Nursing care models for older people with cancer in clinical settings

Nursing care should handle cancer treatment in the light of the ageing process, physically and existentially, by combining knowledge from both geriatric and oncological nursing.

There has been a demographic transition all over the world, including in European countries. The transition is however much faster in Asian countries, and is due to a variety of factors. The most important explanation is the change from large numbers of children in a family to only one or two children. This decrease in the birth rate together with improved longevity means that most countries have some very large cohorts of people born during or right after World War II who are now reaching retirement and older age. So, while the birth rate seems to be stable and low, often below 1.7, in European countries, many people have already or will soon reach the age where functional decline and chronic diseases including cancer develop.

AGEING PROCESS

This change of the demographic composition of a population is often discussed as a threat and a challenge for societies, while it is in fact a story of success. The mortality among newborns has decreased substantially and longevity has improved, and seemingly is still improving. Most people can foresee living a long time after retirement. This very long period, however, is marked by developing diseases and functional decline. Getting cancer may take on a different meaning depending on when, in the aging process, cancer develops. Right after retirement, normally around 60–65, most people are healthy, mobile and live an active life and also report a high quality of life. Their expectation may be to now do all those things they have not had the time or opportunity to do before, and also to remain healthy as long as possible.

Slowly diseases occur, and it is mainly chronic diseases, of which cancer is one. Health complaints of various kinds also develop – chronic pain, communication difficulties, mobility restrictions and so on. Quality of life can still be very good, but recognition that life is not endless is coming closer. In longitudinal studies, it can be seen that, during this process from retirement to death, the number of diseases increase and often people have more than one chronic disease as they grow older. Medical treatment also increases significantly. The paradox is, however, that mobility, working ability and quality of life have improved over the years. Thus the picture is mixed, seemingly life is better, but costs in terms of health care are higher.
The real blow to quality of life is when the person becomes increasingly dependent on others due to limitations in functional ability, and this is the time when it becomes obvious that life has an end. At this stage, the person is in most cases suffering from several diseases and undergoing complex treatments, and their reserve capacity to handle physiological challenges is restricted — the person is fragile. This is the context in which cancer treatment and nursing care is to be provided.

EXISTENTIAL CRISIS
In essence, this means that getting cancer may take on a very different meaning, depending on when it develops in this aging process. It has been reported that people around 75–80 years old have a significantly poorer quality of life compared to younger age groups with cancer, indicating that the existential blow may be harder at a stage where people still hope for a healthy and active life. Studies have shown that developing cancer after the age of 65 means a sudden awareness of the finiteness of life, painful insights into losses but also awareness of possibilities. Similar findings report turning points marking old age as: losing control, disturbed family balance, and life and death suddenly becoming apparent at the same time as hope and enjoyment of life becomes vital. Haug et al. report the need for maintaining the activities of a normal daily life, naming and handling decline and loss, and space for making existential meaning. In addition, the older the person is, the more they suffer from health complaints, and they thus are more fragile and thus they are more sensitive to challenging cancer treatment.

In summary, this means that nursing care should take into account that the person diagnosed with cancer is a physically fragile person in an existential crisis. The cancer experience may take on a different meaning depending on other diseases, other complaints related to health per se, other diseases and treatments related to the cancer and the aging process. It is also essential to listen and to ask the person about desires for the years to come. Nursing care should handle the cancer and the cancer treatment in the light of the aging process, physically and existentially, integrating the knowledge from geriatric and oncological nursing.

This is a healthcare situation in which geriatrics and oncology should go together and merge each other’s expertise in clinical practice. In particular, there are two developments in geriatrics that may be useful in oncological care for older people throughout the process of diagnosis, treatment and aftercare. The first is applying a Comprehensive Geriatric Assessment (CGA) that in turn informs the cancer and treatment plan. The second is organizing care in a Case Management (CM) model, modified to suit the person depending on where s/he is in the process of disease and treatment.

ASSESSMENT MODELS
CGA has been practiced in geriatrics for quite a while, and is a multidimensional and interdisciplinary process to determine frail older persons’ medical status (nutrition, co-morbidities and severity, medication etc.) and mental health (cognition, mood anxiety, fears, etc.), as well as their functional capacity (activities of daily living, gait, balance, activity, exercise, etc.), social circumstances (informal support, social networks, formal care eligibility, etc.) and environmental conditions. This assessment is supposed to be the basis for a coordinated and integrated plan for treatment, rehabilitation, support and long-term follow up. There are plenty of valid measures available to carry out a comprehensive geriatric assessment. It may well be that some more items need to be included due to cancer and cancer treatment.

Case management is a way to structure the care and responsibility in relation to a patient. The model needs to vary in relation to patient groups, the competence in the team and where in the organization the case manager is placed. The model was developed to hinder fragmentation and duplication of programmes and contacts, in particular when the person has complex health needs and is at risk of ‘falling between two stools’. It is slowly implemented in geriatric care and is defined as a collaborative process of assessment, planning, facilitating, care coordination, evaluation and advocacy for options and services. These must meet a patient’s and family’s comprehensive health needs through communication and available resources to promote a high quality, cost-effective outcome (the Case Management Society of America). The models can be applied with different levels of responsibility and interventions included. The minimal model is mainly about case findings, assessing.

Figure 2

Summary and points to consider providing nursing care for older people with cancer and cancer treatment

Life should be in focus not death. Acknowledge:

- the frailty, the variation and the stages of the ageing process
- the existential crisis not only related to cancer but also to the facts of life – it will end somehow
- balance is easily interrupted
- pro-active approach, closely monitoring depending on frailty
- the older person has to balance closeness to loved ones against being a burden to them.
patients’ needs and planning and determining which organisation should take the responsibility for providing care. This model is suitable for insurance companies but not so relevant for nursing care for patients with complex health situations. In addition to tasks included in the minimal model, the coordination model includes being the patients’ advocate, working with them and their support system and also continuous assessment and re-planning. In addition, the case manager may be involved in the care process and provide interventions of various kinds. This model is suitable for cancer patients with a complex health situation and perhaps during the treatment process until discharge. The comprehensive model also includes being an advocate for developing resources, monitoring quality, public intervention and crisis intervention. This model is perhaps most suitable for very vulnerable patients with a complex health and treatment situation, for instance palliative care or end of life care.

In most studies evaluating the case management model in geriatrics, registered nurses trained for the role have been the case managers. When selecting case managers, the professional competence needs to be considered and related to the tasks to be included. The competence required also depends on the knowledge in the team behind the case manager, which should be able to provide advice and guidance and also education to strengthen the case manager’s competence. So far, the research outcome of the case management model has been inconclusive, mainly due to the fact that it is not one model – context and target groups differ. Patients and families, however, favour this model, but more research is needed in the same context and the same target group to establish its effectiveness in providing high-quality care to a vulnerable group of cancer patients. Thus, in my view, this model, combining CGA and CM is worth trying in geriatric oncology nursing care.

The importance of staff wellbeing and the patient experience

We have a crisis in nursing in the UK and in some other parts of Europe – more patients with increasingly complex needs but a shortage of nurses, with more nurses leaving the profession because they don’t believe they can deliver the high quality care they came into nursing to give to patients and /or they burn out. This has important implications for care quality and patient safety.

Jill Maben

To deliver safe care we need to retain staff and support them, help protect them against burnout. In 2010, colleagues and I argued that “really relating to patients takes courage, humility and compassion, it requires constant renewal by practitioners and recognition, re-enforcement and support from colleagues and managers. It cannot be taken for granted” (Maben et al 2010).

Staff need a good work environment to flourish and enable them to give good care, to give safe care. Ten years ago I completed my PhD: I wanted to know if we were preparing student nurses to be resilient and whether they could nurse in the way that they had been taught.

In a questionnaire at the end of their course, my study asked nurses: “As a qualified nurse, what do you anticipate will be your ideals for practice? That is, if you were able to choose how to practice, what would be the kind of care you would like to give?”

I then followed up 26 of these students as they became qualified nurses – 22 women and four men. I analysed the fate of their ideals and values over this period of time. I wanted to understand what the experience was like for them and how this might change over time.

Newly qualified nurses emerged from their education with a strong set of values and ideals. Patient centred holistic care, giving high quality care, using their nursing knowledge and research/evidence-based, safe care.

Effectively, the study demonstrated that over time these nursing ideals and values in most cases eroded and I identified three groups:

1. Sustained idealists
2. Compromised idealists, and
3. Crushed idealists.

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