Palliative care: A gerontological perspective

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Problem statement

Palliative care is a well-defined and relatively well structured nursing model of care for patients experiencing metastatic diseases and who are predicted to die prematurely as a result of their illness. However, not all persons will die of metastatic diseases. Some will die as a result of an aging process and some might die as a result of non-metastatic diseases. In these cases the time of dying will also not come as a surprise, but it may be is less predictable.

Both palliative care and gerontological care are seen as specialised nursing models of care. The similarity in both models is that there is a salient expectation of death within a shorter than average period of time. The question therefor arises whether there is a difference between these two nursing care models where one is focussing on patients who are expected to die from metastatic diseases and the other is focussing on patients expected to die from non-metastatic diseases.

Discussion

Over time similarities in these care models have been observed between the palliative and gerontological nursing professionals. Questions have been raised by gerontological nurses to explore and understand the focus of palliative care with the purpose to transfer some of the palliative skills to the gerontological care model. The most significant difference is the strong restorative focus the gerontological model has on limiting the decline of the elderly persons' functionality over time, whilst the palliative model has a strong focus on managing the patient's pain and comfort needs and preserving dignity.

Before the skills transfer from palliative care can be considered, responses of the gerontological nurses on the following questions had to be analysed:

1. Do gerontological nurses identify an "End of Life Process, or Episode or Event" whilst caring for an elderly person?
2. If the gerontological nurses identify an onset of an End-of-Life Process, how do they manage it?
3. Do gerontological nurses recognize a difference between Palliative care and End-of-Life care?
4. Do persons dying from chronic disease and/or old age and patients dying with cancer, go through the same End–of-Life Process?
5. Does the elderly frail person go through an "End-of-Life Process"?
6. Does the elderly's dying process differ from the patient dying with chronic disease or cancer?
7. Does the nursing of the elderly, in their dying process, require special skills?

These questions have a major impact on our multidisciplinary views and approach as well as on the implementation of appropriate and meaningful clinical processes for the elderly patient or client who is facing the end of their life.

We consider all nurses, social workers and other professional healthcare workers to have the practical and theoretical experience in this subject, but we realise that this subject is not well documented. The interactive workshop provides an opportunity to participate in the understanding of the management of the dying older person and that the processes are recorded.

Method

An explorative qualitative study was set up whereby gerontological nurses were posed the above questions

and their responses were noted by a scribe. This cannot be considered as a formal scientific study, as the intention was to get a general idea of the answers to the questions stated above.

Sample

The South African Gerontological Association sent invitations to its members and a total of fifty participants attended. Of these, 80% were nursing staff, the remaining 20% consisted of occupational therapists, social workers, administrative staff and volunteers. More than 70% of the nurses had five years or longer practical experience in gerontological care and of these approximately 50% had more than ten years' experience.

Results

Two schools of thought on gerontological care were identified. The majority of participants had a pragmatic approach and agreed that there must be an element of institutionalisation to manage frail care facilities efficiently. The elder person must, to a larger extent, conform to the identity, character and ambiance of the facility. A smaller group had a more idealistic approach. They considered that a structured approach to frail care must be avoided and felt that the facility must rather try to comply with the personal likes and personality of the resident as far as possible.

However, there was consensus on the following findings:

1. Nurses do experience an End-of-Life Process in the elderly person and can identify the onset of such, including life style changes. The recognition of the change in the elderly is through a nursing intuitive experience. However, the nurses took time to unpack their perceptions and observations to validate this experience.
2. A volunteer's description of her experience with an elderly friend who became noticeably tired of life and that these feelings/attitude became irreversible. This discussion triggered the nurses and they suddenly identified the End-of-Life Process in the elderly as a process of getting **irreversibly tired of living and tired of life**.
3. The signs and symptoms of getting **irreversibly tired of living and life** can be a sudden happening or an insidious and deceptive process.
4. The most noticeable cognitive signs and symptoms that nurses observe and experience in the care of the elderly are: a weariness of life, a total acceptance of the present state of being, a lack of concern about the current environment that can be misconstrued as peacefulness, a disinterest in previous activities or interests, an absence of previous fighting spirit, a decline in spiritedness, incessant reference to or longing for death and dying,
5. There are also functional signs and symptoms that nurses observe in the elderly, including a sudden decline in the activities of daily living, which result in a noticeable lack of personal hygiene and appearance, requiring more support with grooming, dressing, toileting, transfers, mobility, etc.
6. Nurses agree that the look in the elderly person's eyes is one of the most predictive indicators of the onset of irreversible tiredness of living and life. Nurses clearly identify the longing look for departing this world, the loneliness in being in this world, the waiting for the eternal rest and peace. However, it must be noted that when there is unfinished business (e.g. the saying goodbye to a child in a distant country) there is also clear agitation and an urgency.
7. In severe cases, nurses also experience a "pointed nose phenomena". This is explained as the result of wasting of facial muscles due to lack of emotions over time.
8. Five nursing participants who specialise in the care of the elderly living with dementia concluded that, although their elderly persons have a more significant blunting of emotions, they experience the same signs and symptoms indicating the onset of being irreversibly tired of life and living. They further stated that in the case of the person with dementia, there may be one significant difference, namely the inability of the person with dementia to pretend that *"all is still well"* when it is not, making it easier to identify the onset of irreversible weariness of life and living.

The interview then focussed on the management of the elderly identified with an irreversible weariness of life and living.

1. There was consensus that the care and management of the End-Of-Life elderly person is different to the other elderly in the facility. Whilst the other elderly would continue living in a more structured and stimulating environment, requiring a faster pace of social interaction, the elderly person who is irreversibly weary of life and living, is cared for in an environment where they can set their own pace. This means that they decide on their daily routine and activities of daily living.
2. The focus of the care to the End-Of-Life identified elderly is to preserve dignity and to help them through their End-Of-Life Process with respect. This translates in that their own needs and requests receive priority, with the sole purpose to obtain a peaceful exit of this world.
3. The nursing of the elderly in the dying process requires a special skill which is already implemented by some facilities by using the OMEGA scale. There was a request for further training in the correct application of the OMEGA.

Further data collected emanated from the questions.

1. The gerontological nurses do not differentiate between palliative care and end-of-life care. It is the same process and requires similar skills regarding the dying patient, the family and the environment. All End-of-Life patients/ residents have the same needs.
2. The care and the basic needs of a person dying of old age, a chronic non-metastatic disease or a cancerous metastatic disease remains the same. They all require dignity, respect, the ability to manage their own dying process, and support with any symptoms or signs of discomfort. They want to have it their way, it is their last request.
3. The nursing sciences applicable to how the discomfort of dying can be alleviated (pain, sleeplessness, etc.) depends on the dying person's needs.
4. Finally, it was concluded that there might be an emotional difference experienced by nurses between the care of the person dying from a cancer and those dying from old age. This emotional difference could be explained through the mystery that surrounds cancerous disease, the unwillingness of the cancer patient to accept the End-of-Life Process, the unpredictability of the possible cure of the cancer, the fear of saying goodbye to loved ones and the anxiety of possible pain and discomfort. The End-of-Life Process in the elderly differs as there is a weariness of living this life and a longing for the departure of this world.

Conclusion

The trigger factors to initiate palliative care for patients with cancer is the conclusive diagnosis of cancer by the doctor. The trigger factor to initiate palliative care for the elderly person who is entering the End- of-Life Process is the nursing observation of an irreversible weariness of life and living. The signs and symptoms are well-documented above.

Once the trigger factors have been established, the palliative care for the persons with metastatic and non-metastatic diseases is the same.