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EMPIRICAL STUDIES

Dealing with daily emotions—supportive activities for the elderly in a municipal care setting

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Abstract

There are diverse descriptions of supportive activities in nursing to be found in the literature. What they have in common is their association with good care outcomes, but they may differ depending on the context in which the care is given. In a Swedish municipal elderly care setting, registered nurses (RNs) work in a consultative way and they describe a part of their tasks as comprising supportive activities, without specifying what kind of supportive activities they mean. The aim of the study was to explore the main concern of the support given by RNs to a group of patients in an elderly home care setting. The study was conducted using Grounded Theory. Data were collected using nonparticipant observations regarding the supportive activities of 12 RNs at the home of 36 patients between the ages of 80 and 102 years. Most of the home visit lasted about 40 min but some lasted for 90 min. The central category was about *dealing with daily emotions*. This was done by *encouraging the situation* and *reducing the patient's limitations*, but situations also occurred in which there was a *gap of support*. Support was about capturing the emotions that the patient expressed for a particular moment, but there were also situations in which RNs chose not to give support. To develop a holistic eldercare, more knowledge is needed about the factors causing the RNs to choose not to provide support on some occasions.

Key words: *Support, maintaining wellness, municipal care, the elderly*

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Support in nursing may have many different meanings; it is complex and unspecified. Some literature describes support as a comprehensive activity, the purpose of which is to satisfy needs of all kinds (Stoltz, Pilhammar Andersson, & Willman, 2007). Finfgeld-Connett (2005), however, described support by dividing it into instrumental and emotional kinds of support, which have different purposes. Instrumental support is of a practical nature such as providing support in relation to service, shelter, home help, or financial help, whereas emotional support consists of comforting activities (Finfgeld-Connett, 2005). The comforting activities are not specified with the exception of social support that is described as the possibility of providing social contacts with relatives, friends, or social activities (Finfgeld-Connett, 2007). Fingfeld-Connett (2007) expressed doubts as to whether such activities are within the professional field of registered nurses (RNs), and she suggested that there is insufficient knowledge in the field. Even Stoltz et al. (2007) described social support, but considered this to be an activity for nonprofessionals to perform. Other studies, on the contrary, conclude that social support is essential in the care of the elderly and that this facilitation of social contacts is a task to be performed by RNs because it promotes the cognitive abilities of the elderly and decreases the experience of loneliness among them (Dale, Sævareid, Kirkevold, & Söderhamn, 2010; Drageset et al., 2009; Winningham & Pike, 2006).

Support is also described as being divided into specific nursing activities. Information, for instance, is often adapted to the circumstances of a specific illness (Chin-Yen, Hung-Ru, Ing-Tiau, & Mei-Ling, 2008; Larsson, Hedelin, & Athlin, 2007) or to the individual patient's needs (Larsson et al., 2007). Other forms of situational-specific

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support, expressed by patients, include medical, psychological, or spiritual support in daily life (Harrefors, Sävenstedt, & Axelsson, 2008), but precisely what is included in these activities is not mentioned.

Regardless of how support is described, the common denominator is that activity is associated with good care outcomes (Björklund, Sarvimäki, & Berg, 2008; Chin-Yen et al., 2008; Dale et al., 2010; Drageset et al., 2009; Larsson et al., 2007; Winningham & Pike, 2006). However, the view of support and expected outcomes changes with the technical solutions brought about by the development of today's health care. It would seem that expectations of support also involve technical support and solutions (Stoltz et al., 2007). Another important aspect of the view of support is that of the organization. Stoltz et al. (2007) concluded that the superiors' definitions of support guide the support that is given and also determine the resources required to be able to provide the support. The context in which support is given appears to determine the meaning, purpose, and expected outcome of the activity (Björklund et al., 2008; Chin-Yen et al., 2008; Larsson et al., 2007; Stoltz et al., 2007).

In Swedish elderly home care contexts, it is common for RNs to work consultatively. With this way of working is meant that an RN will be called when a patient, living in ordinary or sheltered housing, is for various reasons in need of care (Nilsson, Lundgren, & Furåker, 2009). The role of the RNs in this form of organization is complex because in relation to the care of the patient the RNs are leaders over different care teams without being included in them (Manley, Webster, Hale, Hayes, & Minardi, 2008). Their function includes clinical, strategic, educational, and evaluative functions (Fontaine, 2007). The clinical function is described as RN care or direct contact with the patient and has been estimated at approximately half of their working time. The other functions are described as different aspects of leadership addressed to professionals and nonprofessionals alike who are involved in the care of the elderly (Fontaine, 2007). RNs have expressed that time pressure is perceived as high in their daily work (Josefsson, Sonde, Winblad, & Robins Wallin, 2007), and that they feel frustrated because of organizational factors leading to their dependency on the judgement of other professional groups in their daily clinical work (Juthberg & Sundin, 2010). At the same time, they have also expressed that they have an opportunity to influence their daily work situation by working as consultants, where they themselves can decide which activity should be initiated for the patient (Josefsson et al., 2007).

One activity often mentioned by RNs in relation to the care of the elderly is support (Manley et al., 2008; Schein, Gagnon, Chan, Morin, & Grondines, 2005). Manley et al. (2008) concluded that RN supportive activities in the elderly home care context are not only directed toward the patient but the organizational position of the RN leads to supportive activity also being directed toward different professional teams and the organization. If this way of giving support would benefit the patient or if it is an organizational solution of elderly care, this is not revealed and neither is it specified as to the kind of support that is meant or its purpose. To develop the care given in elderly home care contexts, it is important to gain more knowledge about what the support is about and how the support can be integrated in nursing and in the daily work of the RNs. The aim of the study was to explore the main concern of support given by RNs to a group of patients in an elderly home care setting.

Method

The study was conducted using Grounded Theory (GT), the aim of which is to generate evidence-based concepts that can describe what is taking place between different actors in a chosen area. Using a predetermined concept, one can clarify what is being studied and develop knowledge about the same (Corbin & Strauss, 2008). This version of GT (Corbin & Strauss, 1990) has its origin in pragmatism and symbolic interactionism in which two principles leave its mark in the method. First are those phenomena affecting events, and this is an ongoing process. This property is in the method, to build change through process (Corbin & Strauss, 1990). Process is seen as a continuous action in relation to a determinate purpose to reach an aim with a problem or a situation (Corbin & Strauss, 2008; Strauss & Corbin, 1998). Second is that actors control their destiny through active choices. Even here you can see a parallel with GT when its purpose is to find out how actors respond to conditions and consequences of their actions (Corbin & Strauss, 1990). When actors are different and the context in which the event is performed is different, it leads to a constructed description of experiences (Corbin & Strauss, 2008; Strauss & Corbin, 1998).

Participants, procedure, and analysis

The study group consists of RNs who are employed in a municipality in the southwestern part of Sweden or by a contractor who is in liaison with the municipality. Whatever the mode of operation, the RN is responsible for the health care of the

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patient living in sheltered or ordinary housing. The RN works on a consultative basis and is independent. Initially, all RNs were orally informed about the study by their directors. The RNs were later contacted individually by telephone and asked to participate in the study. This was done and then the data collection and analysis occurred. For the RNs who accepted to participate in the study, a time was decided when a meeting would take place. In connection with the meeting, the RNs were informed one more time both orally and in writing. The information consisted of the aim of the study and the procedure. Collection of data was done using nonparticipant observation. Inclusion criteria were RNs giving supportive activities to patients 80 years of age and older living in ordinary or sheltered housing, and who were in need of help from both the home help service and from RNs.

Initially, open sampling was used, during the observations, to be open for all possibilities and dimensions. Every individual situation that happened or anything that was said from the moment that the RN came into the patient's home until he or she left was written down without any predetermined schedule. It was also written down in which area of the home they were in, whether there were other persons in the home, and what relation the patient had with the other persons. On the occasion of any lack of clarity around something that happened during the home visit, the RNs were asked to explain this. This was done after the home visit. The RNs also had the possibility of communicating their thoughts, and this was also done directly after the home visit so as not to influence or increase the understanding before the home visit, although the first author who was present at all of the observations had had many years of experience of elderly home care. All questions and answers were written down.

Directly after the home visit, notes were transcribed word by word, and after several readings the text was broken down into sections with a given content. Text sections were compared with each other and placed in groups with similar text content that were assigned a code. In this open coding system, different codes were compared with each other, with the purpose of finding similarities or differences. During the analysis procedure, ideas and assumptions were written in the so-called memos.

After the first data collection and analysis, contact was taken with the next RN for new data collection and analysis. The first analysis and its memos were compared with the second. This procedure lasted until data collection number five, when similar codes were grouped in preliminary categories.

In connection with data collection number six, a theoretical sampling was used to explore the preliminary categories that proved to be significant cases. In this data collection, the second author participated to validate preliminary categories. Questions asked in relation to the observations were how does the RN express given support? In which situations did he or she give expression of support? What does the support involve?

Apart from the previous analysis procedure, an axial coding was also done. Questions such as when, where, who, how, and with what consequences were made regarding the preliminary categories. The purpose was to bring the text together and to increase the level of its content. Preliminary categories became categories, and subcategories were formed that, in turn, were tested against each other.

When the eighth data analysis was performed, the central category was detected. The central category was tested against the other categories to establish them or to find new dimensions in the framework. This occurred in a process that moved from the central category through the categories to the subcategories and back again. It followed that when the central category was tested against the categories, the subcategories were moved and a new category emerged.

The second author participated one more time in connection with the last data collection so as to confirm the categories and see that no new information was found. In GT, it is important to find the categories in the data so that they are not created out of a predetermined theory (Hallberg, 2006). All categories were finally validated by all of the authors. On this occasion, the name of one category was changed.

A total of 12 RNs who performed 36 home visits to different patients between 80 and 102 years of age participated in the study. Most of the home visits lasted about 40 min, but there were three home visits that lasted about 90 min and two that lasted 10 min. The RNs' professional experience ranged between 5 and 32 years; eight of them had a specialist nurse education as district nurses, and one was specialized in geriatrics. One of the district nurses also had training in organization and leadership and another had training in palliative care.

Ethics

Because observations were performed in the patients' homes, each patient received both written and oral information in connection with the home

visit. The information was about the focus of the study, and the patient was also informed that he or she would not personally participate in the study, but that the data collection would be carried out in their homes. The study was approved by the Regional research ethics committee (Reg. no. 2009/456).

Findings

The identified central category *dealing with daily emotions* was the main concern of support that RNs provided to a group of patients 80 years and older in elderly home care settings. This was done by *encouraging the situation* and *reducing the patient's limitations*, but there were also situations in which the RNs did not reach all the way and a *gap of support* occurred.

Dealing with daily emotions

Home visits were always planned from the point of practical nursing tasks such as blood tests, blood pressure, care of wounds, or a review of the medication, but the RNs modified the home visit to what was going on in patients' minds at and around the time of the planned home visits, and the home visit came most of the times to be about something else than what was planned. Patients knew when the RNs would come and could start a conversation before the RNs came inside the house or had time to take off his or her coat or even say hello. The conversation could be about anything, any kind of problems, joys, or household duties and was not always about the care the patient received. The RNs, on the other hand, were always restrained when they came inside the door, aware that they could meet any kind of situation, and to quickly be able to identify what was going on. As one RN expressed it: I begin by scanning the situation.
In most of the cases, the RN would take a lot of time trying to identify what was going on in patients' minds and to find a way in which he or she could support the patient in dealing with the emotions that day's topic brought up. The RN did not suggest solutions when the patient seemed troubled or sad but tried to illustrate the opportunities that were available in any given situation. The RN was always concerned about the patient feeling content at that moment, but understood that it would not last. In some cases, however, when the patient began a conversation, the RN did not try to identify what was going on in the patients' minds but changed the conversation and did not bother about the patient's mood (Table I).

Table I. Central category with respective subgroups.

Dealing with daily emotions		
Encouraging the situation	Reducing the patient's limitations	Gap of support
Encouragement through joy Encouragement by being taken seriously Balancing patients' preferences	Being a link to the environment Being patients' navigator	Neglecting patients' inner

Encouraging the situation

Many times, the patients expressed emotions of hopelessness over their situation. To instill the patient with the belief that the situation could be improved upon was not always correct because there were no solutions, and many times both the patient and the RN realized that it would not get much better than this. As one RN expressed it: "It's difficult; they're old and so sick".
Encouraging the situation was a way for the RN to try to illustrate the rays of hope that were available in each individual situation and the patient needed to be able to deal with the emotions that the situation had brought.

Patient: My memory begins to fail.
RN: But you remembered that I was coming today.
Patient: Yes, that's true.

The way in which the RN mediated the encouragement took different forms depending on the situation and what kinds of emotions that were expressed by the patient.

Encouragement through joy. The use of joy was a common way for the RN to encourage the patient, and this was done in different ways depending on the circumstances. One way was to make the most of a situation that the patient remembered as joyful;

A patient was joking about memories from the past and said:
I have danced with men who had bobbing bellies.
RN: Yes, you have experienced a lot. Maybe you can show me how to dance.

In these situations, the RN would also tell the patient about some good times of their own. It could also happen that the RN took the initiative to remind the patient about happy moments in their lives. On these occasions, the RN often used things in the

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patient's home that they knew the patient had a connection to, such as photographs or something of interest, such as plants, embroideries, or something that related to the patient's hobbies or past profession.

There were also situations in which the RNs made use of jokes. Those situations had two different causes. One was to encourage the patient at times when he or she was joking. The other was to decrease unpleasant situations in which both the patient and the RN knew there was no remedy for. These situations were usually expressed in care-related situational comedy, such as:

Patient: It itches on my back! Check it out!
RN: The itch comes from your disease.
Patient: Remove it!
RN: This, I can't magic away, but I can continue to check it!

Encouragement by being taken seriously. There were occasions when the patient thought that they had done something wrong, such as having said something inappropriate to someone or having forgotten something. Those situations aroused feelings of sadness or anxiety, and the patient expressed that they felt silly and inferior. Most of the times, the patient wanted to talk about this when the RN came, but there were also times when the RN noticed that something was wrong and had to convince the patient to talk about it. The RN dealt with those occasions by showing that the patient was important and that their emotions were confirmed. Besides sitting down and talking about what was going on in the patients' minds, the RN also used body language to show his or her presence and to confirm that the patient was important and that his or her feelings were taken seriously.

The RN was sitting close to the patient and put his/her hand on her and leaned forward and said;
"Don't be sorry! It was not about you they were talking. It was probably a mistake."

Balancing patients' preferences. Patients often expressed how they wanted things to be done. It could be about their medication, treatment of a wound, or the care given by the social services. The RNs always listened carefully and asked questions to decide in what way it would be possible to meet the patients' desires. There were times when the RNs explained that the patients' desires would not be a good solution, but (he or she) the RN would still be anxious to find a solution for the patient that maybe was not always the optimal but would benefit the patient for the moment.

RN: You have many painkillers to take if necessary. You should not, it is better to take them regularly, but you want it like this.

Balancing patients' preferences could also be about negotiating treatment alternatives to enable the patient to live at home.

The patient expressed that he wanted to retain the cathéter à démeure.
RN: I will talk with the doctor and to see if it would be possible to keep it.

Reducing patients' limitations

Depending on the day, the patient's physical and/or cognitive limitations because of their diseases were expressed in different ways. Some days, the limitations were more urgent than on other days. The RNs tried to reduce the effects of the limitations as not being able to handle things for one moment or for one day often resulted in feelings of sadness or worry for the patient, which could be difficult to reverse. It was important that the patients did not lose their self-confidence and this was done by allowing the patient to perform the things themselves and carefully correcting what was wrong without exaggerating the incident.

Patient: Have I divided the drugs right?
RN (look after): The stomach drug was wrong, but you will remember next time.

The RNs adapted their efforts according to what the patient wanted or was able to do by *being a link to the environment* and *being patients' navigator.*

Being a link to the environment. Being a link to the environment was expressed in two ways. One was by helping the patient to get into contact with a family member, health care provider, person, or organization when a problem arose. Depending on the situation, the RN could arrange everything or only contribute with a small part, e.g., find out a phone number or who the patient should contact.

RN: I know that you want to take care of yourself, but now when you have pneumonia you really

need help. Here, (RN makes the telephone accessible) you can call the staff yourself.

The other way was by initiating a conversation about the people who belonged to the patient's social network. It was clear from the conversation that the patient was aware of the person and could remember that they have just met or will meet or that contact must be taken. The RN was familiar with which people were the nearest and dearest and was updated with new developments.

RN: What does your daughter say about……...
Patient (interrupts the conversation): It's right I have to remember to keep her informed.

Being patients' navigator. Being patients' navigator was a way to create understanding about the day's events. Depending on the patient's daily condition, the RN explained more or less what was going on. If the patient was having a difficult day, the RN could explain everything that was done or happened during the home visit, e.g., being the patient's eyes.

The RN retrieves medicine that is in the bathroom. While she is moving in the home she said: "I'm going to the bathroom, now I am opening the door to the cabinet and now I have got your medicine."

Otherwise, only those details were explained that were needed for the patient to put the event into context.

Patient: What is happening with my blood test?
RN: I take them to the laboratory and after the examination, they will send the answer to the physician. The physician will later contact me to inform me about what measures should be taken and then you will have an answer.

Gap of support

On some occasions when the patients talked about how their lives affected them, the RNs changed the topic of the conversation or joked it off and a *gap of support* occurred, which involved one subcategory, *neglecting patients' inner.*

Neglecting patients' inner. On some occasions, the patients talked about their life situation and the difficulties that come with their disease. It could be about living separated from a spouse because one lived in special housing or the feeling of losing physical or cognitive abilities. The RN would always stop to listen but would sometimes change the subject quite soon or diminish the importance of it. For example:

Patient: The house is put on sale and we would move to the apartment. We looked forward to it. And now she lies in hospital and will not come home more.
RN: But you can visit her.

Discussion

The central category "Dealing with daily emotions" expresses a support that reflects two things. One is the moment. The RN does not plan any supportive activities but rather tries to understand the patients' daily condition so that he or she can satisfy the patients' needs for the moment. Living in the present and being able to handle life is found as important for a group of elderly people who were living in special housing (Anderberg & Berglund, 2010). Ternestedt and Frankling (2006) also argued that the daily routines are important because it is in the small daily activities the elderly experience a zest for life. A zest for life was described both by Miller (2008), Olsson, Nyström, Karlsson, and Ekman (2006) and Strandmark (2006) as a necessary part of being able to experience health. Zest for life consists of pleasure, joy of life, and spirituality (Strandmark, 2006). It seems that the RNs by capturing the moment try to support those parts of life or reduce the required activities that seem important for the day, so the patient can have the opportunity to experience the feeling of something that can be described as health. It also seems that RNs made use of those components that Strandmark (2006) described as necessary to experience vital force and consequently health. Besides a zest for life, it is necessary to have self-worth and the strength to overcome obstacles. This is what the next part of the central category reflects, the emotions. Tanner (2007) described how elderly people themselves develop strategies to cope with the changes and difficulties that arise in relation to aging. The aim with the strategies is to sustain one's self-control (Tanner, 2007) that is needed to achieve health (Strandmark, 2006). Bowling and Iliffe (2006) described that health promotion to frail elderly is to help them regain control over themselves, and it seems that it is what the RNs are trying to do. The categories *encouraging the situation* and *reducing patient's limitations* describe how the RNs are trying to

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raise or neutralize patients' emotions in relation to what the patient's life situation offers for the day. This can be compared with Tanner's strategy (2007) to sustain one's self-control. Some of those strategies that the RN uses are similar to the approaches the patients themselves use to cope with the changes and difficulties that arise in relation to aging. Wåhlin, Ek, and Idvall (2006), for example, argued that a sense of humor helps the patient to allay their thoughts and at times the RN used humor in this objective. Björklund et al. (2008) claimed that activities such as hobbies were important for the ability to experience pleasure. Even here you can see similarities with how the RNs use their knowledge of their patients' interests to create a pleasant moment.

Gap of support describes the occasions when the RNs did not have the ability to identify or do something about a patient's needs but neglected the patient's feelings. Having contact with one's inner self is a way to possess spiritual resources, and Strang, Strang, and Ternestedt (2001) claimed that spirituality is one of those components in our inner resources that Strandmark (2006) included in the zest for life. Björklund et al. (2008) believed that possessing spiritual resources is an important aspect of health, but Van Leeuwen, Tiesinga, Jochemasen, and Post (2007) argued that spiritual needs change with disease and illness. Neglecting the patients' inner thoughts can indicate that the RN does not know how to handle the situation. Cavendish et al. (2003) believed that spiritual needs are patient specific, and that the same patient would need many different kinds of spiritual support, but they also recognized the need for more knowledge in the field. Ross (2006) mentioned the importance of developing instruments in the field so as to make it possible to capture the different kinds of spiritual needs. This would help the RNs to identify the spiritual needs and then be able to reach the patients with the support, but the question remains as to why they sometimes chose not to try to identify the need. In relation to spiritual needs, van Leeuwen (2004) mentioned that organizational structure might have an impact on the quality of care, on the treatment given, and on the limitations in the given support, but added that this is an area that must be developed.

Method discussion

Using GT has been appropriate because the purpose of this study was to explore what was going on in the interaction between the RN and the patient from the point of departure of a specific concept. GT is concept driven (Corbin & Strauss, 2008; Strauss & Corbin, 1998), and the method has made it possible to develop the main concern of support to a group of elderly persons in a home care setting.

By collecting data through observations, there has been an opportunity to take part of what the RNs claim to do and not to do. Corbin and Strauss (2008) believed that this is the strength of observations, but there are also many weaknesses such as the difficulty to apprehend everything that is going on.

The possibility of asking the RN questions after the home visits has largely eliminated the difficulties in the observational study and it has been strengthened by combining both elements.

The observer's presence and influence are difficult to address but some measures were taken to minimize the other impacts. Firstly, the second author who had no previous experience of elderly home care was present at a home visit twice to see if there were further events to report and to test whether they made the same observations. It turned out that there were different perspectives of the events on the first occasion, which led to the subcategories changing places. Secondly, on occasions when there were issues after a home visit, the RN was asked to explain the situation. The RN also had the opportunity to make his or her own comments. Thirdly, the researcher had no relationship with the RN nor did she have any information prior to the home visit regarding the patient's problems, disease, gender, etc. This was to have as little prior knowledge as possible. The measures taken probably do not cover all the possible drawbacks of the observations, but they have been an attempt to minimize them.

Conclusion

The main purpose of supportive activities for a group of elderly persons in a municipal care setting is about dealing with their daily emotions. The central category confirms the significance of taking the emotions into account when caring for the elderly. On some occasions, a gap of support occurred and this coincided with the inability of the RN to identify the patient's inner needs, but sometimes they also chose not to try to identify them. To develop a holistic elderly care, more knowledge about psychological and spiritual needs is needed. There is also a need for more knowledge of the factors forming the basis of the reasons why an RN would choose not to provide support on some occasions.

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