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# The role and tasks of family nurse in the care of seniors in their place of residence - field study conducted among nursing staff in Gdańsk

# Rola i zadania pielęgniarki rodzinnej w opiece nad seniorem w jego miejscu zamieszkania- badanie terenowe przeprowadzone wśród personelu pielęgniarskiego w Gdańsku

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**Summary**

Demographic changes taking place in Poland and in the world, a decrease in the number of births and prolonged life expectancy have resulted in an increase in the number of elderly people. The success of today's medicine is among others prevention of chronic disease complications and skillful education of the patient at every level. Longer life expectancy and a quantitative increase in the phenomenon of disability, and above all a shortening of hospitalization and stays in inpatient medical facilities has resulted in moving the patient's treatment and care to the home environment, which is an optimal place of residence for the elderly.

The family nurse and primary care physician are then the most important link in the care of elderly and their families.

The provision of nursing services in the patient's place of residence is characterized by a unique specificity in other areas of nursing. Very often, as a result of the existing situation and possibilities, the nurse has to demonstrate not only professional knowledge and skills, but also flexibility, adaptability and creativity in dealing with a shortage of basic things, e.g. basic auxiliary equipment, access to the patient's bed, etc. The conducted field study shows selected scope of tasks performed by nursing staff in this respect on the example of patients in the city of Gdańsk.

***Key words:*** family nursing; seniors; nursing care; outgoing nursing aid

**Streszczenie**

Zachodzące zmiany demograficzne w Polsce i na świecie, spadek liczby urodzeń i wydłużenie okresu życia, sprawiły wzrost ilości osób w podeszłym wieku. Sukcesem dzisiejszej medycyny jest między innymi profilaktyka powikłań chorób przewlekłych oraz umiejętne edukowanie pacjenta na każdym poziomie. Wydłużenie okresu życia oraz ilościowe zwiększenie zjawiska niepełnosprawności, a przede wszystkim skrócenie hospitalizacji i pobytów w stacjonarnych zakładach leczniczych spowodowało przeniesienie leczenia i opieki do środowiska domowego, które jest optymalnym miejscem pobytu osoby starszej.

Pielęgniarka rodzinna i lekarz podstawowej opieki zdrowotnej są wówczas najważniejszym ogniwem opieki nad osobami starszymi i ich rodzinami.

Świadczenie usług pielęgniarskich w miejscu zamieszkania pacjenta charakteryzuje się niespotykaną w innych dziedzinach pielęgniarstwa specyfiką. Bardzo często w wyniku zastanej sytuacji i możliwości pielęgniarka musi wykazać się nie tylko profesjonalną wiedzą i umiejętnościami, ale również elastycznością w działaniu, umiejętnością dostosowania i kreatywnością w postępowaniu w przypadku deficytu podstawowych rzeczy np. podstawowego

sprzętu pomocniczego, dostępu do łóżka podopiecznego, itp. Przeprowadzone badanie terenowe pokazuje wybrany zakres zadań wykonywanych przez personel pielęgniarski w tym zakresie na przykładzie pacjentów w mieście Gdańsku.

**Słowa kluczowe**: pielęgniarstwo rodzinne, seniorzy, opieka pielęgniarska, wyjazdowa pomoc pielęgniarska,

## Nursing in the primary health care

In 1996, in Ljubljana, the WHO established the Ljubljana Charter, which once again indicated the direction of changes in primary health care, focused on the needs of people and not excluding their partial responsibility for their own health. Primary health care is to provide health services in a broad sense, including health promotion, improvement of the quality of life, prevention and treatment of diseases, rehabilitation of patients, care for sufferers and terminally ill people. It should strengthen the decisions of patients and service providers, as well as promote the comprehensiveness of services, inform appropriately in order to link informal services – self-care, family care with formal services provided by specialized services, and ensure continuity of care in specific cultural environments [1].

According to the world trends, forty years after the war in 1985, the tasks of a nurse in the home environment included "recognition and assessment of the health and social situation of the family, individual persons in the family and determination of their health needs, with particular emphasis on families (persons) of social health risk". The term environment was replaced by the word family and since then the formal beginning of family nursing has been dated [2].

Another legal regulation of February 6, 1997, the Act on general health insurance, enabled the conclusion of civil-law agreements, contracting of health services and introduced equality of entities in access to financial resources. According to this act, nurses and family midwives are providers of health services, and the projects developed by them for contracting services gave them the opportunity to develop and become independent [3].

The primary health care nurse, also referred to as community nurse or family nurse, is obliged to provide comprehensive nursing health care in the recipient's home environment. Its care covers both healthy and sick regardless of gender and age, disabled people and people in terminal condition.

Benefits provided by the primary health care nurse include the following:

1. Services in the field of health promotion and prevention;
2. Diagnostic services;
3. Care services;
4. Medical services;
5. Rehabilitation services.

The Ordinance of the Minister of Health of 2013 contains the list and conditions for the provision of services guaranteed by nurses of primary health care. Visits of a family nurse in medically justified cases are carried out at the patient's home or in ambulatory conditions.

The legal regulations contained in the Acts on Professions and Professional Self-Government enabled nurses/midwives to provide health services individually or in group practice. This facility is conducive to professional and responsible provision of nursing services that guarantee their proper quality [4].

**Nursing problems for seniors in the practice of a family nurse**

Both in Poland and in the world, there is a constant process of population ageing, characterized by decreasing fertility and increasing life expectancy. Demographic forecasts predict a further increase in the number of elderly people, especially those over 80.

Ageing is an irreversible process, defined as a progressive decrease in the functional reserves of the system, which impedes adaptation to environmental changes and leads to deterioration of the body's efficiency. Characteristics of the aging process include: significant biochemical changes taking place in tissues, decreasing efficiency of the body, decreasing adaptability to environmental stimuli, increasing susceptibility to diseases and, starting from the maturity period, increasing mortality. Retirement is most often an experience that begins the so-called late adulthood period. This results in a significant change in the lifestyle and self-image.

**Forms of care for the elderly**

There are many different models of care for the elderly in the world, in addition to hospital wards and geriatric clinics there are daily geriatric hospitals, day centers, home hospitalization, transitional care center or long-term care center. Among others, two forms of care are listed in the literature – the all-inclusive care for elderly program (PACE) and the form of transitional care centers (OOP).

The PACE program covers the care of patients over 55 years of age, both at home and in outpatient clinics, day centers, nursing homes and hospitals, providing access to basic and specialized services. Persons qualified for this type of care have a referral to nursing homes, suffer from 7 to 8 conditions

and require help with 2 to 3 daily activities. This form of care enables elderly people waiting to be admitted to the institution to stay at home in conditions that meet their health, social and rehabilitation needs, and medical services are provided by various specialists cooperating in a therapeutic team. However, transitional care centers of OOPs are responsible for rehabilitation and preparation of patients for their return home after cardiological and orthopaedic hospitalization, after strokes, and people with disabilities who cannot stay at home alone. This program allows the elderly to stay in hospital for a shorter period of time, while a team of doctors, geriatrists, specialist nurses and care staff conducts the treatment process, reduces the risk of re-hospitalization and is cheaper than other forms of care [5].

The best form of social support is the family, a multi-generational family model, but as a result of social and demographic changes, family support is often limited both due to lack of possibilities and unfortunately willingness. The risk of loneliness of elderly people is increased by migration of the closest family members in Poland and abroad, which may increase the demand for assistance in case of illness or disability [6].

In Poland, ministries of health and social policy cooperate in the organization of care for seniors. The aim is to reduce the costs of health care for the elderly through development of outpatient and home-based care, development of long-term care nursing centers, as well as development of social care and care services. The main issue in this work is the role and tasks of nursing staff in the care of seniors in their place of residence.

The most important element of care for the elderly is the institution of a family doctor. When assessing the state of health, fitness and independence of seniors, it assesses their health and social needs. It should be possible to satisfy these needs thanks to the comprehensive care of the family doctor in cooperation with other specialists, geriatrist and physiotherapist, speech therapist, psychologist, family nurse, social worker and organizations acting for the benefit of elderly [7].

In the geriatric team, the nurse also has a very important role in the care of seniors. The nurse should provide information support to the patient, including consultation, counselling and providing basic knowledge on the disease, both instrumental and emotional. Instrumental support consists in shaping the ability to use equipment, facilities or means of care for an ill or disabled person. In the scope of emotional support for seniors, the nurse should observe and help in identifying the problem and look for various methods and forms of solving them. Therefore, nursing care should be continuous and coordinated in order to understand and monitor all the problems faced by older people. When caring for the elderly, the nurse should analyze the physical and mental fitness level and its social and living conditions on an ongoing basis. The scales are used to assess the functional, physical, mental and social-environmental situation, e.g. assessment of basic life activities (ADL),

assessment of complex everyday life activities (IADL). The questions on ADL scale concern the degree of autonomy of the patient in everyday activities such as body hygiene, dressing, using the toilet, sphincter control, taking meals and moving around. A small number of points according to this scale indicates the patient's inability to be independent and the need to use the help of others in basic activities. The IADL instrumental performance assessment scale focuses on the ability to use the telephone, make purchases, prepare meals, clean up, wash, use means of transport, take medicines and use money. This scale enables to assess the patients' independence in functioning in the surrounding world.

The most frequently used scale to assess the level of functional efficiency is the Barthel scale. It is used mainly to calculate the demand for care of third parties, to determine the cost of care. It assesses the point performance of such activities as eating, moving, hygiene, dressing or sphincter control. The number of points obtained qualifies a given person to a group requiring specific care [8].

**Specificity of diseases and ailments of the elderly**

The most common diseases in people over 60 years of age are: cardiovascular diseases, musculoskeletal system diseases and metabolic diseases, mainly diabetes. People in the old age between 86 and 95 years of age are the most difficult diagnostic and therapeutic group, as they are characterized by higher tolerance of existing diseases. Acute inflammatory conditions and the consequences of falls and immobilization become a threat to long-term patients. The costs of treatment of elderly patients are several times more expensive than those of middle-aged patients [9].

In the health care system, in addition to the increase in expenditure, it is necessary to seek effective forms of treatment and care, as well as to apply preventive procedures in the practice of primary health care. Special care is usually required by people over 85 years of age, patients after loss of spouse, elderly people treated with multiple medications, after a recent stroke or myocardial infarction, patients with imbalances, dizziness, limb dysfunction, people with dementia and depression, socially isolated, poor and homeless, undernourished and patients with severe visual impairment [10].

Frequent causes of sudden deterioration in health of elderly people can be: inappropriate use of medication, dehydration, electrolyte disorders, hypoglycaemia, focal damage to the central nervous system, overheating or hypothermia, as well as relocation, or existing conflicts in the family, the feeling of loss of a close relative. The course of disease in the elderly may be atypical or latent [11].

Multiple diseases and the occurrence of ailments accelerate the organism's aging processes, and

symptoms of the progressing process are noticeable for both the seniors and their environment. However, the primary goal of medical and nursing care for elderly patients is to maintain the longest possible psychophysical fitness and independence, i.e. prevention of premature aging and disability, early detection and proper treatment of diseases, early rehabilitation and promotion of health [12].

The care and health problems of elderly people with chronic illnesses concern many areas of life at the same time, overlapping and increasing their complexity, and consequently increasing with age in the biological, psychological and social spheres, causing a decrease in the quality of life of the elderly.

Due to the occurrence of many complex health, nursing, social and economic problems, caring for the elderly is a difficult task for medical personnel, especially for family nurses who are the first contact of the patient with health care. This requires the necessary knowledge of the aging process, in addition to medical, psychological, pedagogical and nursing knowledge. Family nurses working with the patient in their home environment perform many tasks on their own, cooperating with a doctor, physiotherapist, social worker and sometimes with a psychologist [13].

**Objective of the study**

An aim of this paper is to show the scale of tasks and the role that a family nurse has in providing services and taking care of seniors at home on the example of an analysis of the nursing staff's work in Gdańsk.

**Method and research tool**

Method used during this study was the quantitative method. The author's questionnaire of the sociological survey was used as a research tool. This questionnaire consisted of 18 questions and a metric with 6 sociodemographic questions. Using a Microsoft Excel spreadsheet, the research material was statistically elaborated. The main problems were the following issues:

1. What are the most common difficulties encountered by family nurses in professional practice on the part of 65+ patient?
2. Which professions do the family nurses most often cooperate with in addition to the family doctor for the patient's benefit?
3. How are the rights of medication prescription used by primary care nurses?
4. What are the most common tasks performed by family nurses at work with a patient aged 65+ at home?

## Research area and organization

Research on the role and tasks of a family nurse in the care of elderly at home was conducted in the period from January to March 2018 in the city of Gdańsk. Gdańsk is a metropolitan environment. Selection of the population for empirical research has a targeted nature. The main study was preceded by a pilot study. The study group consisted exclusively of nurses of primary health care providing health services at home. For this purpose, a dozen or so family nurses' offices were randomly visited in medical clinics in different districts of Gdańsk, diversified in terms of the range of residence and above all diversified patients' ages. These included offices of the non-public Environmental and Family Care Centre Puls-Medic, exclusively nursing practice, which had five offices in the clinics of Gdańsk-Stary and Nowy Chełm, Suchanino and in two clinics in Gdańsk Główny. For example, respondents from the Non-Public Health Care Institution included nurses employed at the Nadmorski Centrum Medyczne (Seaside Medical Centre), which provided care to patients of ten clinics in Gdańsk, the districts of Wrzeszcz, Nowy Port, Przymorze and others.

## Characteristics of the studied group of family nurses

According to legal regulations (the Acts of 1991, 1997, 2004), a family nurse (primary health care, environmental care) takes care of 2750 patients. The primary health care nurse is obliged to provide comprehensive nursing health care in the recipient's home environment.

The nursing service covers both healthy and sick regardless of gender and age, disabled people and people in terminal condition.

Respondents to the survey were mainly women (97.5%).

Working with a patient of different ages, diseases and many health and social problems at home requires a great deal of professional experience from a family nurse. The majority of respondents were women aged 41 to 60. Detailed data are presented in the diagram below.

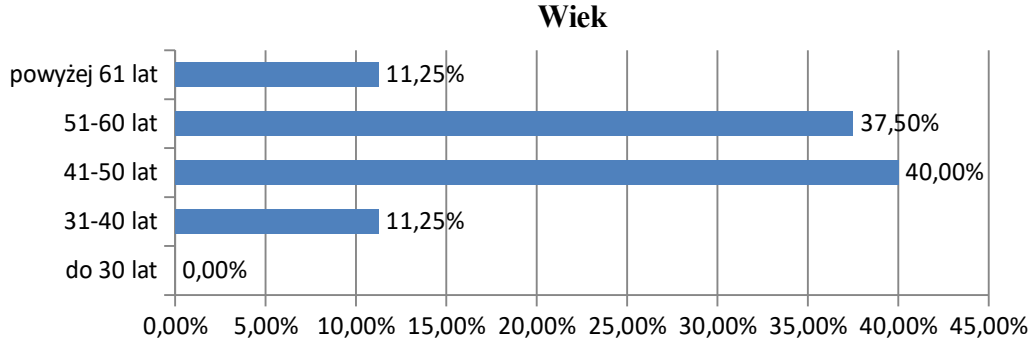


Diagram 1: Age of surveyed nurses.

In the studied group of nurses, up to 11.25% (9 indications) were nurses who have already reached retirement age, and 37.5% of respondents are approaching retirement.

Among the respondents, 32 persons had a nursing degree, while more than half of respondents showed higher education, including 28 with a bachelor's degree and 20 with a master's degree in nursing. The vast majority of surveyed nurses (60%) had higher education, and in addition to medical education, some of the respondents have graduated from other studies, e.g. pedagogy or humanities. Moreover, among the surveyed 71 persons, i.e. 88.75% completed a qualification course in family nursing, 7 persons completed a long-term care course and 8 persons completed other qualification courses, e.g. preventive nursing, geriatric nursing, etc. There were 22 nurses with completed specialization, including 10 family nurses, and the remaining ones: surgical, preventive, health promotion or health care management. Respondents also showed a variety of completed specialist courses: drug coordination – 26 people, vaccinations – 27, ECG course – 22, wound treatment – 28, bladder training – 8 and 22 people showed other courses such as physical examination, cardiopulmonary respiratory resuscitation.

Characteristics of the group in terms of place and work experience of the staff are as follows: there were 37 persons (46.25%) employed in a non-public health care institution, and 10 persons (12.5%) in group practices (non-public nursing health care institution)-33 (41.25%) and in individual nursing practice.

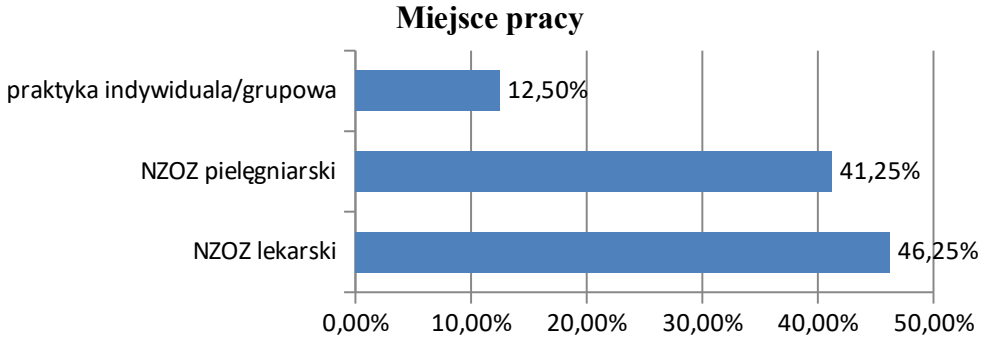


Diagram 2. Place of employment of surveyed family nurses.

On average, depending on the number of patients choosing a primary care nurse (signed declaration of selection), four nurses with the required qualifications are employed in the area of one health clinic. Nearly half of surveyed nurses were employed in medical clinic 46.25% and 41.25% employed in group practice nurses. Less than one in eight nurses surveyed had a direct contract with the National Health Fund.

The work experience of respondents as a family nurse is presented in Diagram 3.

Respondents had a long professional experience, more than half of the respondents have been working as a family nurse for more than 20 years, and only one in four of respondents has been working in an environment of less than 10 years.

**Results of conducted field study**

The vast majority of nurses (88.75%) who took part in the survey declared that they visited on average three or more patients over 65 years of age on a daily basis.

These are most often patients aged 76-80 years.

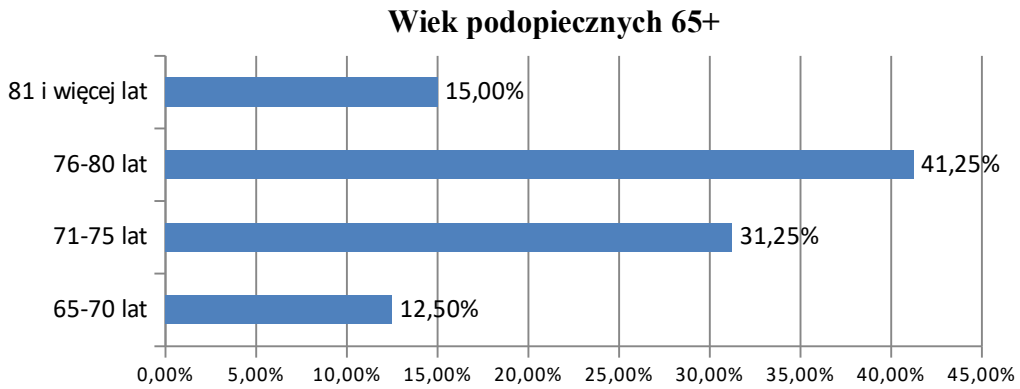


Diagram 3: Age ranges of 65+ patients of surveyed nurses.

The majority of 65+ patients visited by family nurses are over 71 years of age, most often after strokes, amputations of the lower limb (or both), hip surgery, or not very active due to other chronic diseases, civilization, in various physical and mental conditions.

Delivery of services in patients aged 65+ by surveyed nurses is usually commissioned by a doctor, more than half of the respondents also visit patients at the request of patient or family.

In case of 71.25% of surveyed nurses, they very often carry out visits to patients aged 65+, mainly at the request of a doctor, and only 13.75% of the respondents often responded to the request of a patient/family.

Among the services most frequently provided by respondents are:

1. prevention of diseases with health promotion (93.75%)
2. diagnostic visits (93.75%)
3. therapeutic (93.75%)
4. nursing (91.25%)

and the least frequent are rehabilitation services (57.5%).

The list of research results is presented in Diagram 6.

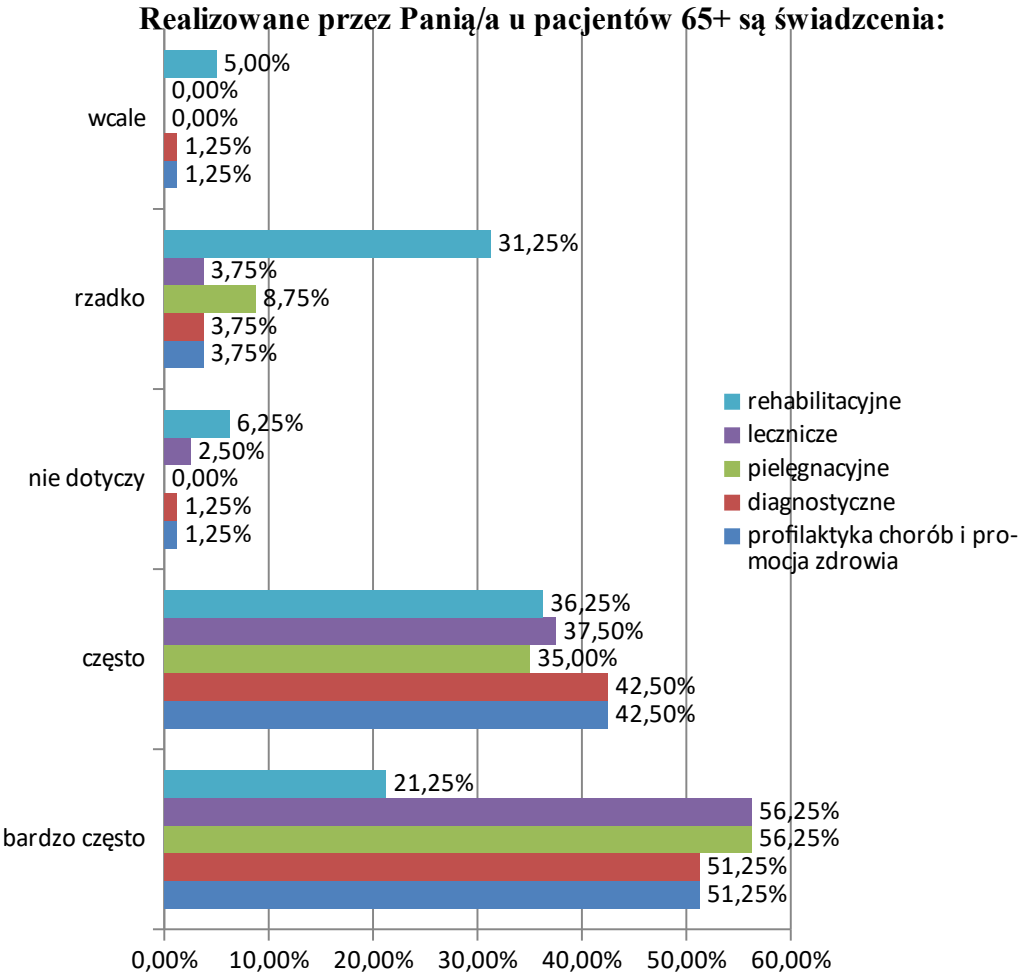


Diagram 4: Services provided by respondents during visits to patients aged 65+.

The vast majority of surveyed nurses in their professional practice with 65+ patient very often or often recognize the conditions and health needs of patients, recognize their care problems, plan and provide patient care, provide preventive, diagnostic, therapeutic and rehabilitation services, carry out medical orders and educate pro-healthily their patients.

More than a half (77.5%) of 65+ patients, in the opinion of surveyed nurses, take advantage of the advice of specialist doctors. In case of services provided by a physiotherapist, caregivers, social worker, nurses of another specialty or forms of activity addressed to seniors, patients use them less frequently. The vast majority of surveyed family nurses (82.5% very often and 12.5% often)

cooperate with a family doctor, 90% cooperate with family/carers in order to provide care to a patient aged 65+.

Another important element in the work of family nurses is the potential for medication prescription. When asked on whether they use the rights of medicines prescription, more than half (67.5%) answered that do not have such rights, 33% have the rights of medicines prescription, and less than 11.25% prescribe medicines and medical devices on their own.

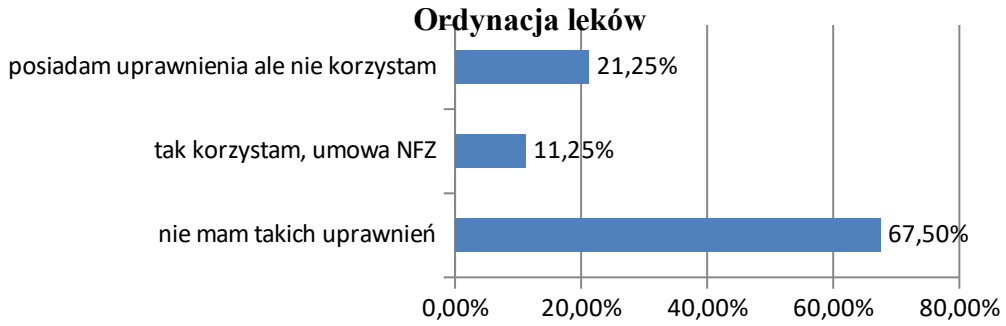


Diagram 5. Prescription of medicines by surveyed family nurses.

The study showed that only 11.25% of respondents prescribe medicines, despite the fact that over 32% have such rights.

Another important aspect of a family nurse's work is the relation with the patient's family. In this case, every second surveyed nurse listed as a difficulty in relations with the family: expectations incompatible with the nurse's qualifications and family claims, yet in the opinion of more than half of respondents (63.75%) the cooperation with the family was assessed as good, and less than 11.25% of respondents assessed it as bad, as shown in Diagram 6.

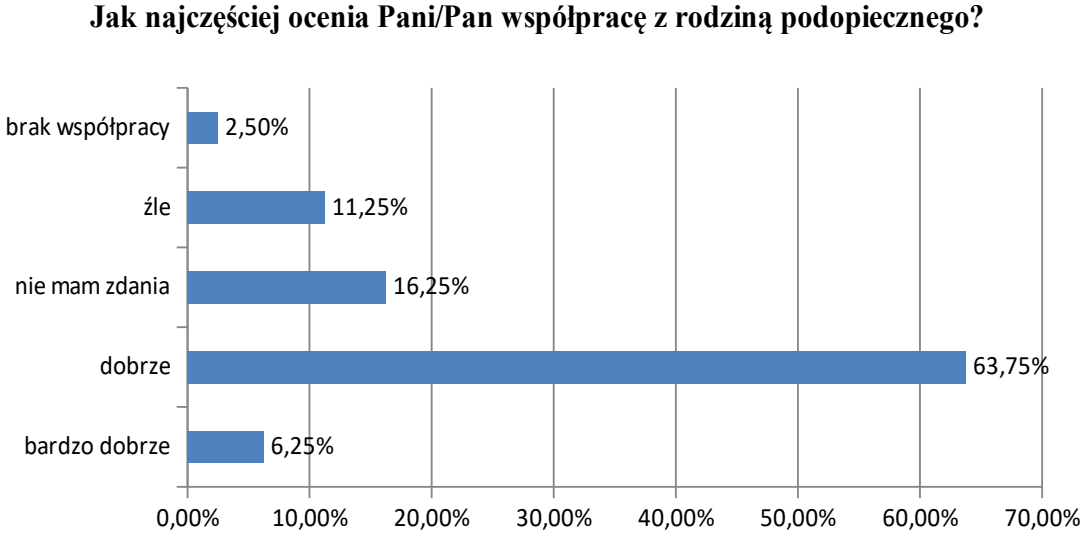


Diagram 6. Respondents' answers to the question how they evaluate cooperation with the family of 65+ patients.

According to the surveyed family nurses, the most frequent difficulties in working with a patient aged 65+ are above all immobilization of the patient/mobility difficulties for 87.5% of surveyed nurses, which is the greatest difficulty in providing services at the patient's home. 80% of respondents indicated that hearing problems at work cause considerable difficulty in providing information and understanding it. However, verbal communication with the patient is a problem for 40% of respondents. Problems resulting from visually impaired patients were indicated by one in three nurses surveyed (36.25%). The vast majority of surveyed nurses (76.25%) stated that in their work with seniors there is no or a rare lack of trust on the patient's part. The material aspect, i.e. the patient's financial problems are a problem in the opinion of 73.25% of respondents. Reduced patient's mood is a problem for 76.25% of respondents. On the other hand, the total lack of cooperation on the patient's part for 37.5% of surveyed nurses is a big problem.

**Summary:**

Savings in health care, above all, shortening of the hospitalization period resulted in moving the treatment continuation and prevention of complications within the scope of health care activities – to the institution of family doctor (Primary Health Care) and the family nurse and the patient's family.

A very rare model of multi-generational families, which can take over the care of seniors, has resulted in an increasing demand for care services in the residential environment and the provision of medical services by nurses of primary health care.

Results of own research conducted among family nurses presented in this study show above all that the number of 65+ patients with deficits of self-care and self-nursing requiring health services to be provided by family nurses in the place of residence, with the simultaneous ageing of this occupational group, is increasing. The most frequent difficulty in providing nursing services is among others immobilization of the patient.

For the majority of surveyed nurses, the financial situation of seniors, especially the lack of care products or therapies, are a difficulty and obstacle in the implementation of health services. Family nurses in the comprehensive care of seniors at home cooperate mainly with the family doctor and many other specialists. Undoubtedly, the new rights to prescribe medicines by nurses, which have been introduced in 2016, are to increase the professional prestige, but the responsibility for prescriptions issued and lack of compensation for additional duties discourages the use of the rights held. Family nurses are authorized to issue prescriptions, apart from many other qualifications acquired in continuous professional development, but in consequence they are relatively rarely used.

The family nurse has an active list of beneficiaries, up to a maximum of 2750, who have signed a declaration on the selection of a primary health care nurse. Primary health care services are financed by an annual capitalization fee, which from 2015 for the benefits of a health care nurse is about 28.56 PLN, the amount is disproportionate to the costs incurred and qualifications.

In conducted studies, an attempt was made to characterize the work of family nurses, their many roles and complex tasks performed in professional practice with the patient aged 65+ in their home conditions. While visiting 65+ patients, the family nurse takes on the role of a diagnostician, therapist, rehabilitator, counsellor, psychotherapist and manager of services for the patient. She provides psychological and physical support in difficult times. Seniors staying in their homes very often only need care services when there is no family or the family is unable to provide care, and patients are not willing to take advantage of the support of municipal family support centers, which unfortunately are paid for. In addition, there is still a reluctance in society to take advantage of day-care homes, not to mention the whole range of 24-hour care services when the need arises.

With a view to the future of family nursing, it is necessary to open up the provision of remote services, tele-services and instant messaging. More often the patient aged 65+ should take advantage of the opportunities offered by the Internet, which will probably facilitate consultations, education and save time in situations that do not require the physical presence of family nurses in

the patient's home.

## Conclusions

The following conclusions were drawn from the study conducted among family nurses in Gdańsk:

1. Family nurses in comprehensive care of seniors at home cooperate primarily with the family doctor.
2. In addition to many qualifications acquired in continuous professional development, family nurses have the rights of medicines prescription, but they rarely use them.
3. Providing services in the place of residence, the family nurse, performing instrumental activities educates the patient 65+ and their family.
4. Nurses most often mention the multidimensional assistance they provide to patients aged 65+ in their place of residence.


## Abstract

Family nurse and primary care physician are the most important link in the care of elderly and their families in the place of residence.

Prolongation of life, increased deficits in self-care and self-nursing, shortening of the hospitalization period has resulted in moving the patient's treatment and care to the home environment, which for the elderly is an optimal place to stay.

This study was conducted using a sociological questionnaire among 80 family nurses, mainly women (78 respondents), working in the city of Gdansk, highly qualified (60% higher education). The family nurse cooperates with other people and, above all, with the family in order to provide care to the patients. The nurse faces new tasks during each visit to the patient. Apart from performing instrumental activities, the nurse provides informational and emotional support to the patient and their family.


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