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link to British Geriatrics Society article [1]



The ‘essence of nursing is contained within the care home walls if anyone stayed long enough to look’, says Chief Nurse for Adult Social Care, Professor Deborah Sturdy.Since 2012 I have, for this same reason, chosen to work in care homes as a nurse, and now as a lecturer in adult nursing, supporting student placements in care homes . I #ChooseGeriatrics because of the breadth of skills required and opportunities offered, the depth of relationships encountered, and the length of shared journeys travelled. You truly walk with residents until the end of their lives.

Breadth

Sometimes care home nurses are respected less than ‘specialist’ nurses. However, often care home nurses may be the only registered practitioner on-site, assessing, monitoring and treating everything from diabetes to delirium, continence to cancer, HIV to heart attack and Parkinson’s to pneumonia. Care is complicated by comorbidities, polypharmacy, frailty, falls and forgetfulness—and textbook treatments may be rejected as adding unwelcome ‘years to life’, rather than longed-for ‘life to years’. No two days are the same; no two residents are the same. The challenge is real; the reward immense.

There exists a tacit hierarchy in nursing, where so-called ‘acute’ care, seemingly synonymous with hospital care, is somehow seen as superior to and more skilled than care home nursing. Antonyms of acute are ‘negligible’ and ‘slow-witted’, painfully reinforcing the stigma against care home nursing. This definition needs to be reconsidered. Clinical conditions encountered in care homes are often chronic and complex, yet sometimes also acute. I have cared for people with head injuries, heart attacks, seizures, strokes, sepsis, and choking, to name a few.

Depth

Written and spoken diagnostic cues may be missing because of communication difficulties or a lack of access to medical notes in a care home setting. Care home nurses may have to ‘work in the dark’, without words and numbers: non-verbal cues (including facial expressions, falls history, appetite and breathing patterns), and an intimate knowledge of residents and their ‘normal’ status, are key to diagnosis. Care home nurses need to really know their residents. It is an honour, a joy, and a necessity to establish deep therapeutic relationships through daily interactions, engaging at a physical, social, emotional and, where relevant, spiritual level. Conversations can cover

everything from diseases to death, favourite foods and fears of being alone at night.

We also work closely with family carers, who help co-create a shared narrative of what matters most to the resident, enabling truly person-centred care which really makes a difference, and brings fulfilment.

Length

We are with our residents until the very end, perhaps for many years.

Following World Health Organization [2] guidance on palliative care, we affirm life and regard dying as a normal process, neither hastening nor postponing death. We integrate the spiritual and psychological aspects of care and support residents to live as actively as possible until their death. ‘Seeing the journey through’ in this way with residents is both poignant and a privilege and teaches me much about living, and dying, well. Who I am is, in part, because of who they were.



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Links
[1] https://www.bgs.org.uk/blog/working-as-a-care-home-nurse-why-i-choosegeriatrics [2] https://www.who.int/europe/news-room/fact-sheets/item/palliative-care