Cogitare Enfermagem

ORIGINAL ARTICLE

NURSING STUDENTS' EXPERIENCES AND PERSPECTIVES ON INSTITUTIONAL CARE FOR ELDERLY IN TOTALLY DEPENDENT PERSONS*

HIGHLIGHTS

1. Care is contemplated and lived away from humanism.
2. Care is provided based on institutional and professional needs.
3. Old age is pathologized and medicalized.
4. Professionals must be trained to provide humanized care.

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ABSTRACT

Objective: To learn the perspectives of nursing students on geriatric care provided in a public home for the aged. **Method:** Qualitative study - grounded theory. Nineteen students who performed social service at a home for the aged between 2020 and 2021 in the state of San Luis Potosí, Mexico, were interviewed based on the criteria of theoretical saturation. The analysis was based on Strauss and Corbin's proposal and was triangulated with the field diary records. **Results:** the central emerging category was "Non-humanistic care", the organization and implementation of care obey more to administrative issues and protocols developed from the biomedical medicalizing paradigm. **Conclusion:** the perspectives dehumanize care, there is no recognition of people's autonomy, and the nursing staff shows weaknesses in psychosocial competences to relate to this population.

DESCRIPTORS: Humanism; Aged Rights; Homes for the Aged; Nursing Care; Continuing Nursing Education.

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INTRODUCTION

In Latin America, most of the older adult population lacks guarantees for access to professional care[1], which contributes to the overload of care in family units, particularly for women[2]. It is the obligation of the Nation-States to provide care facilities and to guarantee access to professional care in conditions of respect for diversity, free of inequality and discrimination[3].

Nursing is a fundamental resource in guaranteeing professional care for this population group, which shows a tendency to increase worldwide[4]. Care operates because of values that not only characterize it, but also shape it, including compassion, solidarity, altruism, empathy and humility[5]; the absence of these values implies the dehumanization of care, a phenomenon that is often accompanied not only by the absence of these values, but also by the presence of a series of anti-values associated with dehumanization and that contribute to the objectification of the subjects[6].

Humanizing care in homes for the aged implies building institutions focused on people's needs, which make it possible to personalize assistance[7]. In addition, it implies the development of professional competencies, such as developing an awareness of others based on knowledge about oneself and the ability to establish dialectical relationships that recognize and prioritize the needs of others[8]. Humanizing care means talking about how one deals with the suffering of others, and how one diagnoses their needs for support and comfort[9], which requires us to be sensitive and develop psycho-emotional skills to act from compassion, kindness, gentleness, charity, altruism, generosity, nobility and courtesy[7].

Maintaining humanism as the central dimension of care in capitalist and neoliberal contexts becomes a titanic challenge; caregivers are exploited, and the work of professional care becomes precarious, demands overwhelm us and, without us realizing it, we develop depersonalizing attitudes[10], routinize tasks and objectify people, ignoring their individual traits, preferences, feelings and values[7]. In contexts such as those mentioned above, care institutions become spaces in which affective distancing and indifference prevail.

The burnout phenomenon to which we have previously alluded has been called "Burnout Syndrome", a concept through which explanations have been generated about the origin and consequences of this exhaustion that leads to depersonalization in the act of care[11], it can also be called "Tired caregiver syndrome"[12] or "burned out worker"[13], terms that allude to the emotional collapse derived from a lack of real interest in the subjects of care, accompanied by a perception of little or no satisfaction with the professional tasks[14].

Now, although Burnout Syndrome has been recurrently mentioned in nursing personnel, little evidence has been generated so far on this phenomenon in the specific field of elderly care, and we did not find any bibliography that addresses it with nursing students, so the objective was to know the perspectives of nursing students on the elderly care provided in a public home for the aged.

The study was based on the theoretical assumption that professional burnout and the phenomenon of dehumanization begins at the training stage, based on the experiences and perspectives that students build regarding elderly care within their practices, so we wondered what are the experiences and perspectives that students in social service have on elderly care from their practice within a public home for the aged?

METHOD

During 2020-2021, a qualitative study was carried out based on the grounded theory (GT) proposal, since we were interested not only in learning about experiences and

perspectives isolated, but also in understanding the real and symbolic interaction processes that contribute to the assimilation of experiences and the shaping of perspectives[15]. The scope was comprehensive to recover meanings and expectations from people's perspective and to understand their daily contexts.

The setting was a public home for the elderly care in the state of San Luis Potosí, Mexico, more specifically, the nursing area. Students in social service who met the following criteria were invited to participate a) they would perform social service in the nursing area of the geriatric care institution, b) they would attend their social service within the period 2020-2021, c) they would participate in the care of totally dependent older adults, and d) they would agree to participate and voluntarily sign the informed consent form.

Finally, 19 students in their last year of undergraduate studies participated; only students in their last year were invited to participate as a strategy typical of theoretical sampling, which requires that the informants have lived the experience to be explored to the maximum, for a better understanding[16]. Both the profile and the number of informants were defined as the application, coding and analysis of the information progressed; the purpose was to identify the characteristics we should look for in the following informants, to ensure the consolidation of the categories[15].

The interviews were based on a script of semi-structured questions, which explored the perspectives and experiences from seven dimensions that we identified based on the literature, interrelated in the practice of humanized care: 1) Ideological, 2) Biological, 3) Psychosocial, 4) Aesthetic, 5) Justice and advocacy, 6) Interaction and involvement of human dignity and 7) Professional training and decentralization of nursing care. Observation records were documented in a field diary. Both techniques were implemented by only one of the researchers, who is listed as the first author.

The observation and interviews were carried out within the institution, with the latter taking place in private spaces, which allowed for the desirable privacy to delve deeper into the dimensions proposed for the interview. The interviews lasted between 45 and 60 minutes, and the topics were exhausted in a single approach. The observation was of the participant type; the researcher, who works as a professional nurse, was involved, and collaborated in the care for the elderly, documenting the organization and performance of professional activities, as well as the intellectual, technical, and attitudinal competencies of the professionals for the care.

The interviews were audio-recorded and transcribed immediately, as required by the theoretical sampling strategy[16], for subsequent analysis according to the Strauss and Corbin[15] proposal. The codes and notes on the conceptual and theoretical ideas were obtained in an artisanal manner by the two authors responsible for carrying out the coding processes. For open coding, the interviews were reviewed on several occasions to reduce them to codes; subsequently, in axial coding, the data were grouped logically to form connections between categories and subcategories; finally, for selective coding, a central category was identified, and the interrelationships were structured, triangulated with the field diary records, thus, during this analysis and using the note technique, it was possible to propose the hypothesis that explains the connections between categories, identifying the properties of these categories, to generate the theory[15].

The research complied with the ethical-legal requirements for research involving human subjects, and the protocol was structured according to the principles of the Declaration of Helsinki and the General Law on Health Research in Mexico. The study was classified as minimal risk, with written consent, guaranteeing anonymity and confidentiality of the information, so the names of the participants have been omitted in this article, as well as any characteristic that makes them identifiable. The protocol was reviewed, approved, and monitored in its methodological and ethical aspects by the Committee of the master's degree in human Rights of the Universidad Autónoma de San Luis Potosí No. 2020/12.

RESULTS

Nineteen nursing interns participated, 4 men and 15 women, with an average age of 23, a minimum of 18 and a maximum of 27. Except for three participants (one woman and two men), the rest of the participants, in addition to working at the old age home, cared for patients at home. Four lived with a partner and the rest were single. Their professional caregiving experience was virtually the same, the four years involved in undergraduate professional training.

The central category that emerged was "Non-humanistic care", given that it was documented that both the organization and implementation of care are based more on administrative processes and protocols centered on the hegemonic biomedical model than on the recognition of the uniqueness of people, of their needs from a holistic aspect, or of the prioritization that people themselves make from their own scale of values.

They discussed nursing responsibility for ensuring physiological stability, focusing their speeches on hemodynamic monitoring, bathing and other hygiene activities, wound healing, among others.

The main thing is to check vital signs, make position changes, channel them when they are in the clinic...put the handrails, I have adequate body mechanics so as not to hurt them.... (Participant 2)

I thought it was just basic care like changing their diaper and taking their signs, but later I noticed that there was more care, like postural changes.... (Participant 7)

When they discuss the planning and organization of their daily activities, these derive exclusively from physiological needs, those that can be estimated using measurement scales that they can interpret as professionals and act on in a protocolized way.

To begin with, you could evaluate her with physical assessment scales, with geriatric scales, that would be one way. (Participant 3)

Well, starting with the age, the state of consciousness, the geriatric symptoms that they present and well, yes, the physical state in general; that, maybe because of their age, because of the extremes of life, the care they need will not be the same physiologically as a young adult. (Participant 14)

Care is administered from standardization, perceiving old age as a unique and invariant experience.

Every grandparent is listened to, has all their care, everyone is cared for no matter what they have, everyone is cared for equally (Participant 12).

You must talk to them well, treat them in the right way without saying how, you are bad or making them feel bad. Not talking to them loudly or with words that should not be said (Participant 2).

Elderly people are perceived as lacking willpower, as not knowing what they need or want, which ends up depriving them of their autonomy. The "dignified treatment" is understood and lived from the standardization of the experience, under the assumption that all people in old age live the same deficiencies, and therefore require the same care.

Well, I believe that they are treated with dignity even though most of them are not conscious, but there is that dignified treatment, that respect, that care that provides quality and warmth for the nurse towards the patient, whether they are conscious or not. (Participant 14).

But within this biologist perspective there are tensions, since in their narratives they

recognize that the people they care for have needs and demand actions that go beyond the biological.

When I was putting a grandmother to bed, she asked me to cross herself so that she could go to sleep (Participant 17).

Pedro told me that he prayed to the Virgin a lot for his daughter, Pedro, well! He trusts me a lot (Participant 12).

I saw some grandparents going to mass, or I saw older adults who were in their room, praying, and I tried to give them their space. (Participant 3)

The claim of ignorance of will and autonomy can perhaps be explained by the difficulties they have in recognizing the holistic complexity that constitutes people, or by the absence of competencies to intervene in the satisfaction of needs that go beyond the biological, and that require more than standardized procedures to be resolved.

To be human with the grandparent, and to treat them as we would like to be treated ourselves and as if they were a family member (Participant 2).

To attend to a matter that is not of a physiological order, it is seen as an act of charity, not as part of care, given that they think of care only from a biomedical perspective.

When I crossed the grandmother, I felt nice because, I don't know, I think it varies what happens in her life, I don't know whether she crossed her children or her grandchildren. And I did it out of generosity (Participant 17).

Care in the form of a "maquila" is sustained by the existence of an institutional culture based on administrative norms that are accepted without discussion. The organization of activities takes place without much reflection on how this guarantee or does not guarantee the humanization of care. Their position as students represents a constraint for them to implement or propose activities more centered on people and less on the routines of the services.

I think I am more empathetic [than the nurses] with the patients, if I tell the nurses they just tell me "oh yes, we'll see it right away" and they take away my intention... they limit me because I am not in charge (Participant 10).

I feel that the interns do it with more affection, I feel that they [nurses] perhaps because of the responsibilities they have, they are busier and must do the work whereas we work as interns also must do the work, but we do have a little time to interact more with the older adult. (Participant 3).

The hierarchical interprofessional relationships are an obstacle for students to contribute to making institutional spaces more humane.

[The relationship] between interns and staff has not been excellent, I have had friction with the rank and file, we bring new ideas, and they are in their comfort of not wanting to do things that could be better for the grandparents, but they have even said that they have been here for 25 years, and we are not going to tell them how to do it or to change that. (Participant 15)

Well, look, with the nursing staff you do draw a line, you do talk to them, but you don't go beyond the line, if the staff allows you to [perform an activity that is not routinely done] then yes. (Participant 12).

DISCUSSION

Care is configured as non-humanistic care, centered on the hegemonic biomedical paradigm, which is not far from the students' own perception of care, since their training is also predominantly based on this paradigm. Although it was documented that, during their stay in the home for the aged, they have had some attitudes tending to the humanization of care, these are limited, since they do not have sufficient competencies to defend the need to transform care towards a more humane paradigm, an issue that should not be lost sight of in the framework of the above, is how the hierarchical and organizational forms deprive them of agency to influence such action.

The first thing that seems relevant to bring up for discussion has to do with the profile of the informants in this research, since some of their characteristics have been mentioned as contributing to professional burnout and dehumanization. Most of them have been working double shifts since their student life, and given that most of them are women, it is possible that even triple shifts; the overlapping of formal and domestic work shifts, are conditions that have been associated with the development of burnout syndrome[17]. In the same vein, it is important to consider that theoretical contributions have shown that younger people tend to develop earlier and more frequently symptoms associated with physical and psychosocial exhaustion in the exercise of professional care[18].

The central emerging category was non-humanistic care, since it is exercised from a position that is far from what is stated in the literature as humanistic[7,10-11], and this is due to personal, professional, and institutional situations. The care as they perceive it does not place the persons subject to care at the center of the therapeutic interaction, but at the periphery; what is placed at the center are the needs of the institution and the profession, implementing routines and protocols centered on the biological dimension, which could be explained by the historical predominance of the biomedical paradigm in health careers[19].

They perceive that care is organized because of the routines and dynamics of the institution, as well as on the professional functions recognized to them, which center the idea of care on the biomedical paradigm, and in this sense, normalize the placing of techniques and procedures as the axis of the institutional organization. This goes unnoticed even by most students, since during their professional training, they have developed the bio-medicalizing perspective, which enables them to see old age as a homogeneous and pathological condition, while denying the existence of the spiritual, social, and psychological spheres[20], which are the dimensions that make us recognize the particularities and identities.

In care, older adults' will and autonomy are not recognized, and this is also related to the predominance of the biomedical perspective, a view that prevents them from recognizing that immobile, older and slower bodies have other ways of communicating their needs and desires, but also that these desires or needs are not only physical, but that spiritual and psychosocial needs emerge, whose satisfaction is vital in terms of guaranteeing quality of life[21].

Part of the configuration of care is based on the imaginary of a "dignified treatment" that is constructed because of the indicators centered exclusively on the techniques and procedures involved in care, making invisible the transcendence of the perception of the person receiving care. García[22] has been insistent in pointing out how necessary it is to prioritize the subjective burden experienced by the caregiver, since recognizing this subjectivity enables us to recover the ability to feel compassion, an emotion that humanizes care.

It is imperative to leave the protocol in the technical-procedural field and recognize us as human in front of the one we care for. The demands of care in people go beyond the biological and are installed in the plane of subjective wellbeing, which includes cognitive and affective components, since not having no impact on their hemodynamics does not

make them any less important; the evidence indicates that the older the person is, the greater the religious and spiritual needs, this being a resource to overcome stressful events, deal with difficult processes and give meaning to the loneliness that can be experienced within homes for elderly care[23].

This configuration of care is due to multiple situations, one of the most important of which is due to the limitations to relate psychosocially and spiritually with older adults, a limitation that, although it may be associated with their own personality and life history, may also be related to absences within the professionalizing programs. This is particularly serious because it implies not only the possibility of omitting care, but also for the elderly themselves, the inadequate management of communication and emotions increases their psychosocial risk, contributes to work and cognitive burnout, increases stress levels, and has been documented to have an impact on the onset of depression, anxiety, and sleep disorders, affecting their performance and reinforcing dehumanization and depersonalization in care[24].

The previous one, is particularly worrying, since communication skills are indispensable for nurses, as we spend all day with those we care for; in fact, communication and emotion management skills have been shown to be positively correlated with the sense of professional self-efficacy or job satisfaction, which in turn would prevent or delay dehumanization and depersonalization in dealing with the people who demand their care[25].

We have focused so much on standardizing nursing language that we are forgetting the importance of communicating with those we care for, and then communication becomes a challenge, particularly when we are divided by a generation gap with those we care for and with whom we find no similarities. Therapeutic communication with the elderly not only fulfills a social function but also an affective one, and represents a human right, in the words of Lozano and Fajardo[26:88].

Affective communication is a determining factor that facilitates belonging to a group, it generates quality of life by promoting self-confidence and develops socioemotional competencies, since by receiving treatment with communication and affection the older adult forges control over his or her emotions.

Caring for people implies considering them in their integrality and promoting active aging, an aging that is multidimensional and that demands not only the physical, but also the subjective; where psychosocial integration emerges as a criterion that determines the quality of life, and where the absence of this, constitutes a form of abandonment of old age[27].

Finally, we identified that one of the conditions that contribute to the dehumanization of care is the presence of an organizational culture that deprives the subjects of their autonomy and identity, but according to what the informants in this study have shared with us, not only those who receive care but also those who provide it, thus establishing conditions of inequality, violence and discrimination that contribute to dehumanization[28]. To institutionalize the subjects, it seems mandatory to detach them from their qualities, dehumanization then becomes one of the main tools that the hegemonic biomedical paradigm must prevail and seems to be the only way to care for people not through other people, -because we are also made invisible-, but through technology, plans and protocols that are often not designed based on our realities.

Among the limitations of the study, we can point out the lack of previous research studies on the subject in students, which forced us to resort to the discussion with research that has focused on professionals and not on people in training. Similarly, ethnic diversity did not exist, and gender diversity was quite limited, variables that would have been relevant to discuss as part of the phenomenon.

FINAL CONSIDERATIONS

This study explores the perspectives of nursing students on the elderly care provided to older adults in a public home for the aged. There are personal, professional, and institutional conditions that contribute to the fact that care shows a tendency to move away from humanism, more concerned with attending to the needs of the institution or concerned with limiting itself to professional tasks, than with responding to the felt needs of people, who are conceived from the predominance of a hegemonic biomedical paradigm, as subjects without autonomy to give their opinion on the care they need. It is necessary to reinforce within the nursing education programs, competencies and skills of interaction with the elderly, so that nurses assume the professional and ethical responsibility to ensure humanized care.

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Substantial contributions to the conception or design of the work; or the acquisition, analysis, or interpretation of data for the work - **León FHAD de, Flores YYR**. Drafting the work or revising it critically for important intellectual content - León FHAD de, Flores YYR**.** Agreement to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved - **León FHAD de.** All authors approved the final version of the text.

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