Spiritual End-of-Life Care in Dutch Nursing Homes: An Ethnographic Study

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Keywords: Nursing home, end of life, spirituality, qualitative research

A B S T R A C T

Objectives: The aim of this study was to explore if and how spiritual needs are assessed and if spiritual care is provided to Dutch nursing home residents, including residents suffering from dementia, and if and how caregivers communicate and collaborate regarding the residents' spiritual needs.

Design: Two researchers conducted an ethnographic participatory study in a Dutch nursing home between April 2010 and June 2011, on a psychogeriatric unit (mostly dementia) and a somatic unit for residents suffering from physical disabilities. Inductive thematic analysis was used to identify patterns and trends and to interpret the data.

Results: The physicians did not actively address spiritual issues, nor was it part of the official job of care staff. There was no communication between the physicians and the spiritual counselor. When a resident was about to die, the nurses started an informal care process aimed at (spiritual) well-being, including cuddling, rituals, and music. This was not mentioned in the care plan or the medical chart. The nurses even supported the residents outside their professional role in their spare time. Furthermore, we identified different occupational subcultures (eg, nurses and physicians), in which behavior of residents was given different meaning, depending on the frame of reference within the subculture. Spiritual issues were addressed only informally and were not part of the formal care process, either for residents suffering from dementia or for those with physical disabilities. Our results raise questions about how the lack of communication about spiritual end-of-life care between disciplines, and the informal and formal care processes affect spiritual well-being.

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their care. This raises questions about if and how spiritual needs are responsible for spiritual end-of-life care of the residents entrusted to study revealed that elderly care physicians did not always feel responsible for spiritual end-of-life care of the residents they are being optimally positioned to take up this role, a recent focus group approach central to Dutch nursing home care and as such they are responsible for the coordination of the resident’s care plan. Despite being optimally positioned to take up this role, a recent focus group study revealed that elderly care physicians did not always feel responsible for spiritual end-of-life care of the residents entrusted to their care. This raises questions about if and how spiritual needs are addressed in practice. To explore this topic we performed an ethnographic study. The aim was to investigate the following:

1. if and how spiritual needs are assessed and spiritual care is provided to Dutch nursing home residents suffering from dementia or physical disabilities;
2. if and how caregivers, including physicians, nurses, and other staff communicate and collaborate regarding the topic of addressing the residents’ spiritual needs.

Methods

Design

We performed an ethnographic participatory study with data being collected by 2 researchers, an elderly care physician (M.J.G.) and a social scientist (M.T.M.), on 2 units of an urban nursing home: a psychogeriatric unit (mostly dementia) and a somatic unit for residents with mainly physical disabilities. They presented themselves on the unit as researchers. To avoid influencing the practice of spiritual caregiving, the goal of the study was communicated in broad terms (ie, as focusing on communication between staff members). Therefore the goal of this was covert. Terms related to spirituality were not used to avoid raising awareness regarding spiritual care among the staff. Residents, relatives, and personnel were notified of the presence of the researchers by the management of the nursing home. It was agreed with the management that any observed detrimental practice would be reported. The study protocol was approved by the Medical Ethics Committee of the VU University Medical Center, the nursing home management team, and the board representing residents and families.

Setting

M.J.G. and M.T.M. participated as nurse aides on the psychogeriatric unit between April 2010 and December 2010, and continued on the somatic unit between December 2010 and June 2011. There were 32 residents on the psychogeriatric unit, divided over 2 subunits, and 26 residents on the somatic unit. The care teams consisted of 1 team manager (registered nurse), 10 certified nurse assistants, 5 nurse assistants in training, 10 nurse aides with different competences and qualifications (all referred to as nurses), and 1 staff member who directed an activities program for the residents (eg, special breakfast projects for a selected group of residents, and light classical music sessions on the unit). A day shift generally consisted of 2 nurses, 1 nurse in training, 2 nurse aides, and the activity therapist on 3 days a week. Three elderly care physicians and 2 general practitioners in training provided the medical care on the 2 units. The nursing home had an on-staff Roman Catholic spiritual counselor who provided care to all denominations. M.J.G. and M.T.M. worked as nurse aides alongside the regular nurses on the unit in various shifts, helping the nurses wash and dress the residents and assisting the residents in the bathroom and with eating and drinking. They presented themselves on the unit as researchers. Initially the staff of the units were conscious of the researchers, but their presence and participation in the caregiving on the unit soon became routine.

Data Collection

Two hundred shifts (a total of approximately 1600 hours) were spent on the units during the course of the data collection: 180 day shifts, 16 evening shifts, and 4 night shifts. M.J.G. and M.T.M. had informal conversations with all persons present on the unit during shifts: residents, relatives, nurses, team managers, physicians, therapists, and the spiritual counselor. We attended formal meetings that were planned and formally recorded in the resident’s medical chart and/or care plan (eg, bedside consultations by the physicians on the unit, meetings with proxies of the residents, and multidisciplinary team meetings on residents’ care planning). In addition, we collected data through informal conversations and from the resident’s care plan and care files. Finally, M.J.G. and M.T.M. kept a reflective diary in which they reported their feelings, reflections, and interpretations of the observations and conversations. Sometimes the conversations and observations triggered questions. These were discussed between M.J.G. and M.T.M. on a regular basis and were followed by additional formal interviews if it was thought this would help explain/deepen/ enrich the observations. Thus, 11 formal interviews were held with nurses (4), physicians (3), spiritual counselor (1), residents (2), and a resident’s proxy (1). All interviews were recorded and transcribed verbatim. In sum, the data sources were the following: observations, informal conversations and formal meetings, additional formal interviews, and information from the resident’s care plan.

Analysis

To identify patterns and trends in the data, and to interpret the data, we used inductive thematic analysis. There were no preconceived themes; all themes emerged from the data. Data triangulation was used to ensure consistency and we searched for convergence among the different sources of data to discover themes. M.J.G. and M.T.M. compared their field notes and reflective diaries concerning the 2 subunits of the psychogeriatric unit every 2 weeks. The field notes and reflective diaries were independently read and re-read by M.J.G. and M.T.M., who performed the fieldwork, after which field notes and reflective diaries were compared and analyzed for differences and similarities. Field notes and interview transcripts were initially coded using open codes based on the words used by M.J.G. and M.T.M. in the field notes or by the participants in their interviews. Interim reports were discussed with other members of the research group. As a starting point for the present study, “sensitizing concepts” were used as a general sense of reference and guidance, which entailed the following broad notion of spiritual care that comprises elements similar to other recently published definitions and is derived from our earlier conducted systematic review on spirituality at the end of life:

1. Spirituality encompasses 3 dimensions: Spiritual Well-Being, Spiritual Coping, and Spiritual Cognitive Behavioral Context (which in turn includes Spiritual Beliefs, Spiritual Activities, and Spiritual Relationships).
2. Spiritual Well-Being comprises several aspects, including peacefulness, completion of life, and a sense of purpose and meaning. Spiritual Well-Being can be seen as an outcome of spiritual care.
3. Spiritual Coping, as well as the Spiritual Context (Spiritual Beliefs, Activities, and Relationships) may contribute to Spiritual Well-Being.

After the observations on the psychogeriatric unit, we continued on a unit for residents with physical disabilities. Our aim was to compare the findings in both units, and to explore whether any difference between the residents’ disabilities was perhaps reflected in a different approach toward spiritual caregiving at the end of life.

Results

The following themes emerged from our study:

- Formal spiritual end-of-life caregiving
- The informal end-of-life care process
- Spiritual end-of-life caregiving on the psychogeriatric unit and the somatic unit
- Distinguishing psychosocial and spiritual aspects of caregiving
- Occupational subcultures within the nursing home

Formal Spiritual End-of-Life Caregiving

During our study, a total of 14 residents died on the 2 units. We found that the physician was called for bedside consultations when the resident was ill or when the nurses observed signs of discomfort, such as pain, anxiety, or challenging behavior, or when they observed a general decline in the resident’s health condition. These cases were also discussed in multidisciplinary meetings or in meetings with residents and their families. Spiritual needs were not mentioned in the care plan and were not discussed with residents during bedside consultation or in multidisciplinary meetings. Spiritual needs and spiritual care were never a topic.

We interviewed the elderly care physicians responsible for the residents on the units where we conducted the observations and invited them to talk about their perceptions and practice of addressing the residents’ spirituality or their spiritual needs. They confirmed that they did not actively address spiritual issues, such as spiritual beliefs or spiritual needs at the end of life, as the following quotations from interviews with 3 of the physicians demonstrate:

“I never really asked [about spiritual needs], sometimes I ask: are you afraid of dying? But I don’t ask it at the end of life, but at an earlier stage.” Interview physician 1

“I hesitate to bring it up, because I am afraid to impose something [the physician’s own spirituality] on the resident or that they will take it the wrong way.” Interview physician 2

“I think you have to be very cautious, and you must be very clear about what you can or cannot bring up in a conversation like that.” Interview physician 3

When asked about how discussing spiritual issues could be facilitated, one of the physicians referred to additional training and guidelines.

“I would like to do it [address spiritual issues], but I would need additional training on how you address these issues, or what kind of questions I could ask the resident, because based on my own spiritual beliefs I have certain ideas about the topic, but that’s not the way to address them, you see. Everyone has his own spiritual path, so guidelines are needed, because I cannot address these issues based on my own spirituality.” Interview physician 2

We did not observe any formal communication between the physician or any of the nurses and the available on-staff spiritual counselor; however, we did observe the spiritual counselor in action several times. She was on the unit after one of the male nurses died unexpectedly, which had a great impact on the other nurses. We also witnessed her holding special religious services for residents suffering from dementia. Several times we found that her presence invited ad hoc requests by nurses or physicians to see a resident. An interview with her confirmed that she intentionally presented herself and her expertise informally in this way.

“The informal end-of-life process increased my presence in the unit. If I was visible [to nurses and physicians] they will notice me and maybe think of a resident who might need me. Recently a nurse on the psychogeriatric unit spoke to me informally, saying: ‘Good to see you, Mrs V recently told me she wanted to talk to a priest.’ The weeks before I had visited this unit more often, that may have made them think ‘Maybe we should talk to her’ when they see me.” Interview spiritual counselor

The Informal End-of-Life Care Process

The deaths of the 14 residents during our study were mostly preceded by a gradual deterioration of their health, which required more frequent bedside consultations by the physician. When a resident was close to death, we observed that the nurses started an informal care process that was not initiated or arranged by the physician, nor was it mentioned in the care plan. In all cases we found that, after one of these consultations, the nurses discussed the situation of the resident and his or her loved ones among themselves during their break; should they call the relatives, should the resident be taken to the special room on the unit where they provided special care for residents for whom death was imminent?

This also happened to Mrs J, one of the residents of the psychogeriatric unit. She had problems with eating and drinking, and had lost a lot of weight. Otherwise she was comfortable: there were no signs of pain or fear, there was no skin breakdown. After the physician’s bedside consultation that morning, everyone agreed that it would not be very long before she passed away, and she was brought to the special room on the unit. The nurses spoke in low voices, carefully rearranged the flowers on a little table and put on Mrs J’s favorite classical music. The small essential oil burner filled the room with the scent of lavender. They left the room, leaving the door ajar so any sign of discomfort would reach them quickly. At least every half-hour they checked on her during that busy shift, adjusting tone, mood, and loudness of their voices. On a previous occasion I noticed that an extra bed was brought into this room for the relatives, so they could comfortably stay the night. Relatives were served meals and sometimes were encouraged to have a time-out, or sit with the resident in ‘shifts’ when they were getting too tired. Reflective diary

This attention exceeds the treatment of psychosocial and physical symptoms, such as anxiety, pain, or shortness of breath. Much attention was given to supporting the relatives so they could experience their connectedness to the resident these final hours, accept the imminent death of their loved one, and let go. After observing these informal care processes a few times, we asked one of the experienced nurses to describe the way she provided end-of-life care to the residents and their loved ones during the final days.

“I was having my coffee break and I said: I have a strange feeling about this man. I saw something in his eyes, I thought: something is wrong, and I told my colleagues: ‘I am going to Mr K now to help him, but I want to talk to him first. I will let you know when I am ready.’ I stood beside his bed and said: ‘Listen, is there something you want to get off your chest?’ He looked at me, and I held his hand, and said: ‘You know where it’s at, you are increasingly short of breath.’ I
said: ‘Is there anything you need?’ You know, the way you should ask these things, very straightforward. I said: ‘Is there anyone?’ And yes, he said: ‘My son.’

His care file said that his son was only to be notified after he passed away. His daughter, too. And when my shift was almost finished I went to see him, he looked at me with tears in his eyes and I knew that I would not see him again. I was so glad that he had expressed his last wish. At the end of my shift I tried to call his son, but the number was out of order. Finally, with the help of someone else, they reached his son, and when I came back on the unit a few days later I heard his son had sat beside his bed that night, and I thought: thank God, he must have passed away peacefully.” Interview nurse B

This case shows how nurses also want to mediate between family and the resident, for the resident to be at peace when he or she dies, and to accept the way relationships with loved ones have developed, to achieve closure.

We observed many nurses meet needs of the residents outside their professional role. This included shopping for residents, but also taking them out to important events, such as weddings or funerals of loved ones, in their spare time. In many instances, we also found that this involvement had a personal significance for the nurses.

Nurse M, an elderly woman originally from South America, decided to take Mrs P to the wedding of her daughter. She knew that her daughter’s partner had insisted on marrying sooner than originally planned, because Mrs P’s dementia was progressing, and she was eating less and less, in spite of the nurses frequently offering and urging and despite the fact that she was offered food that she especially liked. When her daughter visited Mrs P on the unit and discussed the new wedding date, she started to cry and said that she couldn’t find anyone to accompany her mother to the wedding. The daughter had said explicitly that her wedding and her mother’s attendance signified the completion of their relationship to her. Reflective diary

In an interview regarding this event, the nurse in question expressed why she accompanied the resident and what this meant to her personally.

“For me this all was very meaningful, how shall I put it: death is part of life. At a certain age you pass away. So the moment I saw the daughter in tears when she said: ‘I have no one to escort my mother to my wedding, what am I to do?’ I thought: I cannot leave it at this, and I said: ‘I will escort your mother to your wedding.” Interview nurse M

Spiritual End-of-Life Caregiving on the Psychogeriatric Unit and the Somatic Unit

After the observation period on the psychogeriatric unit, we continued our study on the somatic unit for residents with mainly physical disabilities. Obviously, some residents of the psychogeriatric unit could no longer verbally express their needs and wishes at the end of life, but others were still able to indicate their wishes with the help of their relatives and the nurses. We discovered that many residents with mainly physical disabilities also needed the support of loved ones and nurses to express their needs. The caregiving goals of the nurses appeared to be the same, and the individual residents were approached and comforted in a way that was appropriate for their cognitive status, but otherwise very similar.

One of the residents on the somatic unit for residents with mainly physical disabilities who died during our study was Mrs G. She was an artist and had recently had her last exhibition. She was 79, and suffered from rheumatoid arthritis and terminal heart failure. She had had surgery for ovarian cancer, and had had no symptoms in the past years. Recently she had suffered severe vaginal bleeding. Her gynaecologist was contacted, there were no more curative options. She was feeling progressively weak due to the blood loss. She had an appointment with the cardiologist regarding aortic valve replacement, and discussed with the physician that she considered not having the operation, because her gynaecological problems were becoming more serious than her heart condition. She asked to talk to her ex-husband, her 2 sons, the team manager, and the physician. She mentioned that her recent exhibition had completed her life and that she was very grateful to her ex-husband and sons that they had participated in organizing it.

The following weeks she became visibly weaker. Another family meeting was arranged. One of the nurses sat close to her son, who suffered from schizophrenia, to support him if necessary. She explained to him that his mother was very ill now, and that she would not live much longer and that she would have to let him go soon. He was very tense and seemed to struggle to find arguments to counter what she said but couldn’t find them. They were left alone to say their goodbyes. Later on I saw her son with a nurse who was comforting him, he was sad, but not as tense as before. The nurses treated Mrs G’s pain, comforted and supported her in the process of letting go. She died the next morning. Reflective diary

We observed no significant difference between the psychogeriatric unit and the somatic unit regarding this process of end-of-life caregiving by the nurses, in which a peaceful death and completion between loved ones was essential spiritual caregiving goals. As for the example of Mrs G: she was still able to initiate and participate more actively in this process of completion, but the nurses’ approach of the resident and their comforting of the relatives was essentially the same. We wanted to know whether the nurses agreed with us. In informal talks during coffee breaks they confirmed our observation. In a formal interview, nurse B underlined it.

“Basically it makes no difference to me whether a resident is suffering from dementia or not. Maybe a resident with dementia doesn’t understand things the same way, for instance when you tell them that they will get a little morphine. In my experience most residents who are going to die soon have a very clear mind, even in dementia. Maybe I give residents with dementia that little bit extra, for instance when someone loved a certain scent or music, a hug, but basically it doesn’t make any difference to me, every individual deserves as much as another, depending on the situation. Sometimes residents need a little support to let go, residents with dementia too. There was this woman [suffering from dementia], she was so tense, we did not know what was bothering her, I went up to her and said: ‘Look, you are making it so much harder for yourself, maybe you don’t feel that you are ready to die, but I don’t think that this is what you want either, so try to let go.’ And shortly after that I saw her relax completely, like she was finally ready.” Interview nurse B

Distinguishing Psychosocial and Spiritual Aspects of Caregiving

As the quotations show, the psychosocial and spiritual aspects of caregiving are distinct but not separate: Mrs G’s concerns about her son, for instance, had an emotional and social aspect, but her intention was also to complete her significant relationships at the end of her life. The exhibition of her artwork that her family had organized for her was a social gesture, but also a contribution to the completion of her life, as she stated. A similar distinction can be made in the relationship between Mr K and his son.
Occupational Subcultures Within the Nursing Home

The communication between nurses about their observations of the residents’ behavior and the meaning they attached to this behavior was different from the communication between nurses and physicians. The case below illustrates how the nurses’ perceptions of a patient’s desire not to live anymore was communicated to the physician in terms of a medical problem.

Mrs R was a resident on the psychogeriatric unit. She had severe dementia. She lay in bed, or sat in the unit’s living room in her customized wheelchair. During our study, we noticed that she became increasingly fatigued and tense when she was being dressed. Assisting her at mealtimes was also getting more and more challenging and at some point she no longer ate and drank sufficiently. Nurse I said: “I last saw Mrs R about a week ago. She basically sits or lies with her mouth open all day, and this makes it easy to put the food in her mouth when you assist her with her meal. After the meal she often brings up the food or coughs, especially when her daughter has helped her. But now she starts retching and bringing up food after only a few spoonfuls. I think this is the only way she can show us if she wants to eat or not, this retching and heaving is the only way she can express that she is ready to die, to express her wish: no more. I think it is best to stop offering her food when she retches, to respect this wish.”

This was also discussed during the nurses’ breaks: Mrs R wants to show us she doesn’t want to live anymore, and this is the only way she can express her wish. Later that day the on-staff physician visits Mrs R for a bedside consultation and talks with the nurses about recent developments. To my astonishment, Nurse I introduces this development as a swallowing problem. The physician diagnoses the problem as “swallowing problem in the context of progression of dementia” and records this in her medical chart. Later that day in a meeting with the daughter of Mrs R the problem of retching and heaving is presented by the physician as a “swallowing problem due to the progression of dementia.” Reflective diary

Among themselves the nurses discussed and labeled observations regarding residents and their care problems and behavior differently, as compared to when they were talking to the physician during bedside consultations. Mrs R’s wish not to live anymore changed into a swallowing problem. We found there were occupational subcultures within the nursing home, related to the different professions, in which behavior of residents was given different meaning, depending on the frame of reference within the occupational subculture (ie, nurses and physicians). This was observed several times in situations with other residents.

Discussion

We explored how spiritual needs are assessed and spiritual care is provided to Dutch nursing home residents by multidisciplinary teams, and if and how caregivers, including physicians, nurses, and other staff communicate and collaborate in addressing the residents’ spiritual needs. To focus our observations, we started from sensitizing concepts derived from our earlier systematic review, which resulted in a global conceptual framework.23 We did not observe any formal spiritual end-of-life caregiving during our study, such as communication between the physician and the spiritual counselor on spiritual needs of the resident or a mention of spiritual needs in the care plan. The spiritual counselor chose not to present herself or the unit in an informal way, which may have contributed to the informal spiritual end-of-life caregiving, but it may also have impeded formal communication with nurses or physicians on spiritual needs. In interviews, we asked the physicians what they needed to facilitate the assessment of spiritual needs and spiritual caregiving. One of the physicians referred to the need for additional training and guidelines as part of their vocational training to become an elderly care physician. In our focus group study,24 this was also underlined by the participating elderly care physicians. The vocational training for elderly care physicians includes a curriculum on end-of-life care, but it does not address the assessment of spiritual needs or (the coordination of) spiritual caregiving.

We did observe many informal examples of spiritual end-of-life care. The goal of these informal caregiving activities appeared to be to help the resident die peacefully, to complete his or her life and his or her relationships with loved ones. Based on our systematic review,23 we developed a model on spirituality at the end of life that captures these aspects in the dimension Spiritual Well-Being, which is the outcome of spiritual caregiving. According to this concept of spirituality, the nurses provided spiritual care by helping the resident to complete her life (Mrs P); to emphasize the purpose and meaning of life (Mrs G); to die at peace with loved ones (Mr K); and by providing spiritual activities that contribute to spiritual well-being (Mrs J).

The nurses even supported the residents in completing meaningful relationships with loved ones outside their professional role. We label these initiatives as informal care, because these issues were addressed by the nurses on their own initiative and were not discussed in formal meetings, such as multidisciplinary team discussions. The spiritual counselor may also contribute to spiritual well-being at the end of life by turning to spiritual resources, for example, spiritual beliefs and spiritual activities, such as praying or meditating, and by relating to the resident on a spiritual level. These aspects of spiritual caregiving at the end of life were not observed during our study.

No major differences were found between the psychogeriatric unit and the somatic unit. We observed the same informal resident-oriented spiritual care activities. In this respect, our findings are in line with those observed by The and colleagues in a similar setting.24 The nurses confirmed this resident-oriented approach in informal discussions during coffee breaks, during our observations, and in a formal interview. Many physical progressive and chronic diseases also involve cognitive impairment (eg, stroke, Parkinson disease, and multiple sclerosis). This may partly explain why nurses used similar strategies in their approach of residents suffering from dementia and residents with physical disabilities. Furthermore, the resident-oriented caregiving seemed to be tailored to the specific cognitive possibilities and spiritual needs of the individual resident. For the nurses, residents, and relatives, moving a resident to the “special room” symbolized that a resident would die soon. This move denoted the last stage of the resident’s life and signaled the need to support each other (nurses, relatives, and sometimes the resident) in sadness and joint preparation for the death of the resident.

In several situations, we could distinguish psychosocial and spiritual aspects in the patients’ needs. The nurses and physicians did not make this distinction. In her study, MacKinlay24 also found that “there is an overlap between psychological and spiritual dimensions,” and that “spiritual needs assessed and diagnosed as psychosocial will not be met by appropriate strategies.” This differentiation between psychosocial and spiritual aspects should be included in additional training for elderly care physicians.

Spiritual caregiving in this particular Dutch nursing home may differ from such caregiving in other places and countries. In their comparative study on physician presence in nursing homes for residents with dementia and pneumonia, Helton et al16 showed that the physicians in Dutch nursing homes spend significantly more practice time in the nursing home than their US counterparts. This means they report significantly more symptoms, know the staff and their
oriented approach, with respect and kindness toward the resident. In our study, we found occupational subcultures within the nursing home, with different “languages” within the subcultures (i.e., the language of the nurses among themselves, and the language between nurses and physicians). In the example of Mrs R, the nurses believed the resident was communicating that she felt her life was completed. They did not want to force her to continue to live by forcing her to eat, and Mrs R was in no position to stand up to them. The nurses discussed this moral dilemma among themselves. However, in their communication with the physician, the nurses downplayed their worries, maybe even replaced them by a physical problem, dysphagia, thus bypassing the discussion and collaboration by nurses and physician on a possible spiritual need. Her-togh and The describe a similar example, in which the nurses’ experience of the behavior of the resident also differs from the way the physicians and the psychologists explain this behavior. It is important that physicians are aware of these different occupational subcultures within the nursing home and the frames of reference and “languages” that define them. These different frames of reference may make it difficult to communicate and fully address every dimension of a symptom.

We found the nurses to be adequate in supporting the residents and their loved ones and in meeting their spiritual needs. According to our concept of spirituality, resident-oriented care supported the spiritual well-being of the resident. Informing other disciplines within the nursing home culture of the importance of the informal resident-oriented care may help develop curricula that address palliative care in all its aspects.

Limitations and Generalizability

This study was performed in a single nursing home, situated in the northern part of the Netherlands. In a previous focus group study,18 we identified cultural differences between the participating physicians in the northern and southern parts of the Netherlands. The Roman Catholic cultural background predominates in the southern part of the Netherlands. The Protestant background, with iconoclasm as part of its cultural heritage, characterizes the northern part. Spirituality seemed to be a more integral part of life and of caregiving in the southern part of the Netherlands: the participants seemed to be more at ease with spiritual issues. These cultural characteristics may have influenced the results of our study. The findings of this study are not generalizable beyond the context of this nursing home in the northern part of the Netherlands.

Conclusions/Recommendations

We found that spiritual issues were only informally addressed by nursing staff and were not translated to the formal care process of residents suffering from dementia, as well as residents with only physical disabilities. Our results show occupational subcultures within the nursing home, each subculture using a different language. This raises questions about the communication on spiritual end-of-life care between disciplines, and if and how this communication contributes to the spiritual well-being of the resident. Informing other disciplines within the nursing home culture of the importance of the informal resident-oriented care by the nurses may enrich the formal multidisciplinary diagnostic and therapeutic approach. The informal resident-oriented care was instrumental to the residents’ spiritual well-being. Further research is required to determine the best way to reinforce an approach that improves spiritual well-being, is resident-oriented, and involves being respectful and kind toward the resident. As the elderly care physicians have a leading role in the multidisciplinary team approach in Dutch nursing home care, examining the educational needs of physicians with regard to spiritual caregiving may help develop curricula that address palliative care in all its aspects.

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