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Helping Residents in Nursing Homes Find Peace

by

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Introduction

Residents in nursing homes frequently feel abandoned and bewildered. They have not only been moved from their homes, a place of safety, but they have often been removed from their homes against their will. The loss of one's home has a tremendous impact on a person's sense of self esteem, especially among the elderly and those in poor health.¹ Not only has there been a change in their residence, but these individuals have also been moved from a "very busy" complex technical, material and social world to a very sedate way of life. Many nursing home residents find themselves alone and without the joys of an independent existence for the first time in their lives.

Bringing understanding and comfort after such dramatic changes can perhaps only be accomplished through the spiritual realm. Spirituality can be defined as that aspect of one's life which inspires the desire to transcend the realm of the material. It is generally understood in terms of intrinsic personal beliefs and typically includes attitudes and beliefs related to a higher deity and/or nature. Such beliefs may or may not be associated with a specific religious tradition or covenant.²

Although aging affects the body and the mind, there is no evidence that spirituality succumbs to the aging process, even if the patient suffers from a chronic, debilitating disease.³ It may be that as one's physical strength weakens with age, the spiritual dimension intensifies with a deeper exploration into one's self. Thus, not only may the elderly have a fully intact or even heightened sense of spirituality, but the serenity associated with spirituality may become more significant as these individuals face their inevitable mortality.⁴

There is a growing emphasis on the care of the spiritual component of the nursing home residents. Spiritual care can help the residents strengthen their defenses so that they might better cope with changes. Reports have shown that meeting the spiritual needs of patients helps them cope with life in a nursing home.⁵ Several instruments for assessing spirituality in the elderly have been developed.^{6, 7, 8} Spiritual care helps patients gain a higher degree of mind and body harmony and generate self-healing and self-knowledge, yet it rarely, if ever, is included in standard medical care.⁹ Spiritual care should not be separated from physical care.¹⁰ When nursing home residents are not given the opportunity to live with meaning and hope, their total care is limited. Yet, in many nursing homes, the care emphasis is placed solely on traditional medical care, and the paperwork needed to meet complex accreditation standards takes priority over providing complete care.¹¹

There is no question that health care workers find it challenging to deliver spiritual care. Since it is difficult to help the elderly find a sense of peace, this area of care has been delegated to clergy. Care providers must bring their whole being to the encounter with the patient. The key is listening to the patient's fears and hopes. Hicks has suggested that spiritual care, which is essential to helping these elderly nursing home residents find peace, can be categorized into four phases: self-comfort, assessment, intervention and evaluation.¹² Those who provide care can develop this expertise through self-study, special education and practice with patients.

Care providers who have examined and reconciled their own spiritual beliefs are more able to address each patient's unique spiritual needs.¹³ Providers who are uncomfortable with their personal spirituality should refrain from providing spiritual care, but can ask others to provide this care. Care providers can systematically alter health care by addressing human suffering.¹⁴

Suffering has been equated with spiritual pain. Simply recognizing suffering in the patient is the first step in providing compassionate care.¹⁵ Listening to the patient is an integral part of spiritual care. The ability to listen is an art that requires the care provider to completely attend to the patient with open ears, eyes, and mind.¹⁶

Methods

This project was undertaken at a 124 bed private nursing home affiliated with Louisiana State University Health Sciences Center in Shreveport, Louisiana (LSUHSC-S). Patient care interventions were undertaken by a spiritual care nurse with 38 years of experience. She is an advanced practice registered nurse experienced in geriatrics, infectious disease, infection control, and hospice care. She is a frequent lecturer on

the subjects of growing older gracefully and end-of-life care.

In an eleven month period, the nurse made 624 visits to 83 nursing home residents (69 female and 14 male). Their ages ranged from 55 to 95 years. All residents were Caucasian and Christian and middle or upper-middle class. Residents were selected on the recommendation of the social coordinator of the nursing home and on a random basis. Each resident was placed into one of four classifications determined by their ability to react to another person:

Category I: Alert – able to converse using appropriate affect – able to remember the person that they conversed with for up to one week.

Category II: Intermittently alert – able to converse but loses interest during a lengthy conversation (more than 30 minutes).

Category III: Distracted – able to hold a meaningful conversation for less than 5 minutes.

Category IV: Disoriented – unable to hold meaningful conversation, but physically alert.

Category V: Comatose – unable to respond to physical stimuli.

The spiritual care nurse visited the residents during the 7 a.m. to 3 p.m. shift. Visits lasted from 10 to 60 minutes, with the average visit lasting approximately 15 minutes. At the suggestion of the nursing home personnel, the nurse would enter the chosen resident's room and, using her nursing skills and intuition, assess the resident and determine the appropriate intervention she thought would help the resident. The nurse found she had to shut the door and turn off the television so that she might enter the resident's world. Interventions included: spiritual conversation, life reminiscence conversation, verbal prayer, non-verbal prayer, singing sacred songs, imagery, massage, hugs, making the resident's environment more comfortable, bringing a special food, providing psychological support for the family, phoning the family at the resident's request, deep breathing exercises, taking the resident outside to the garden, and reading scripture.

Even though there may have been more than one intervention during a visit, only the primary intervention was counted, i.e., the intervention which took the greatest duration of time. For example, the resident may have discussed a life story unrelated to his or her spirituality, but because most of the visit was spent on a spiritual aspect of their life, this was recognized as the intervention.

There were two types of conversation. In the first, spiritual conversations, residents discussed the nature of their spirituality and belief systems, and how they coped with their present situation. In the second, life reminiscence conversations, residents discussed events in their lives related to their spirituality, such as instances where they lost, renewed or strengthened their faith. The nurse began each conversation with the question, "How are your spirits?" and then sat near the resident and gently touched their hand or arm as she listened. To initiate this type of conversation, the nurse would look around the room for evidence that spirituality was important to the resident, i.e. a cross, a Bible at the bedside, religious magazines, or religious programs on the television. The spiritual nurse would comment on these objects, and in most instances, the residents would begin to discuss their belief system, how it had sustained or failed them, and whether it had made a difference in how they viewed their life at this point in time. If the resident was initially not talkative, the nurse would ask open-ended, non-judgmental questions and the resident would open up, often unleashing a dam of emotions. At this time, the resident would reveal their innermost spiritual feelings.

Without exception, the prayer used was the Jesus Prayer, which is: "Oh Lord, have mercy on me." It was nonverbal, except in situations where the resident asked to be prayed for. For a nonverbal prayer, the residents were not told that the nurse was praying, but she touched their hands and closed her eyes as she prayed. If a resident requested that the nurse pray for him or her, the prayer was either spoken or sung. This was counted as a prayer intervention rather than singing a sacred song.

For the singing of sacred songs intervention, the spiritual nurse brought a popular 1950s hymnal and, when appropriate, asked residents if they would like to sing a hymn. If the resident wanted to sing but did not request a specific hymn, the spiritual nurse selected one she believed the resident would know. All hymns requested by residents were available in the hymnal.

When residents described feelings of imprisonment, the nurse would take them via wheelchair outside to a garden where conversations were primarily about their love of nature. Similarly, during the spiritual conversation, residents might ask, "Why am I still here?" The nurse used a guided imagery intervention entitled "The Waiting Room." After assisting the residents in becoming relaxed, she had them imagine a waiting room where they spent time reviewing their life.¹⁷ After the intervention, all of the residents stated they had a better understanding of their situation.

In every intervention, the nurse touched the resident either by holding their hands or touching their arms, legs, or feet. This was not listed as an intervention. Massage and hugs were the tactile interactions classified as interventions. Massage was used if the resident asked the spiritual nurse to

rub his or her back, feet, or neck. Hugs included embracing the resident, touching the shoulders and face. Residents preferred to be hugged from the front, instead of the side or back, and disliked being hugged by the nurse standing in front of them while the resident was in a sitting position. Residents preferred to be touched on the arms, hands, and feet. Not infrequently, residents voiced their pleasure in being touched with comments such as, "I feel like a real person when you touch me."

The spiritual nurse intervened to make the environment more comfortable when residents indicated that they were too hot or cold. The temperature of the room was very important to the residents. Most of the time the resident complained that it was too warm. Removing some of the bed linens, adjusting the thermostat of the air conditioner to cool the room, or placing a cold cloth on the resident's forehead brought tremendous contentment. These simple interventions constituted acts of caring. No words were spoken; the nurse's caring presence was enough to afford a sense of peace.

If a resident had a yearning for a special food, the spiritual nurse brought this on the next visit, unless it was contraindicated in their diet.

Psychological support for the family included talking with a daughter or son regarding their parent's condition. Often the nurse comforted them about their feelings of guilt for placing their parent in a nursing home.

Sometimes residents could not physically reach the telephone and would ask the nurse to dial a family member's number. The nurse would then quietly leave the resident alone for a private conversation.

Deep breathing exercises were taught by instructing the residents to breathe in and out slowly. Residents would ask the nurse to read from the Bible. The nurse would ask the resident their favorite scripture and then read it aloud.

The resident's reactions to the interventions were subjectively analyzed by the spiritual care nurse. She used her nursing skills and intuition to observe resident response and to determine if the resident became more peaceful. The resident's pulse and respiratory rate were measured before and after the intervention in those residents placed in the coma-state category and in the distracted category (if the resident was asleep), since overt reactions were difficult to observe. Vital signs were not taken on all of the residents because the nurse could readily identify signs of contentment and peace in those placed in the other categories.

Resident permission was not initially obtained because this project began as the nurse providing spiritual care in a clinical setting. Residents' responses were carefully recorded after each resident visit and then reviewed. After the data were analyzed, an Institutional Review Board exemption was provided due to the retrospective nature of the study.

Results

Of the 624 visits, 611 (97%) had positive responses. Table 1 (see appendix) reports those residents with no or negative responses to intervention by category. Table 2 (see appendix) shows interventions by category, table 3 (see appendix) reports the variety of common positive verbal responses to intervention by category, and table 4 (see appendix) reports positive physical responses to intervention by category. Some residents were visited more than others. Typically, this was the result of the residents having visitors, whether the resident was asleep, or if the nurse was in the room providing care when the spiritual nurse visited. Not all of the nursing home residents were included due to time constraints.

There were 14 men in the study. Seven of the negative responses were from men whereas there were only six negative responses from the 76 women. It appeared that sometimes it was more difficult for men, regardless of their age, to share their feelings during the interactions.

Category I: Alert residents (n = 40)

There were 34 women and six men in this category. Interventions per resident ranged from one to 39. There were 466/470 positive interventions, three interventions with no responses, and one negative response. Two residents were more interested in watching television than engaging in a life story conversation (one man and one woman), and one man was sleeping and did not respond to silent prayer either overtly or physically. In the negative response, one woman began to feel uncomfortable talking about her belief system, so the nurse changed the conversation to life stories and the resident became more relaxed. The responses of this group were easy to measure because of their ability to communicate verbally.

Category II: Intermittently alert residents (n=13)

There were 11 women and two men in this category. Interventions ranged from 1 to 15 per resident. There were 67/70 positive interventions. There were three interventions with no responses. One man and one woman did not respond to silent prayer, and there was one instance of no response to a life story conversation. There were no negative responses. Due to the inability of these nursing home residents to concentrate for long periods, the nurse found it important to quickly begin the intervention at the onset of the conversation.

Category III: Distracted residents (n=18)

There were 15 women and three men in this category. There were between one and six interventions per resident. There were 45/50 positive

interventions, three residents did not respond and there were two negative responses. One woman said she didn't want to talk to anyone after the nurse had begun the spiritual conversation; a second man would grunt his answers and then fake sleep. A third resident did not respond to silent prayer. In the two negative responses, a man requested to be left alone when the nurse began a life story conversation and a woman said "I don't want to talk to anyone, all I want is to get out of here" when the nurse began the interaction. The nurse respectfully stopped and left the room. The nurse did not use verbal prayer with this group because of the residents' inability to concentrate. Spiritual conversations were limited to two interventions; each occurring when the residents were especially alert. These residents' responses were less overt, but the nurse observed their response from the way the resident's smiled, became more peaceful or just went to sleep that they were more content.

Category IV: Disoriented residents (n=7)

There were six women and one man in this category. There were between two and six interventions per resident. There was one negative outcome (15/16 positive interventions). While the nurse was nonverbally praying for a female resident she opened her eyes and said very emphatically that she didn't want any of that "praying stuff." The nurse stopped, and the resident went back to sleep.

Category V: Coma-state residents (n=5)

There were three women and two men in this category. Interventions per resident ranged from one to three. All of the responses to the 18 interventions among this group were positive and all were physical.

The quality of the interactions is best given by example. The following are three examples of positive effects elicited by the spiritual interventions: In the first example, the resident was a member of the intermittently alert group. On the spiritual nurse's initial visit, Mrs. H appeared despondent, due to her daughter's recent premature death. During their conversation, the spiritual nurse learned of the resident's love of old gospel songs. On the next visit, the nurse brought the hymnal and selected hymns that were about loss. Both she and the resident sang these hymns. Mrs. H remembered every word. After each hymn, Mrs. H commented on how the hymn made her feel so much better. The next visit, the nurse selected hymns about faith and after the song was over the resident responded that all was now well with her soul. In the last days of her life, where it was very difficult to talk with her, the nurse sang the sacred song titled "I'll Fly Away." The resident sang all four verses very clearly and even harmonized with the nurse. Afterwards, the resident passed into a very restful sleep, whereas before she was very agitated.

A second example is Mr. C. He was admitted in a near coma-like state and, with each breath, he screamed indecipherably. The hospital admission coordinator and the spiritual nurse attempted to calm him with kind and reassuring phrases such as "It's going to be okay, Mr. C," but these methods had no effect on his state. The spiritual nurse got down on her knees, and started singing to him "Oh Lord, have mercy on Mr. C" over and over again, very softly. Mr. C immediately stopped screaming and settled in peacefully.

A final example is of Mrs. S, who was blind. She was always very peaceful, with a constant smile on her face. One day the spiritual nurse found her crying. She related to the nurse that she thought she was losing her mind because she had become confused several times that day. The nurse reminded her of how she had always believed in God and that if her mind had begun to become weak, God would take care of her. The spiritual nurse then sang the Jesus prayer to her several times. Mrs. S then smiled and said "Oh, yes, I strayed for a minute, but I do have faith that God will take care of me. Thank you for reminding me".

In each experience where the respirations and pulse were decreased after the intervention, the pulse and respirations were faster than average before the intervention. (Pulse was over 70 and respirations were over 20). For eight of ten residents, pulses were reduced by over 12 points and respirations were reduced by five.

Discussion

This study used the three key activities of spiritual care: being with the resident in their suffering or other problems of need, listening to them verbally express anxieties, and touching them either physically, emotionally or spiritually to assure them of their connectedness to life.¹⁸ These interventions constitute the care provider's theology of caring. This process is called spiriting and includes knowing the patient in his or her complexity, identifying and nurturing, listening with one's being by using presence and silence, and fostering connections that are sacred to the patient.¹⁹

The nurse used her nursing skills and intuition to determine the resident's needs. Of these tools, intuition may be the one most questioned. Importantly, intuition is not some mystical power that appears from nowhere without a rational basis.²⁰ One definition of intuition is the immediate knowing of something with the conscious use of reason.²¹ A second definition considers intuition to be another dimension of knowing that is as important as deductive or inductive reasoning.²² Three types of intuition can be considered: cognitive inference, gestalt intuition and precognitive intuition.²³ Even though it is not usually discussed, health care professionals use intuition daily in making decisions about patients. Mixed with rational analysis, intuition is an appropriate method of reasoning.²⁴ As

care providers become more experienced, their thinking moves from relying on past experience and rule-based analysis to intuition.²⁵ According to one study, when nurses become experienced and use their intuition, their theory, practice and wisdom work in synchronization.²⁶

During life reminiscence interventions, residents told stories of their lives that related to spirituality, i.e. when they had joined a church and why, if and when they had ever lost their faith, and when they had felt closest to God. The difference in life review and reminiscence is that life review is based on the examined life while reminiscence is more partial and tells about a certain moment in time.²⁷ Proust²⁸ emphasized the significance of memories in giving meaning to one's life. The author maintains that it is not the sharing of memories that bind people together, but the feeling of warmth forged from a sentence here and there that bring them close, generating a mood of trust.

Prayer is described as valuable in the care of the elderly.^{29, 30, 31} Aldridge provides an excellent review of the power of prayer and the positive effects of spiritual healing in the medical settings.³² The Jesus prayer was chosen because all of the residents in the study were Christian. The prayer was non-denominational, simple, and easily interpreted by residents, in the way that they saw fit.^{33, 34} The nurse never prayed for the resident unless the resident requested her to pray for them. If the resident felt comfortable being touched, the nurse touched them in the nonverbal prayer.

This project was not an attempt to assume the role of clergy. Nursing has always been an integration of all areas of health care and this is true with care of the nursing home resident. It is our perspective, and that of others, that nurses cannot leave all of the spiritual care to the clergy especially since the clergy's time is limited with the patient. Nurses and chaplains should enjoy mutual support as they attempt to meet the spiritual needs of the patient.³⁵

Music has been a valuable therapeutic tool for patients in many areas of care³⁶ and has provided psychological benefits by evoking feelings and emotion.³⁷ The human voice, even if off-key, is an instrument for evoking emotions. Singing, with the analysis of thought-provoking lyrics, can be very useful. However, music therapy is best used only after an accurate assessment of patients' needs.³⁸ Often during the sacred song interventions, the spiritual nurse would begin singing an old hymn and the resident would join her without looking at the hymnal. The spiritual nurse noted the obvious pleasure on each resident's face during and after the song.

The way that we look at residents is important to the residents. If they see or feel pity, or feel they are being treated as a baby then they can lose their dignity.³⁹ The spiritual nurse easily found the beauty in each of the residents and she tried to reflect it back to the resident. Many times she would tell the residents how beautiful they were and when they would scoff at her remark, she would tell them of the beautiful light she saw in

their eyes. She would pick up their hands, all wrinkled and worn, and then ask them to see the labor of love they had given through these hands and suggested they be proud of what they had given through these hands.

The spiritual care nurse found that her time was not only rewarding for the resident; it was also a powerful experience for her. Many times, she felt the weight of her own life issues as she entered the facility, but after interacting with the residents, she had more energy and felt more fulfilled. In fact, in her many years of nursing experience, she had never been so satisfied with her nursing practice. Attending to the physical and spiritual needs may be a way for health care personnel who suffer burnout to regain joy in the health care profession.

The spiritual nurse did not expect a long-term improvement with the interventions. The goal was to bring some amount of peace to the moment. All of the residents in the alert category and in the intermittently alert category remembered the nurse when the nurse returned on the next visit. The nurse felt a bond with the resident after they had completed each intervention, and she believed they felt a connection to her.

This study should be interpreted in the light of certain limitations. No specific measurement was used to gauge peace or a positive response. The nurse used her nursing skills and intuition to determine if the resident was more peaceful after the intervention. Additionally, the spirituality nurse did not follow up to see if the resident sustained a level of peacefulness for a period of time. She attempted to talk with the nurses and other care providers about this, but they appeared too busy. Nevertheless, the care providers working in the nursing home seemed grateful that someone could take time with the resident. In fact, many voiced the opinion that they wished that they had more time to talk with the resident.

Conclusion

Dossey⁴⁰ states, "Walking into the patient's room with nothing to give but one's self is a humbling, but unbeatable experience." She is correct; being able to be fully present with the resident, to love the resident regardless, to listen to the resident actively, and to share time with the resident is as important as technical nursing skills. This can be a sacred experience. The nurse was successful in bringing some form of peace to 97% of the residents in this study. These interventions were based on nursing assessment and intuition and have not been previously reported.

Health care personnel can affect the nursing home resident's sense of peace. This may be achieved through conversing with the resident about what is spiritually important, listening to their stories, praying a simple prayer verbally or nonverbally or through something as simple as just being with the resident without judgment. It is not about doing but caring.

The quality of care in nursing homes may be improved by changing the strategies of care to include honoring their spirit. "The secret of caring for the patient is in caring for the patient."⁴¹ Caring includes partaking in suffering, a call to love thy elder. It is heartwarming to know that residents can find peace when a nurse answers this call.

Appendix

Table 1. No or negative response to intervention

	No response		Negative response	
	Gender	Intervention	Gender	Intervention
Alert	1 man	Life story	1 woman	Spiritual conversation
	1 woman	Life story	—	—
	1 man	Silent prayer	—	—
Intermittently alert	1 man	Silent prayer	—	—
	1 woman	Silent prayer	—	—
	1 man	Life story	—	—
Distractible	1 woman	Spiritual conversation	1 man	Life story
	1 man	Life story	1 woman	Touch
	1 man	Silent prayer	—	—
Disoriented	—	—	Woman	Silent prayer

Table 2. Interventions by category

	Alert	Intermittently Alert	Distracted	Disoriented	Coma State
Spiritual conversation	123	20	2	—	—
Life reminiscence conversation	75	5	2	—	—
Verbal prayer	39	7	—	—	—
Singing sacred songs	64	8	15	6	5
Imagery	30	—	—	—	—
Massage	24	5	5	1	—
Hugs	28	6	7	4	—
(Continued on next page)					

Table 2. Interventions by category (Cont.)

Making environment more comfortable	24	—	—	—	3
Special food	12	—	—	—	—
Psychological support for family	11	3	—	—	—
Nonverbal prayer	10	6	14	5	10
Deep breathing exercises	10	4	—	—	—
Taking resident outside to garden	10	2	—	—	—
Phoning family at resident's request	6	—	—	—	—
Reading scripture	4	4	—	—	—
Total	470	70	50	16	18

Table 3. Variety of positive verbal responses to interventions .

	Alert	Intermittently Alert	Distracted	Disoriented
So good to be touched	90	11	—	—
Thank you for talking about God	84	20	—	—
I look forward to our weekly meetings	31	—	—	—
Thank you for caring	42	4	—	—
While praying, resident thanked God for having nurse as friend	24	—	—	—
You are the only one that cares for me	47	—	—	—
I feel better now	28	13	—	—
Singing hymns makes me closer to God	25	—	—	—
Thank you for praying for me	39	—	—	1
I love you	30	—	—	—
You help me through these bad times	10	—	—	—
Thank you for being my friend	12	—	8	—
(Continued on next page)				

Table 3. Variety of positive verbal responses to interventions (Cont.)

I feel like dancing when I see you	—	2	—	—
You boost my spirits	—	4	—	—
Thank you for caring for our loved one	—	2	8	—
Stay a little longer	—	—	9	—
Total	459	56	28	1

Table 4. Positive physical responses to interventions

	Alert	Intermittently Alert	Distracted	Disoriented	Coma State
Entered into a peaceful sleep	3	8	3	3	—
Less restless	4	3	—	4	—
More content & less agitated	—	—	7	29	4
Smile from the resident	—	—	3	3	—
Decreased respiration & pulse rate	—	—	4	—	6
Lip ceased quivering	—	—	—	3	—
Less gurgling	—	—	—	—	8
Total	7	11	17	15	18

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