Nursing Patterns of Knowing in Dementia Care

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Do nurses require specialized knowledge in order to provide good care for those with dementia in residential care? My aim in this paper is to examine this question with an interest that stems from my work in a long term care facility and my current role as an advanced practice nurse. I will provide a brief overview of dementia and the role of residential care and then in the context of this setting I will review Carper’s patterns of knowing along with the other ways of knowing that have been identified by other nurse scholars since Carper’s seminal work.

Dementia and Residential Care

The population to be discussed in this paper include those with dementia in residential care. Dementia is not a normal part of the aging process, rather it is a group of degenerative neurological diseases that results in impairments in memory, thinking, orientation, comprehension, calculation, learning capacity, language, judgement and executive function to a degree sufficient to affect daily activities (BCMA, 2004; Provincial Dementia Service Framework Working Group, 2007). While dementia is not a normal part of aging, the risk of developing dementia increases with age, therefore, as the population’s ages the number of people with dementia will increase (Provincial Dementia Service Framework Working Group, 2007). Dementia progresses through the stages of mild, moderate and severe and the amount and type of care that is needed changes throughout the stages. Once a person has reached the severe stages of dementia, they typically require twenty four hour care and supervision (Provincial Dementia Service Framework Working Group, 2007). For many people who have dementia, residential care is eventually a reality (Knopman, Berg, Thomas, Grundman, M, Thai, & Sano, 1999). The
knowledge that informs the nursing care that people with dementia receive once in residential care will be examined as this paper progresses.

**The Patterns of Knowing**

It is a testament to Barbara Carper that her seminal article entitled “Fundamental Patterns of Knowing in Nursing” written in 1978 continues to be discussed as a framework for epistemology in the discipline of nursing. In this work, Carper identified four patterns of knowing including empirics, ethics, aesthetics and personal knowing and claimed that these form the basis of nursing knowledge (Thorne & Sawatsky, 2007). This article has been referred to as one of the most influential articles in nursing in the twentieth century and the patterns of knowing have been identified as an appropriate way for nurses to organize and reflect upon their knowledge (Johns, 1995; Wainwright, 2000). When Carper’s work was published it was viewed as a shift from a reductionist perspective into a more humanistic view of nursing that illustrates the complexity and diversity in nursing knowledge (Heath, 1998; Zander, 2007). While this article continues to be referred to it has not been blindly accepted by nurses or nursing scholars, in fact, quite the opposite has occurred. There have been many who have criticised and commented on this work and while the summary of criticism extends beyond the scope of this paper, suffice it to say that there are comments relating to definitions of the ways of knowing as well as criticisms related to dividing knowledge into sections rather than a holistic view of knowledge acquisition (Johns, 1995; Porter, 2010; Wainwright, 2000; White, 1995). In addition to critical viewpoints, there are nurse scholars who have built on to Carper’s work including Munhall (1993) who described ‘unknowing’ as a pattern of knowing as well as White (1995) who identified ‘sociopolitical’ as yet another way of knowing in nursing. There are others ways of knowing that have been identified including ‘experience’ and ‘intuition’ (Zander, 2007)
however these will not be expanded on in this paper. Like others who have added on to Carper’s four ways of knowing, I propose the notion of ‘historical knowing’. I define historical knowing as that knowledge that nurses have in their area of practice illustrating changes over time. In the time that I have been interested in residential care of those with dementia, I have observed that the pervasive beliefs of the time dramatically affected knowledge and therefore care practices. I will now review care of the elderly with dementia by referring to Carper’s patterns of knowing, Munhall’s unknowing and White’s socio-political knowing, beginning with my own proposed ‘historical knowing’ in dementia care.

**Historical Knowing in Dementia Care**

I am interested in the history of residential dementia care as it illustrates the origins and evolution of knowledge and subsequent practice in this area of nursing. This historical overview of dementia care in North America is by no means exhaustive, however, it highlights a part of history that is rather telling as to how nurses came to be where they are today. In the early 1900’s it was common for families to care for their elders however as families began to move to different geographic areas to work, the elderly with dementia began to be institutionalized (Lacey, 1999). Those institutionalized elders with dementia were placed in either mental hospitals or housed in almshouses or poorhouses and while neither setting was ideal, the almshouses were typically dirty, crowded and known for abusive care (Lacey, 1999). This population remained in almshouses longer than other populations who were transitioned to other forms of care, likely due to limited options otherwise. Between 1900 and 1940, many seniors with dementia were moved to mental hospitals and it was during this time that the “medicalization of institutional care” occurred (Lacey, 1999). While the movement from a poor house to a hospital would be somewhat of an improvement, this population was not acutely ill
but needed around the clock care for meeting their basic needs. In the period between 1940 and 1950, the nursing home was created and because of the influence of hospitals, nursing homes simply adopted the hospital based system of care (Lacey, 1999; Morris, 1995-1996). By the 1960’s and 70’s the focus of care changed somewhat from “warehousing” the elderly with dementia to trying to find methods of rehabilitation and improving the quality of life. It was during this time frame that therapies such as horticulture and music therapy for the elderly with dementia began (Lacey, 1999). While there were strides made at this time, the central focus in care homes were medical problems and ways to efficiently manage these people. The very name ‘nursing home’ illustrates that the focus was on the nurses who care rather than the people who live there. In nursing homes with a biomedical, positivistic care model, the nurse would relate to a person through their diagnoses or disease and this focus would lead to a further focus on the appropriate therapy, usually pharmacological, as their primary care (Hill, 2008; Penrod, 2007). In this model of care, nurses focused on the inability of a person rather than the ability and this focus was again on the physical element of the person at the expense of the psychosocial, spiritual needs of the individual (Chenoweth et al., 2009; Coker, 1998). Much of what we know about the efficient running of nursing homes came from this time (Bergman-Evans, 2004). However, it became apparent to certain individuals, such as Kitwood who will be discussed later, that while the physical needs of those in care were being met, the emotional, social and spiritual needs were neglected (Gaspard & Garm, 2009; Hancock, Woods, Challis & Orrell, 2005, Nazarko, 2009). It was apparent that if the focus was on the disease the ‘person with dementia’ was lost. A holistic model of care was needed for this population and this began the shift towards person-centred care.
Person-centered care is a model that changes the focus from institutional and biomedical goals to the individual needs of the person in care and is increasingly viewed as the ideal model for residential dementia care (Brooker, 2004; Chenoweth et al., 2009; Gaspard & Garm, 2009; Nazarko, 2009; Price, 2006; Robinson, 2007). A recent document published by the Alzheimer Society of Canada states that a priority policy option for Canada is to “create national person-centered standards for care facilities” (Alzheimer Society of Canada, 2010, p. 51). The earliest author of the concept of person-centered care in dementia was Thomas Kitwood. Kitwood defined person-centred care as care that values the individual, attempts to view the world from the individual’s perspective and creates a positive social environment for every person to reside in. (Brooker, 2004). Thomas Kitwood was a pioneer in dementia care and his ideas were pivotal in changing the thinking and ‘knowing’ around dementia care (Hill, 2008). A central component to Kitwood’s theory was the concept of ‘personhood’ which is defined as the status that is given to one human being from another that implies value, respect, and trust and recognition (Kitwood, 1993). Embedded in person-centred care is the notion of upholding one’s personhood and it has implications in care situations in that it encourages us all to ensure that dignity and respect of the resident is maintained.

Thorne and Sawatzy (2007) claim that nursing knowledge is informed by the patterns of knowing as well as the ideologies in nursing and health care. Person-centred care, is an ideology that is increasingly spoken about in health care (Alabaster, 2006; Clayson, 2007). While some may be concerned that person centered care is rhetoric and overly idealistic for practice, I have seen person centred care implemented and feel strongly that this is an ideology that is beneficial to those in care and can be implemented with success. I also believe that person centred care can co-exist with evidence based practice. This belief comes from what I have seen in practice
and read in research as person-centred care has driven research into areas where there are discrepancies between what is (actual practice) and what should be (practice influenced by person-centred care). It is this variance that is responsible for some of the positive changes that I discuss when focussing on empiric knowledge later in this paper.

In reviewing the ‘historical knowing’ of care for those with dementia up until the contemporary ‘person centered care model’, I aimed to provide a context for nursing knowledge development of this population. Nurses generally are the professionals that lead the care in residential care settings they are pivotal in shifting a care facility from an “institution” to a “home” that is person-centered. The focus on person-centred care has had an enormous impact on the knowledge development and translation in nursing and this will be explored further as the other ways of knowing are described.

**Empirical Knowing in Dementia Care**

Carper (1978) noted that the discipline of nursing was experiencing a sense of urgency to develop empirical knowledge that explains and predicts phenomena specific to nursing. A driving force of this was for nursing to be viewed as a profession with a unique body of knowledge (Risjord, 2010). Empirical knowing refers to the knowledge that is quantifiable, objective, and testable as well as the theoretical frameworks upon which nurses base their practice (Zander, 2007). The nursing knowledge needed to care for those with dementia is extensive, particularly as the disease advances and residents are unable to communicate due to cognitive loss. Nurses require a strong knowledge base in pathophysiology, medications, cognitive assessments, pain management, rehabilitative and behaviour management strategies (Chang et al, 2009; Williams et al., 2005). While nurses need a strong knowledge base in all of
these areas, there are also some shifts taking place in ‘taken for granted’ knowledge as a result of the shift towards person-centred care. Two areas that are under scrutiny with the lens of person centered care include the empirical knowing relating to bathing and the knowledge related to the use of restraints in residential care. In addition to clinically oriented knowledge, those who work in dementia, have theoretical frameworks and underpinnings. Nursing for this population relies not only on the theoretical framework of person-centred care, but also draws upon other nursing theories.

Earlier I reviewed the historical evolution of nursing homes to provide a context of how knowledge has been influenced by historical changes in philosophy. The beliefs and understandings of the past have dramatically affected the way in which nurses have developed knowledge around caring for the population of older adults with dementia. The early ‘institutional’ focus encouraged nurses to provide care that focussed on the physical needs of the person, at times as great cost to the spiritual or emotional needs of an individual. While person centred care is not specific to nursing and is an underlying philosophy that guides all practice, it has encouraged nurses to question practices that were once taken for granted. In January 2011 the Alzheimer Society of Canada made public a document entitled “Guidelines for Care: Person Centred Care of People with Dementia Living in Care Homes”. This document clearly outlines the expectations and philosophy of care beginning with the statement “The Alzheimer Society believes that people with dementia have the right to enjoy the highest possible quality of life and quality of care by being engaged in meaningful relationships which are based on equality, understanding, sharing, participation, collaboration, dignity, trust and respect” (Alzheimer Society of Canada, 2011, p. 9). This statement identifies the importance of a need for ethical care as well as meeting other more physical needs in a respectful and dignified manner. This
stance is very important and holds up the expectations for nurses and very importantly, it guides practice and further knowledge development in nursing. The publication by the Alzheimer Society of Canada notes that bathing should be completed in a way that is person centred (Alzheimer Society of Canada, 2011). While this may appear to be common sense, to anyone working with the care of those with dementia, this is a large step forward. For certain individuals with moderate to advanced staged dementia a tub bath is often viewed as extremely frightening (Rader et al., 2006). I have heard residents talk about the fear of being put into a vat of boiling oil when being placed into a tub with the ‘therapeutic jets’ working. Despite these fears, forced bathing has been an accepted practice for years which is likely an unfortunate residual practice dating back to the days when physical care outweighed the psychological or spiritual aspects of the person. However, now with the lens of person-centred care this is viewed in a different light. Forced tub bathing has been challenged by nurse researcher, Joanne Rader, who lead led a research team that investigated the need for tub bathing that was able to show with good evidence that microbes are removed from other forms of bathing equally or at times better than tub bathing. This research concluded with the message that forced bathing could and should end in residential care (Rader et al., 2006). Nurses, now have the evidence to challenge and finally put an end to forced bathing in the care homes where they work.

In addition to forced tub bathing, another area of knowledge that is being challenged with respect to person-centered care is the use of chemical restraints which are psychotropic medications that are used as a means to reduce a residents function or behaviour. It is interesting to note that while physicians visit nursing homes to see their patients, it is primarily nurses who lead and manage care in these settings. As noted earlier, nurses hold a significant amount of knowledge about each resident, their disease and prognosis, their medications and as well as their
family situation. Nurses are able to impact the care of those with dementia more than physicians can due to the fact that physicians are unable to alter the environment or the approach whereas this is within the scope of nursing. That being said, it is often nurses that request physicians orders for psychotropic medications for the residents if they are anxious, agitated and/or wandering. While many nurses attempt environmental or care interventions first, there still appears to be a heavy reliance on chemical restraints in residential care which is concerning as these medications are linked to an increase in falls that result in fractures, sedation, hypotension, delirium and other negative side effects (Moore & Haralambous, 2007). A recent publication in a Victoria magazine indicated that the use of psychotropic medication in British Columbia is higher than other areas in Canada (Wipond, 2011). With the guiding principles inherent in person centred care that include truly knowing each resident and how to meet their needs through environmental or care, I believe that the use of psychotropic medication as chemical restraints needs to be carefully reviewed with a real effort made towards the reduction of use of these medications.

The use of physical restraints is another area where the principles of person-centred care can shift knowledge in dementia care. In April 2009 nursing homes across British Columbia began tracking their restraint use in the Resident Assessment Instrument that was mandated by the BC Ministry of Health. When those statistics are available, it is likely that there may be concerns about the use of restraints in residential care. Physical restraints have been used extensively in care in the past although there are many who recognize the need to decrease their use in residential care and have had success with education (Pellfook, Gustafson, Bucht & Karlsson, 2010) Physical restraints raise ethical issues relating to the autonomy of the individual patient as well as nonmaleficence issues as the use of restraints has caused harm (reduced mobility, skin
breakdown, as well as psychological damage) including deaths in persons in care (Mohr, 2010). Similar to chemical restraints more work is needed to create physical restraint free environments in residential care. It is important to note that the philosophy of person centred care will provide a theoretical framework guiding practice for nurses in residential care to find ways that meet the individual needs of each resident. While there are some instances where restraints are unavoidable as in the case when others are being harmed by a resident who is acting in a responsive or a protective manner, in most instances there are alternatives to the use of restraints when the underlying needs are recognized and then met.

In addition to the clinical knowledge related to dementia care that has been discussed, there are theoretical frameworks that guide care and are aligned with person centred care. The notion of ‘personhood’, while perhaps not labelled as such, has been central theme in many nursing theories. “Because nursing is an activity carried out by persons with other persons, no nursing theory can give an account of itself without giving something of an account of what it means to be a person” (Green, 2009, p. 265). Nursing theorists Hildegard Peplau and Martha Rogers maintained that a human being was a unitary being that interacted with others and these relationships were critical (Green, 2009). And while one could look at numerous nursing theorists, Parse’s Theory of Human Becoming captures the essence of what each person values and holds true for themselves which is very much in line with personhood (Green, 2009). Retaining a person’s sense of personhood is linked very highly to quality of life for that individual. Quality of life for a person with dementia in residential care is as important as their safety and physical care. Parse informs us to encourage and invite the client to explain how they envision their health, their own circumstances and how they define quality of life or what is important to them (Parse, 1997). With Parse’s theory, residents are viewed as co-participants in
their own health and as experts as to how things should happen to meet their definition of quality of life (Parse, 1997). “In the human becoming perspective, nursing is not defined by knowledge but is, instead, focused on the nurse-person relationship. The person, rather than the nurse, is the expert concerning health and quality of life because only the person living the life can define it’s quality” (Saltmarche, Kolodny & Mitchell, 1998, p. 81). Although those with dementia have memory issues and other cognitive losses, residents with dementia retain the right to make the choices that they are still able to make. This may include eating a particular food, or whether they accept or refuse medication, or whether they prefer a tub or bed bath. Person centered care is in alignment with Parse’s theory in that it encourages nurses to listen to the person and adapt nursing care to meet residents individual needs which results in good care. I view Parse’s Theory of Human Becoming as relating to the issue of quality of life as it defines quality of life according to each person’s definition and in the end there is no better means to determine this.

The movement towards person-centred care is, in my view, a humanistic, ethical shift that is resulting in improved care by all team members in these settings. The evolution towards this framework is changing expectations in residential care and simultaneously knowledge development is also becoming more in line with this philosophy of care. While there are areas where improvements are still needed including the use of restraints in care, these areas are under scrutiny for change with the model of person-centred care as a guiding philosophy.

**Esthetical Knowing in Dementia Care**

Esthetic knowing requires that the nurse interprets and understands behaviour as a whole to form an empathic understanding (Zander, 2007). Empathy, or the ability to deeply understand what another is experiencing, is critical to good nursing care is very much a part of person centered care (Kitwood, 1997). Carper (1978) notes “the more skilled the nurse becomes in
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perceiving and empathizing with the lives of others, the more knowledge or understanding will be gained of alternate modes of perceiving reality” (p. 17-18). There has been work done in research in dementia to learn what behaviour means and how this can inform practice. Kontos and Naglie (2007) explored the use of imagination as a strategy in person-centered care through the use of videotaped vignettes of observed events on a dementia unit (using actors) and then created six focus groups to discuss the drama. These researchers found themes emerging including the fact that through the use of imagination sympathetic connections were present between the viewer and the actor as well as a shared bodily experience which enabled the nurse to understand the actors behaviour more than they had prior to the experience. Although the use of imagination is not a strategy that is often discussed in health care, Kontos and Naglie (2007) provide rationale for its use with those with later staged dementia in gaining an understanding of what that person is experiencing.

By the imagination we place ourselves in [a sufferer’s] situation, we conceive ourselves enduring the same torments, we enter as it were into his body, and become in some measure the same person with him, and thence form some idea of his sensations, and even feel something which, though weaker in degree, is not altogether unlike them (Kontos & Naglie, 2007, p. 562).

While imagination may be an unusual nursing intervention to use, being able to understand the experience of a person with dementia is a central component of being able to implement person-centered care into practice. Rasin and Kautz (2007) supported this claim stating that “person centered knowledge included the recognition that resident’s behaviour was influenced not only by the disease process of dementia, but also by their feelings, social and
emotional needs and past experiences” (p. 34). Therefore person-centered care requires caregivers to understand behaviour by finding the meaning behind it and to provide care that is responsive to that individual’s needs which I believe is what Carper would identify as esthetical knowing in nursing.

**Personal Knowing in Dementia Care**

Carper (1978) refers to personal ways of knowing as being the knowledge about individuals that provides a sense of awareness and understanding. Personal knowledge requires that nurses are engaged with their patients and have a connection with them (Zander, 2007) As dementia advances, residents are often unable to articulate their thoughts and feelings and therefore, strategies are needed to develop this ‘personal knowledge’. The literature provides some insights into how nurses often learn about their residents well. These include 1. continuity of care where nurses consistently look after the residents, 2. involving the family in care, and 3. the use of life stories. These methods provide a means to learn about the residents well and develop a sense of knowing about the person with dementia. Residential care nurses who know the residents they care for become ‘tuned into’ their residents and often pick up on changes far before others who are farther away from the person can. In order to gain this knowledge, the literature points to the need for consistency in staffing. (Dowling, 2007; Rasin & Kautz, 2007). This is an organizational issue that has a major impact on the care that residents receive (Dowling et al., 2007) as does the impact of having family involved in care. Families are critical in dementia care as often the person with dementia loses the ability to communicate as the disease process continues. Families or friends who have known the residents well become the link from the past to the present. Coker (1998) found that one of the key barriers to the nurses not being able to find key information about a person was that family were not present at
admission or throughout the residents’ time in the residential care facility. Families and close friends are important not only for key information relating to care, but families are often the link to the resident’s life stories. Unfortunately, as dementia progresses, one’s ability to retrieve these memories and communicate them to others diminishes. Every person has a unique life story and in order to provide true person-centered care, nurses need to know these stories (Coker, 1998; Clarke, Hanson & Ross, 2003). Egan et al. (2007) noted that the use of life histories can increase quality of care for those with dementia and may also decrease aggression as nurses learn more about the person including the triggers that may result in that person responding in a responsive manner. The process of obtaining a life history is also therapeutic in that the very act of listening to a story tells the person that they are worthy of this effort and they have value (Clarke et al., 2003, p. 698). Therefore, there is therapeutic meaning simply in spending time with a person obtaining the life history in addition to learning key information that can contribute to person-centred care.

Thorne and Sawatsky (2007) point out that in addition to knowing the person in care well, the nurse must have knowledge of his/herself. Dementia care is often difficult as it requires patience, perseverance, critical thinking and a genuine caring about others. Those that have these qualities, know their strengths and weaknesses and have an interest in providing care for individuals with dementia, are often much more able to give care that meets the residents needs. It is interesting that personal knowing is linked to ethical knowing which is discussed next.

**Ethical Knowing in Dementia Care**

The care of those with dementia in residential care is filled with ethical decisions as the dementia progresses. One author refers to this area of care giving as “walking a tightrope” (Martin, 2003, p.24), where caregivers must constantly strive to provide respectful, appropriate
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and responsive care; preserve a person’s autonomy; provide a safe environment and at the same time, honour an individual’s personhood (Hope, 2009; Woods & Pratt, 2005). Ethical knowing is considered the moral aspect of knowing and relates to being concerned with acting in a morally correct manner (Carper, 1978; Zander, 2007). Nurses who care for older adults with dementia work with an extremely vulnerable population and have been entrusted to provide safe and ethical care. The principles of autonomy, beneficence, nonmaleficence and justice come into play and at times are at odds in many situations where there are no right or wrong answers but rather nurses are prompted to look at each case individually and with the context in view. An example of this is the determination of a resident with dementia to refuse care – how does a nurse meet the principle of autonomy (right to choose) when he/she is there to promote safety and health and wants to do no harm (nonmaleficence)? Providing care for those with dementia is rewarding in so many ways but it is also an ethical quagmire for care providers. Nurses are guided ethically by their own facilities policies but are also guided by the overarching Canadian Nurses Associations “Code of Ethics for Registered Nurses” 2008, which provides a foundation for nurse’s ethical practice. The ethics inherent in the model of person-centered care are also an ethical guidepost of care that encourages all members of the care team to reject approaching the resident as an object and strive instead to actualize an authentic personal relationship between two persons (Kitwood, 1997). This may also be considered a form of relational ethics, which according to MacDonald (2007) “focuses on the role of relational context or the experience of relationships in influencing moral choices” (p. 123). Bergum (2004) further expands on this and articulates relational ethics as the ethics involved in every day interactions with people where the nurse must respond in a way that resonates with his/her moral compass in mind. “In the end, it seems that relational ethics is really about understanding and knowing ourselves as we engage
with others. In nursing and in health care, the particular environment of health and illness is a profound and important means by which we confront ourselves in a community of other people within a focus of relationships” (Bergum, 2004, p. 502). In the context of providing care to those with dementia, as alluded to earlier, personal knowing, where the nurse is aware of the history, preferences, care abilities and needs of the person they are providing care for is linked closely with relational ethics.

**Unknowing in Dementia Care**

Munhall (1993) proposed a way of knowing called ‘unknowing’. Unknowing refers to the nurse acknowledging that he/she does not know all there is to know about their patient or their patient’s situation remains open to learning more. “This position of openness is necessary in order to understand the complex realities of people and their world-view” (Zander, 2007, p. 9). Nurses who work in dementia care need to be aware of the areas where they need further knowledge and make an effort to learn more. Unknowing creates a sense of learning readiness and is seen as an optimal situation for knowledge translation between research and practice (Heath, 1998). I also view unknowing as being important element in developing research questions. Nurses who are working in this area as well as those who support them, such as advanced practice nurses, are in a place where they can identify areas where further research is needed. Knowledge development is a continual process that stems from the identification of that which is ‘unknown’ to the known.

**Socio-political Knowing in Dementia Care**

The final pattern of knowing that I will discuss is socio-political knowing described by White (1995). White (1995) states that nurses need to be aware of the socio-political context of caring that affects the person he/she is looking after as well as the context of nursing in society and how it has the
power to influence health care decisions. While individual nurses may not need to become politically active if they are not so inclined, they need to be informed about the context of their own profession and how their patients are affected by their social reality. We live in a society that values youth and cognition and elderly with dementia are one of the more marginalized populations in our society (Kane, 2002; Kitwood, 1997). When looking at the context of elderly with dementia, the overriding social element that is addressed in the literature is the “stigma” attached to dementia (Kitwood, 1997). This stigma exists across the health care sectors in community, acute care and in residential care. It’s devastating outcome is that it may potentially lead to the person with dementia and their caregiver to become socially isolated at a time when they most need support. There are also stigmas attached to dementia and those within long term care facilities (Dobbs, et al. 2008). The dementia journey begins with the awareness that there is a problem, eventually to a diagnosis, issues relating to managing at home and then to the later stages of the disease where many choose residential care. Therefore a family may be struggling in the community but when a bed finally becomes available, the families agonize over admitting their family member due to feelings of guilt, sadness but also due to this stigma. Indeed, nursing homes are often viewed as a last resort for those requiring care and their caregivers (Noonan, Tennstedt & Rebelsky, 1999) In addition, there is also inadequate funding for current residential care in addition to a lack of beds for those with dementia (Provincial Dementia Service Framework Working Group, 2007). As a result of inadequate number of long term care beds, there are long waiting lists and by the time a person with dementia moves into residential care they are generally quite progressed in their dementia process. In addition, the person caring for them will often be facing caregiver burnout. This has implications in terms of the care needs of the resident as well as the emotional support and understanding the caregiver will require. Often caregivers are exhausted and emotional at the time of residential care placement and nurses need to be empathetic and understanding of their experience. As a result of this, residential care is very much
affected by the socio-political conditions and I agree with White that this way of knowing is very important.

**Summary**

At the beginning of this paper I asked the question if nurses who work with those with dementia in residential care have specialized ways of knowing that enable them to provide good care. Although alluded to throughout this paper, it seems appropriate to clarify what I mean by ‘good care’. It is my belief that good care is that which results from knowledge in all of the areas that have been described in this paper but perhaps what is essential is that, to quote the words of Tom Kitwood, “good care ... is highly respectful of personhood” (Kitwood, 1992, p. 271). My hope is that through describing the patterns of knowing in the areas identified by Carper, Munhall, White and myself, I have illustrated that there is a specialized ‘knowing’ in this area of practice. While the ways of knowing were viewed as distinct sections, I view these as an integrated and cohesive whole. The philosophy of person centered care is an ethical standpoint developed in response to gaps in historical philosophies of care and is responsible for shifting knowledge development in all of the ways of knowing. Nurses who approach dementia care with a belief in the ethics inherent in the philosophy of person-centered care, understand and appreciate the empirics related to dementia care, have a sense of this population's socio-political environment and can identify and act upon areas where unknowing exists are able to provide the best care possible. Increasingly there is the acknowledgement and expectation that every person with dementia in residential care should receive compassionate and knowledge informed care that honours and upholds their personhood.
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