ill health characterised by the 'domino effect' affects older people who are described as being 'frail', such as those people who already have impaired cognition, impaired physical function and mobility. A single event such as a fall in a frail individual can result in a cascade of events, such as immobility, pressure ulcers, dehydration, urinary tract infection, delirium, and prolonged or lasting cognitive impairment. It may sometimes be burdensome and futile to search for an underlying condition, and it may be most appropriate to focus care on the presenting syndrome or to begin end-of-life care (National Confidential Enquiry into Patient Outcome and Death, 2009). Chapters 5–13 explore aspects of evidence informed nursing care based on the key features of clinical geriatric care, within a framework that is relationship centred and appropriate to the context in which it is delivered.

## Summary

Our discussion has offered an explication of the nursing contribution to the healthcare of older people and their family carers. We have advocated investment in the promotion of gerontological nursing principles and the development of expert gerontological nursing practice as a legitimate way to meet the needs of the growing number of people around the world. Importantly, we have set out the essential connections that nurses need to make between theory, practice values and evidence in response to the policy imperative to deliver evidence informed care. This key messages contained within this introductory chapter are highlighted in the box below. Furthermore, by making these connections nurses will be better placed to respond to the reasonable request of older people as illustrated in our opening quote (Box 1.1) to work with older people in appropriate age-sensitive ways. Interestingly, in reviewing literature on health professionals' views and engagement with quality improvement, Davies *et al.* (2007) conclude that nurses think differently about what constitutes best care to other professional groups. In particular Davies notes that nurses have a tendency to place greater emphasis on achieving patient satisfaction, meeting both psychosocial and physical care and on the relationships that they form with the person. In doing this, we suggest, nurses show that they intuitively begin to make connections between the evidence, clinical knowledge and more conceptual understandings about ethical dimensions and relational aspects within the dynamics of care delivery. Our task in the chapters which follow is to explicate this in relation to nursing with older people.

### Key messages

By making connections between theory, evidence, values, relational care and knowledge of the three C's (age-related changes, life challenges and conditions), nurses are equipped to deliver safe and effective nursing with older people.

## References

- AHMAC (Australian Health Ministers' Advisory Council) (2004) *Age-friendly Principles and Practices. Managing Older People in the Health Service Environment*. Victorian Government Department of Human Services, Melbourne, Australia. Available at [www.health.vic.gov.au/acute-agedcare](http://www.health.vic.gov.au/acute-agedcare)
- American Association of Colleges of Nursing (2004) *Nurse Practitioner and Clinical Nurse Specialist Competencies for Older Adult Care*. Hartford Geriatric Nursing Initiative. Available at [www.aacn.nche.edu/Education/dpf/APNCompetenceis.pdf](http://www.aacn.nche.edu/Education/dpf/APNCompetenceis.pdf) (accessed 25 August 2009).
- Anderson F (1985) An historical overview of geriatric medicine: definition and aims. In: Pathy MSJ (ed.) *Principles and Practice of Geriatric Medicine*. John Wiley & Sons, Oxford.
- Booth J, Tolson D, Hotchkiss R, Schofield I (2007) Using action research to construct national evidence-based nursing care guidance for gerontological nursing. *Journal of Clinical Nursing* **16**, 945–953.

- Campbell AJ, Buckner DM (1997) Unstable disability and the fluctuations of frailty. *Age and Ageing* **26**, 315–318.
- Cigolle CT, Langa K, Kabeto MU, Tian Z, Blau CS (2007) Geriatric conditions and disability: The Health and Retirement Study. *Annals of Internal Medicine* **147**, 156–164.
- Cronqvist A, Theorell T, Burns T, Lutzen P (2004) Caring about—caring for: moral obligations and work responsibilities in intensive care nursing. *Nursing Ethics* **11**, 63–76.
- Davies H, Powel A, Rushmer R (2007) *Healthcare Professionals' Views on Clinician Engagement in Quality Improvement: A Literature Review*. The Healthcare Foundation, London.
- Department of Health (2001) *National Service Framework for Older People*. Department of Health, London. Available at [www.doh.gov.uk/nfs/olderpeople.htm](http://www.doh.gov.uk/nfs/olderpeople.htm)
- Dewing J (2004) Concerns relating to the application of frameworks to promote person centredness in nursing with older people. *International Journal of Older People Nursing* **13**, 39–44.
- Dopson S, Fitzgerald L, Ferlie E, Gabbay J, Locock L (2002) No magic targets! Changing clinical practice to become more evidence based. *Health Care Management Review* **27**, 35–47.
- Fredriksson L, Eriksson K (2003) The ethics of the caring conversation. *Nursing Ethics* **10**, 138–148.
- Fried LP, Ferrucci L, Darer J, Williamson JD, Anderson G (2004) Untangling the concepts of disability, frailty and comorbidity: implications for improved targeting and care. *Journals of Gerontology A. Biological Sciences and Medical Sciences* **59**, 255–263.
- Griffiths P (2008) Metrics for nursing. *Nursing Management* **15**, 10–11.
- Haesler E, Bauer M, Nay R (2006) Factors associated with constructive staff–family relationships in the care of older adults in the institutional setting. *International Journal of Evidence Based Healthcare* **4**, 288–336.
- Hayes N, Webster J (2008) Give old people a seat at the modernisation table. *Health Service Journal* 5 June.
- Heath H, Phair L (2009a) Shifting the focus: outcomes of care for older people. *International Journal of Nursing Older People* **4**, 142–153.
- Heath H, Phair L (2009b) The concept of frailty and its significance in the consequences of care or neglect for older people: an analysis. *International Journal of Older People Nursing* **4**, 120–131.
- Huber B (2005) Implementing the Madrid Plan of Action on Ageing. United Nations Department of Economic and Social Affairs, Mexico. [www.un.org/esa/population/meetings/EGMPopAge/EGMPopAge\\_21\\_RHuber.pdf](http://www.un.org/esa/population/meetings/EGMPopAge/EGMPopAge_21_RHuber.pdf)
- Inouye S, Studenski S, Tinetti ME, Kuchel GA (2007) Geriatric syndromes: clinical, research, and policy implications of a core geriatric concept. *Journal of the American Geriatrics Society* **55**, 780–791.
- Isaacs B (1981) Is geriatrics a specialty? In: Arie T (ed.) *Health Care of the Elderly*. Croom Helm, London.
- Jutel A (2008) Beyond evidence-based nursing: tools for practice. *Journal of Nursing Management* **16**, 417–421.
- Kagan SH (2009) Guest Editorial: Boundaries and barriers: redefining older people nursing in the 21st century. *International Journal of Nursing Older People* **4**, 240–241.
- Kelly T, Tolson D, Schofield I, Booth J (2005) Describing gerontological nursing: an academic exercise or prerequisite for progress? *International Journal of Nursing Older People* **14**, 1–11.
- McCormack B (2004) Person-centredness in gerontological nursing: an overview of the literature. *International Journal of Nursing Older People* **13**, 31–38.
- McCormack B, Ford P (1999) The contribution of expert gerontological nursing. *Nursing Standard* **13**, 42–45.



- Milisen K, De Geest DE, Schuurmans M *et al.* (2004) Meeting the challenges for gerontological nursing in Europe: the European Nursing Academy for Care of Older Persons (ENACO). *Journal of Nutrition, Health and Aging* **8**, 197–199.
- NHS Education for Scotland (2003) *Continuing Professional Development Portfolio. A Route to Enhanced Competence in Caring for Older People*. NES, Edinburgh.
- National Confidential Enquiry into Patient Outcome and Death (2009) *Deaths in Acute Hospitals: Caring to the End?* NCEPOD, London.
- Nolan MR, Davies S, Brown J, Keady J, Nolan J (2004) Beyond person centred care: a new vision for gerontological nursing. *International Journal of Nursing Older People* **13**, 45–53.
- Nursing and Midwifery Council (2009) *Guidance for the Care of Older People*. NMC, London.
- Ravaglia G, Forti P, Lucicesare A, Pisacane N, Rietti E, Patterson C (2008) Development of an easy prognostic score for frailty outcomes in the aged. *Age and Ageing* **37**, 161–166.
- Rolfe G, Sergott J, Jordan S (2008) Tensions and contradictions in nurses' perspectives of evidence-based practice. *Journal of Nursing Management* **16**, 440–451.
- Rycroft-Malone J (2006) The politics of the evidence based practice movements: legacies and current challenges. *Journal of Research in Nursing* **11**, 95–108.
- Schulz R, O'Brien A, Czaja S *et al.* (2002) Dementia caregiver intervention research: in search of clinical significance. *The Gerontologist* **42**, 589–602.
- Tolson D, McAloon M, Schofield I, Hotchkiss R (2005) Progressing evidence based practice: an effective nursing model? *Journal of Advanced Nursing* **50**, 1–10.
- Tolson D, Schofield I, Booth J, Kelly TB, James L (2006) Constructing a new approach to developing evidence based practice with nurses and older people. *World Views on Evidence Based Nursing* **3**, 62–72.
- Tolson D, Schofield I, Booth J, Kelly T (2007) Partnerships in best practice. In: Nolan M, Hanson E, Grant G, Keady J (eds) *User Participation in Health and Social Care Research: Voices and Evaluation*. Open University Press, Berkshire, pp. 33–49.
- Tolson D, Booth J, Lowndes A (2008) Achieving evidence based practice: impact of the Caledonian Development Model. *Journal of Nursing Management* **16**, 682–691.
- Topinkova E (2008) Aging, disability and frailty. *Annals of Nutrition and Metabolism* **52** (Suppl. 1) 6–11.
- United Nations (1999) International Year of Older Persons (IYOP) in Asia and the Pacific. Social Development Division, United Nations ESCAP, 16 December 1991. 74th plenary meeting: Implementation of the International Plan of Action on Ageing and Related Activities. Available at [www.unescap.org/ageing/res/res46-91.html](http://www.unescap.org/ageing/res/res46-91.html)
- United Nations (2002) Madrid International Plan of Action on Ageing. Report of the Second World Assembly on Ageing, Madrid, 8–12 April 2002. United Nations, New York. Available at [www.un.org/esa/socdev/ageing/madrid\\_intlplanaction.html](http://www.un.org/esa/socdev/ageing/madrid_intlplanaction.html)
- Waikato District Health Board (2009) *Principles of Best Practice in Older Persons Care: Towards Integrated Services Delivery*. WDHB Hamilton, New Zealand.
- Way R, Lynch T, Bridges J (2008) Learning from older people who use urgent care services. *Emergency Nurse* **16**, 20–22.