Nursing and health care of the elderly

Ubolratana Popattanachai*

Abstract

Nurses play a critical role in providing health care for all age groups and in all varieties of health delivery systems. Their role assumes greater importance in certain settings (viz. rural areas where patient:physician ratio is very low) and for special categories of patients including the elderly whose care warrants specialized skills. Accordingly a need for enhancing the competency of nurses to augment their efficiency in patient care was felt. This study was undertaken for developing a cultural competence model and integrating it into the Nurse Practitioner (Primary Medical Care) Curriculum at Boromrajonani College of Nursing, Surat Thani, Thailand. The study was conducted in four steps: (i) analysing the data and identifying the problems; (ii) designing the Cultural Competence Model to be integrated into the Nurse Practitioner (Primary Medical Care) Curriculum; (iii) using the first and second drafts of the model as the lessons for training classes 7 and 8 of nurse practitioners in the Nurse Practitioner (Primary Medical Care) Curriculum; and (iv) monitoring the performance of nurse practitioners who had received such training in care of the elderly in the local social context.

The representative samples for this study included the 177 nurse practitioners (NPs) who received training in the Nurse Practitioner (Primary Medical Care) Curriculum at Boromrajonani College of Nursing, Surat Thani, 172 colleagues of those NPs, and 110 patients of those NPs. Data were collected by asking the sample population to fill in the questionnaires particularly prepared for this study, as well as by conducting interviews with them. Standard deviation was used to analyse the quantitative data collected through the questionnaires while the t-test was used to analyse the qualitative data collected through interviews with 12 NPs.

The result of this study revealed that NPs receiving training in the Nurse Practitioner (Primary Medical Care) Curriculum integrated into the Cultural Competence Model became aware of their working capacity being significantly higher than that of those undergoing regular training without this model, especially with regard to preventive, promotive and curative health care of the elderly patients. Patients served by the trained NPs recognized the improvements in quality of service as indicated by the high average points of NPs’ performance. It was also found that those NPs achieved greater self-awareness, became aware of individual differences, and acknowledged individuality. In addition, they gained better understanding of elderly patients and their families’ decision-making on health, and could communicate health issues to people. Those NPs’ attitude towards working and how to work in communities improved substantially. The approach and results from this study can be used as a guideline for other countries in the WHO South-East Asia Region, but would need to be adjusted to suit individual cultures towards improving the quality of care especially for elderly members of the community.

Key words: 1. The Cultural Competence Model
2. The Nurse Practitioner (Primary Medical Care) Curriculum

*Director of Boromrajonani College of Nursing, Surat Thani, Thailand
Health refers to the dynamics of physical, mental, social and spiritual well-being. In other words, it is the well-balanced combination of all those components. This combination results from the association of physical, mental, intellectual and social factors. Health-care workers have to be able to maintain people’s physical, mental and social health as well as recognize the relationship between ailments and various risk factors. Health care of the elderly is now recognized as a special area that demands exact skills and knowledge for effective delivery of health services. To be capable of doing that, not only are nurses required to have the basic knowledge about human biology, psychology and social sciences, they also need to treat patients with skill, generosity and attention. In the meantime, health-care workers have to be sensitive to patients’ feelings, considering their work as an opportunity to learn new things and motivate themselves to achieve the perfection and potential of humanity (Prawase, 2004). It is necessary for health-care workers to realize that community health-care services, in fact, are an integration of medical and social services—contributing to the concrete development of community health system including improved care of the elderly people (Pagaiya and Garner, 2005).

Currently, no doctors are affiliated with community health centres or primary health-care centres in Thailand. The development of nursing care workers’ potential and ability is, thus, held to be one of the keys to achieve the goal of providing quality health service; and to improve community dwellers’ health including care of the elderly. In the recent past, the country’s health-care education system usually focused on academic content and professional capacity or solely on the physical and mental dimensions, not including the social and spiritual ones that are of immense importance and value for elderly patients. As a result, it was not organized on the basis of the realities of life and society, and did not fully meet the requirements of contemporary care of the elderly.

It is also necessary to adjust the current health-care education to make health-care students gain a better understanding of human beings, as well as of what is going on in the society. Students would be required to promote people’s awareness of taking good care of one’s own health throughout life to ensure a healthy ageing process. Recognizing professional nurses as the vital mechanism of operating primary health-care units, the Boromarajonani College of Nursing, Surat Thani planned the Nurse Practitioner (Primary Medical Care) Curriculum to train professional nurses at primary health-care units to have professional knowledge and ability as well as a good attitude towards providing primary health care for patients. Following the educational reform of all institutes affiliated with the Boromarajonani College of Nursing, the Nurse Practitioner (NP) Curriculum and teaching methods were integrated into the prevailing social contexts. This led to the change of nurse practitioners’ attitude towards people’s health and ailments especially of elderly patients; nurses do not presuppose what patients did, and do not blame patients’ doings (Wongkhongkhathep, 2007).

The Boromarajonani College of Nursing, Surat Thani, revised the curriculum under the educational reform programme to train its NPs (primary medical care) to perform their duties with an even better understanding of what contributes to health behaviour of individuals, and, in the meantime, to develop people’s potential to independently take care of their own health.

**Objective**

The study aimed at developing the Cultural Competence Model to be integrated into the Nurse Practitioner (Primary Medical Care) Curriculum.

**Methodology**

The population and representative samples of this study included:
Two hundred professional nurses from the Public Health Regions 15 and 17 who were trained in the Nurse Practitioner (Primary Medical care) Curriculum at the Boromarajonani College of Nursing from 2006 to 2007. Those nurses were divided into two groups including 100 nurses trained in the regular curriculum and another 100 nurses trained in the curriculum integrated into the Cultural Competence Model that included focus on care of elderly members of the community. In the context of Thailand, a professional nurse is a person who has graduated in nursing from a university and has passed a professional examination such as for doctors and engineers. Their duties are in the nature of general services or basic nursing care.

Two hundred colleagues of professional nurses from the Public Health Regions 15 and 17. The ratio of colleagues to professional nurses stood at 1:1 (real population is used as a sample for this study). A practitioner nurse has the same qualification as a professional nurse and gets specific training for treating and diagnosing simple ailments. They are able to take certain decisions to manage patients or refer them to a doctor. This is one of the ways to solve the problem of insufficient doctors (physicians) in Thailand.

Two hundred patients of professional nurses from Public Health Regions 15 and 17. The ratio of patients to professional nurses stood at 1:1 (real population was used as the sample for this study).

The study was conducted in five steps:

Step 1: Collecting data from textbooks, documents, related studies, and individuals affected by nurse practitioners’ performance as well as analysing problems from such data.

Step 2: Designing the first draft of the Cultural Competence Model to be integrated into the Nurse Practitioner (Primary Medical Care) Curriculum with emphasis on proper care of the elderly.

Step 3: Using the first and second drafts of the Cultural Competence Model integrated into the Nurse Practitioner (Primary Medical Care) Curriculum to train the nurse practitioners of Class 7.

Step 4: Using the second draft of the Cultural Competence Model integrated into the Nurse Practitioner (Primary Medical Care) to train the nurse practitioners of Class 8.

Step 5: Assessing the work performance of NPs who were trained in the Nurse Practitioner (Primary Medical Care) Curriculum integrated with the Cultural Competence Model within a period of 6-12 months after the training in the social context of communities, especially the elderly members.

- Comparing the capacity of NPs trained in the curriculum integrated into the Cultural Competence Model as well as those trained in the regular curriculum.
- Presenting the Revised Cultural Competence Model integrated into the Nurse Practitioner (Primary Medical Care) Curriculum to all concerned.

Tools for data collection

The tools for data collection included:

(1) Appraisal forms (comprising 20 items) for evaluating the cultural competence activities in three different areas;
(2) Questionnaires (comprising 37 questions) for evaluating the capacity of NPs working in primary health care units in four different areas;

(3) Interviewing forms (comprising 25 questions) for assessing patients’ awareness of NPs’ health-care services; and

(4) Lecture notes taken by professional nurses trained in the Nurse Practitioner (Primary Medical Care) Curriculum.

**Data analysis**

The analysis comprised the following steps:

(1) Using percentages to distribute the representative samples’ individual data.

(2) Using the t-test to make comparison of the scores of the NPs’ capacity on the basis of the awareness of NPs who were trained in the Nurse Practitioner (Primary Medical Care) Curriculum integrated into the Cultural Competence Model and their colleagues.

(3) Using ATLAS.ti to analyse the qualitative data acquired by means of the in-depth interviews with nurse practitioners as well as their colleagues and patients.

**Results/observations**

The following results were obtained:

- The general information about the representative samples has been shown in the table below.

<table>
<thead>
<tr>
<th></th>
<th>Nurse practitioners trained in the regular Nurse Practitioner (Primary Medical Care) Curriculum</th>
<th>Nurse practitioners trained in the Nurse Practitioner (Primary Medical Care) Curriculum integrated into the Cultural Competence Model</th>
<th>Colleagues of nurse practitioners trained in the regular Nurse Practitioner (Primary Medical Care) Curriculum</th>
<th>Colleagues of nurse practitioners trained in the Nurse Practitioner (Primary Medical Care) Curriculum integrated into the Cultural Competence Model</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number</td>
<td>87</td>
<td>90</td>
<td>85</td>
<td>87</td>
</tr>
<tr>
<td>Gender (Females)</td>
<td>100%</td>
<td>100%</td>
<td>40%</td>
<td>37.97%</td>
</tr>
<tr>
<td>Average age (years)</td>
<td>40.07</td>
<td>36.18</td>
<td>35.80</td>
<td>40.48</td>
</tr>
<tr>
<td>Married</td>
<td>67.6%</td>
<td>61.11%</td>
<td>17.65%</td>
<td>24.14</td>
</tr>
<tr>
<td>Bachelor of Science</td>
<td>88.5%</td>
<td>95.56%</td>
<td>88.24%</td>
<td>96.55</td>
</tr>
<tr>
<td>Working at community health centre</td>
<td>77.01%</td>
<td>70%</td>
<td>75.29%</td>
<td>71.26%</td>
</tr>
<tr>
<td>Average years working as nurse</td>
<td>18.33</td>
<td>14.28</td>
<td>10.2</td>
<td>7.5</td>
</tr>
<tr>
<td>Average years working as nurse practitioners</td>
<td>6.65</td>
<td>5.82</td>
<td>3.0</td>
<td>2.5</td>
</tr>
<tr>
<td>Income per month in Thai Bahts</td>
<td>23 179</td>
<td>19 752</td>
<td>20 742</td>
<td>20 793</td>
</tr>
</tbody>
</table>
The patients included 110 individuals of whom 79.1% were females. Their ages ranged from 41 to 60 years with an average of 49.95 years. Many of these (38.2%) were agriculturists. Only 59.1% had had primary education while two third of these were being supported by government health insurance schemes. Of these, 29.9% had symptoms of respiratory infections. The average time for which they availed of the services was 3.51 months.

The difference in becoming aware of one’s own capacity in respect of NPs trained in the Regular Nurse Practitioner (Primary Medical Care) Curriculum and those trained in the Nurse Practitioner (Primary Medical Care) Curriculum integrated into the Cultural Competence Model stood at 0.05.

Colleagues of NPs are aware that the working capacity of NPs trained in the Regular Nurse Practitioner (Primary medical Care) Curriculum and those trained in the curriculum integrated into the Cultural Competence Model in general and four specific areas including care of the elderly is significantly different. Such difference stood at 0.05.

Patients’ awareness of the services provided by NPs trained in the Nurse Practitioner (Primary Medical Care) Curriculum integrated into the Cultural Competence Model was found to be high on average, especially awareness on NPs’ recognition of patients’ dignity, which got the highest score.

The results of implementing the Cultural Competence Model:

- The Cultural Competence Model was implemented through diverse activities like viewing photographs of interviewing community dwellers while studying the actual condition of communities. These activities were carried out to make the NPs trained in the Curriculum integrated into the Cultural Competence Model change their attitude towards people’s health and illnesses; better understanding of the health needs of the elderly; develop their self-study skill; and have a sound understanding of other people’s views, logic and deeds. The result of evaluating cultural competence activities through appraisal forms indicates that the attitude towards activities, instructors and students is quite positive. Most NPs trained in the curriculum integrated into the Cultural Competence Model, according to the data collected from their lecture notes, have changed their attitude remarkably towards patients in a variety of ways as follows:

  - Instead of persisting with their conventional knowledge and experience in living their lives and providing health care for patients—an attitude that prevents them from learning new things, the NPs performed their duties on the basis of actual scenarios, keeping focus on age and the social context of patients.
  - The NPs have a better understanding of patients’ individual characteristics; individual patients have different views, beliefs, educational background, and experience in living their life. This is especially true for elderly people.
  - The NPs’ ways of working have already been adjusted—as evidenced by their even more comprehensive methods of collecting patients’ data. In the meantime, patients’ data, which are diverse, have been integrated as well. To improve nurse practitioner-patient relations and gain patients’ confidence, the NPs have
developed their skills at interpersonal communication like more attentively listening to what patients say while providing services for them.

- The work experience of NPs trained in the Nurse Practitioner (Primary Medical Care) Curriculum integrated into the Cultural Competence Model (n=12), as assessed through in-depth interviews, demonstrated several gains that can be summarized as below:
  - Better understanding that the definition of health varies according to individual contexts and age.
  - Improved recognition that the background of individual patients and their families as well as their necessity and capacity (as in elderly patients) of taking decisions on health care.
  - Acknowledgement of the fact that emphasizing health communication is far better than treatment with medicines.
  - Changing NPs’ attitude towards community health-care provision.
  - Having more opportunities for access to community dwellers.

Discussion

Based upon Herbert Blumer’s Symbolic Interactionism (Farganis, 1993), the researcher has developed the Cultural Competence Model and integrated it into the curriculum on nursing science. Blumer’s theory states that individuals are the social products that are perceived and responded to by people. Individuals vary according to an individual’s perception and self-development. As human beings want to interact with or respond to other people, they need to have a sound understanding of the meaning of other people’s acts and speeches, and then act in accordance with such meaning or what the people with whom they interact really do. It is critical for communities and health-care providers to understand the realistic needs of the elderly. To develop the Cultural Competence Model, the researcher used some activities on Symbolic Interactionism—which include viewing some photographs of interviewing patients to encourage the NPs to eliminate their misunderstanding about patients, interviewing patients to enable the NPs to communicate with patients without presupposition or prejudice, conducting an in-depth study on the data collected on the basis of recognizing patients’ personal background and circumstances, interpreting the data collected without any presuppositions, and incorporating the adjustment of views and attitude towards patients to each course of study. The findings of this study agree with the concept of studies on activities to promote the learning process (Oitip Tongdee, 1987 and Carter, 2003). Both studies concluded that if the trainees or learners are aware and accept the importance of intervention or motivating parameters, it will change their attitude and will finally lead to a change in service behaviour and pattern. Another study done recently from the same institute (Songsri Kittiraktrakul, 2011) supported the concept of humanized health-care services that uses the idea of providing services to family members. It was found that health-care personnel provide services to all patients and customers without expecting anything in return as they consider that customers are their family members. This is especially true for the elderly who need greater social and psychological support.

Comparison of the work performance of NPs trained in the Nurse Practitioner (Primary Medical Care) Curriculum integrated into the Cultural Competence Model with that of NPs trained in the regular curriculum

According to the awareness of NPs and their colleagues, the work performance of NPs trained in the Nurse Practitioner (Primary
Medical Care) Curriculum integrated into the Cultural Competence Model was significantly different from that of NPs trained in the regular curriculum. The difference stood at 0.05. This is because the Cultural Competence Model includes the activities that are consistent with NPs’ own experiences in serving patients, understanding elderly members’ needs and meeting specific interventions. The NPs are given theoretical lessons and assigned to put the lessons into practice by their instructors or specialists. Their lessons are associated with what they have learned or experienced such as viewing the photographs of communities, interviewing patients or conducting in-depth case studies—which makes the students aware of their own mistakes or deficiencies in providing health care to people. The interaction between nurse practitioners and other people or patients contributes to higher efficiency (Dunn and Dunn, 1998). Also, the NPs trained in the Curriculum integrated into the Cultural Competence Model become aware of the individual differences of people. These NPs, as a result, can use self-control and improve the paradigms of their working.

Patients become aware that health-care services provided by NPs trained in the curriculum integrated into the Cultural Competence Model have reached the acceptable level, as indicated by the high average point. This is probably because the NPs, after receiving training in the curriculum integrated into the Cultural Competence Model, improve their performance to respond to patients’ demands for health care including those of the elderly. The study conducted by Thawikiat Bunyaphaisancharoen et al. (2005) revealed that the general public’s expectations of the quality of health-care services include the immediacy of services around the clock, home visits, and follow-up treatments. This finding is consistent with that of the study conducted by Uthaiwan Sukimanin (2005) stating that the work performance of nurses at primary health-care units meets patients’ demands. In addition, such a finding is consistent with that of the research conducted by Somchit Nucharoenkun et al. (2007), which revealed that NPs whose performance is outstanding are familiar with local people; they listen to patients’ demands. In the meantime the local people feel confident about and have faith in NPs’ professional skills. Besides, the result of this research is consistent with that of another qualitative study, which revealed that NPs trained in such curriculum really recognize individual’s basic necessities, communicate with patients to gain a better understanding of their problems, and devote more time for patients (Thawikiat Buncharoenphaisan et al., 2005).

After receiving training in the Curriculum integrated into the Cultural Competence Model, the NPs remarkably changed their views on servicing patients. The NPs perform their duty upon the basis of information that they gather; they do not persist with their conventional knowledge and experience in living their lives and providing health care for patients, which prevents them from learning new things. This reflects the NPs’ self-awareness and a sound understanding of people.

The differences in individual people’s views, beliefs, knowledge and experience in living their lives contribute to differences in individual people’s health-care behaviour. This indicates that NPs accept patients’ individuality and special needs of the elderly. This is in conformity with the study of Bundura (1978) using the Modelling Process for changing the behaviour of people. The basic belief is that personal behaviour is developed through inter-relationship and involvement with other persons. In general, there are three basic components in the development of personal behaviour; one own’s personality, perception and other person’s behaviour, which affect their thinking and perception. By perceiving and noticing other person’s behaviour, we can introduce new and positive behaviour and get rid of negative behaviour.

The NPs have changed their ways of working—as evidenced by their even more
comprehensive methods of collecting patients’ data. Also, they have integrated patients’ data, which are diverse. To improve nurse practitioner-patient relations and gain patients’ confidence, the NPs have developed their skills at interpersonal communication like listening more attentively to what patients say while providing services for them. It is thus believed that NPs trained in the curriculum integrated into the Cultural Competence Model will be able to have a profound understanding of patients’ feelings, and work on health care in close collaboration with all groups of community dwellers, including the elderly, who have unique needs.

All the aforementioned changes are consistent with the result of Suni Wongkhongkhathep (2007)’s study on the Evaluation of the Integrated Teaching Methods for Teaching Nursing Students, which revealed that learning in real situations results in students gaining a sound understanding of people’s feelings, logic and acts; the nursing students listen more attentively to and have good relations with other people. Moreover, the changes are also consistent with the qualitative data collected from the nurse practitioners trained in the curriculum integrated into the Cultural Competence Model, revealing that the nurse practitioners’ better understanding of communities including elderly patients results from their training; the nurses’ perspective of patients has become wider, more profound, and more comprehensive so the actual problems can be discovered especially in special category of patients viz. the elderly. If a nurse practitioner, for example, takes a patient’s blood pressure and high blood pressure is detected, it is the NP’s responsibility to enquire about its likely causes such as stressful family background, unhealthy lifestyle and eating habits, and any other degenerative disorder, etc. before referring the patient to the doctor.

Good health in the ordinary sense refers to happiness or being happy, a state of being in which a person can work in or live his/her life normally. Poor health, on the other hand, refers to the physical illnesses that prevent people from working; as long as people can work, in a sense they are still in good health. This is not in line with the conventional definition that refers to physical and mental health or holistic health. There is hence a greater need to orient health practitioners to these terms through which they can relate better with communities especially in rural settings, as well as with those who are not part of the workforce because of their age.

In order to gain more profound and comprehensive insights into patients’ problems as well as to avoid making patients feel frustrated in following NPs’ knowledge and belief-oriented instructions, the nurse practitioners searched for data on individual patient’s context that affect their own decision-making on health care. To change their attitude towards working with communities, the nurse practitioners regard community dwellers’ involvement and self-reliance on health care as important. To have a better understanding of the elderly, the NPs focus on interaction with patients’ families or a group of people, not with a single patient.
This is a proactive way of providing nursing services to patients. Nurse practitioners are required to play a major role in understanding patients’ ailments and looking after people when they fall ill.

This study aims at developing the Cultural Competence Model for enhancing the nurse practitioners’ working capacity to provide health-care services to patients on the basis of realizing patients’ individual differences. However, according to the results of this study, it is easy for some nurse practitioners to change their attitudes towards patients, while quite often some NPs resume working in a conventional manner. It is quite important for those NPs to get some time to gradually adjust themselves to the new working practices. As a consequence of this, the individual nurse practitioners are to be evaluated in terms of “what they have learnt” as well as “how they are supposed to learn”. The NPs collaborated actively in receiving training on the curriculum integrated into the Cultural Competence Model. This helped in promoting good relations between instructors and students.

**Conclusion**

It will be appropriate if those who are planning to improve human resources for health can take cognizance of the improvements through this model and use it extensively to enhance nurse practitioners’ capacity to provide holistic health-care services for patients, especially the elderly members of the community. This will be the right way to narrow the gap as well as lessen the conflict between health-care workers and patients, and probably the ideal way to provide efficient preventive, promotive and curative health services for the elderly and ageing populations.

**References and bibliography**