

Workshop No. 9c - Congress Oncology Nursing Society of Switzerland 29th March, Berne

Developing a support model for nurses working in extended community practice

Susan Fletcher BA BSW MSW
Senior Social Worker

Abstract

Much of nursing practice involves working with people in intimate, emotional and often distressing care situations. The anxiety generated by this work has been traditionally 'contained' by employing strategies such as, professional socialisation (the concept of the good nurse), structuring the work into tasks and encouraging a team approach to support.

This research project identifies the new nursing field of extended community nursing practice (programs such as drug and alcohol withdrawal) where nurses are finding themselves in more 'counselling-type' roles, typified by an increase in the emotional intensity of the engagement in the nurse-client relationship. In this new environment the old skills, strategies and support frameworks are no longer sufficient

The aim of this research was to design and evaluate a program, comprising of a series of supervision sessions (based on a social work model) to meet the developing needs of nurses in this new practice field.

Findings include;

- The concept of extended community care practice
- The need for relevant theory, skills enhancement and the provision of a supportive space
- Highlighting the hidden sorrow inherent in nursing
- Illustrating the relevance of inter-professional research

The small sample size means that there are important restrictions on generalising the findings. Nevertheless, the findings highlight the need to develop a support model that can respond to the needs of these nurse practitioners.

Introduction

The field of health work has long been recognised as containing 'emotional zones' (Fineman, 1993) and the important contribution of skilled emotional management is being acknowledged increasingly as a valuable part of the nursing process. Hochschild (1983) coined the term the 'managed heart', later referred to as 'emotional labour' (Bullan, 2000) to *'stress that a professional carer's skill lies not only in the accomplishment of technical tasks, but also in the creation of the 'correct' emotional climate. The word 'labour' used in conjunction with 'emotion' emphasises that the caring aspects of a nurse's role can be hard and productive work, in a similar way to physical and technical labour and therefore should be equally valued'* (Bolton, 2000)

Hochschild (1983) further describes the 'something extra' that nurse may add to the relationship with the client as a 'gift'. In offering this 'gift' nurses risk involving themselves at a deeper emotional level in stressful care situations. Bolton (2000) says that this means that they also have to work *'extra hard to enact professional feeling rules and present the image of the professional carer. In this way nurses must work doubly hard on their emotions'*

Background

The community health sector has developed over the last 30 years. Initially the largest community health workforce consisted of district nurses and mental health nurses, providing curative, preventative and social support activities to people in community settings or in the client's home. Increasingly there is evidence that a holistic and comprehensive community approach to health, where a focus on psychosocial and mental health is included with physical care, is more effective in improving health and wellbeing (Brown et al, 1999, Smith, 2000, McDonald and Smith, 2001)

Recent developments have seen this concept of community health provision extended to programs such as drug and alcohol withdrawal, enhanced maternity and the addition of palliative care to district nursing teams. These programs typically involve a sole nurse practitioner working intensely with clients, usually in the client's home. Even though the interventions are usually time limited (in the case of drug and alcohol withdrawal it is seven visits over a two week period), the clientele frequently represent to the service, thus extending the engagement and deepening the relational aspect of the care.

The development of a chemotherapy program in this region illustrates the challenge to the nurse working in this new practice field. Until the last four years clients exhibiting symptoms would be admitted to the hospital with an acute episode where x-rays and scans would either confirm or suggest a cancer diagnosis and they would quickly be sent on to larger (usually specialist urban) hospitals for further investigations and treatment. The stress of travelling long distances to treatment on clients and families was recognised and a treatment program was developed locally – nursing staff were trained and a visiting oncologist enlisted to offer this treatment closer to home.

This program has proven very successful for clients and families but nursing staff in the program began accessing private counselling sessions to deal with a range of unmet support needs. As one of these counsellors, this researcher has learned that the issue for nursing staff in this program was not so much the nature of the illness (although that of course played a part) but the fact that the nurses were forming an ongoing relationship with the client and their family, journeying through the ups and downs of the treatment process and having to adjust expectations as they moved from active to passive treatment when the cancer developed into the palliative stage. The nurses reported a much deeper sense of loss than when they barely had time to connect before the patient left for another hospital, only reappearing if they chose to spend the last stage of their life in our hospital. Nurses often described identification issues, such as the client 'being of a similar age', 'reminding them of a family member', death anxiety about 'finishing up like this' or 'just working their way into my heart' to explain why they felt overwhelmed by the intensity of the relationship they had developed with some of these clients.