Case Study

Model of transpersonal caring in nursing home care according to Favero and Lacerda: case report

Modelo de cuidado transpessoal de enfermagem domiciliar de Favero e Lacerda: relato de caso

Modelo de cuidado transpersonal de enfermería domiciliar de Favero y Lacerda: informe clínico

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ABSTRACT

Objective: The aim of this paper is to report the experiences of applying a model of transpersonal caring in nursing home care according to Favero and Lacerda to adult patients after hematopoietic stem cell transplantation.

Method: This is a case report on the application of this model to an outpatient monitored by a bone marrow transplant service. In addition to the initial outpatient contact, the patient received home care visits in October 2014. Data were recorded in the field diary and analysed according to the Care Model and Clinical Caritas Process.

Results: The provided care served as support to meet basic human needs, and strengthen the belief system. It also promoted the necessary emotional care to cope with the treatment and professional maturity in the caring relationship.

Conclusion: The experience description revealed that the model can support the application of the Theory of Human Caring in home care and the use of care models in practice, professional training, and research development.

Keywords: Models, nursing. Home health nursing. Nursing theory. Nursing care.

RESUMO

Objetivo: Relatar a experiência da aplicação do Modelo de Cuidado Transpessoal de Enfermagem Domiciliar de Favero e Lacerda a paciente adulta pós-transplante de células-tronco hematopoéticas.

Método: Relato de caso da aplicação deste Modelo a paciente em acompanhamento ambulatorial em Serviço de Transplante de Medula Óssea. Além do contato inicial em ambulatório, foram feitos três encontros domiciliares em outubro/2014. As informações foram registradas em diário de campo e analisadas, considerando o Modelo de Cuidado e o Processo *Clinical Caritas.*

Resultados: O cuidado atuou como suporte ao atendimento das necessidades humanas básicas, fortalecimento do sistema de crenças, promoção do cuidado emocional para enfrentamento do tratamento e amadurecimento profissional na relação de cuidar.

Conclusão: A descrição da experiência permite inferir a contribuição do Modelo para a aplicação da Teoria do Cuidado Humano no cuidado domiciliar e a utilização de modelos de cuidado na prática assistencial, formação profissional e desenvolvimento de pesquisas.

Palavras-chave: Modelos de enfermagem. Enfermagem domiciliar. Teoria de enfermagem. Cuidados de enfermagem.

RESUMEN

Objetivo: informar la experiencia de la aplicación del Modelo de Cuidado Transpersonal de Enfermería Domiciliar de Favero y Lacerda a una paciente adulta postrasplante de células madre hematopoyéticas.

Método: informe clínico de la aplicación de este Modelo a una paciente en acompañamiento ambulatorio en Servicio de Trasplante de Médula Ósea. Además del contacto inicial en ambulatorio, hubo tres encuentros domiciliares en octubre/2014. Las informaciones fueron registradas en diario de campo y analizadas considerando el Modelo de Cuidado y el Proceso Clinical Caritas.

Resultados: el cuidado actuó como soporte a la atención de las necesidades humanas básicas, fortalecimiento del sistema de creencias, promoción del cuidado emocional para afrontar el tratamiento y madurez profesional en la relación de cuidado.

Conclusión: la descripción de la experiencia permite deducir la contribución del Modelo para la aplicación de la Teoría del Cuidado Humano en el cuidado domiciliar y la utilización de modelos de cuidado en la práctica asistencial, en la formación profesional y en el desarrollo de estudios.

Palabras claves: Modelos de enfermería. Cuidados de enfermería en el hogar. Teoría de enfermería. Atención de enfermería.

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INTRODUCTION

A Care Model (CM) is defined as the theoretical structure that interconnects the concepts, assumptions, and methodology of care. It is a set of fundamental concepts of nursing, healthcare, environment, and human beings, and assumptions supported by a theoretical and philosophical framework that aims to guide nursing care[1]. Because this instrument can systematically guide nursing care, its use must be promoted and inserted in the care activities of nurses[1-2].

In 2013, a Model of Transpersonal Nursing Home Care ("MCTED")[3] was created according to the Lacerda Care Process[4]. This model is based on Transpersonal Caring (TC) of the Theory of Human Caring[5] and on own assumptions from these references (Illustration 1). For TC to occur, the subjects involved in the care relationship must come together and connect, called the caring moment[5]. It also occurs through the Clinical Caritas Process (CCP) that comprises ten elements described by the theoretical foundations of Jean Watson for the scope of TC.

The caring moment is when TC occurs between the nurse and patient; the nurse influences the one-being-cared-for and is influenced by the one-being-cared-for[5-6]. In this sense, applying the MCTED can support the process of adapting to changes after hematopoietic stem cell transplantation (HSCT). Moreover, the growth and development of the nursing body of knowledge reveals the need to create and implement the care models that emerge from professional practice[7].

MCTED[3] had not yet been applied in practice at the time of this study, generating the following concern: How is the MCTED of Favero and Lacerda applied to patients after HSCT? To answer this question, the goal was to report the experience of applying the MCTED of Favero and Lacerda to adult patients after HSCT.

METHOD

This paper is based on a case report of the application of MCTED by a nurse of the bone marrow transplantation service to a 45-year old patient, codenamed M.G., after HSCT. The nurse visited the patient at home on three occasions for 2 hours each visit, on average, in October 2014. The home visits were based on the phases of Lacerda's Care Process[4]: initial contact, approach, transpersonal encounter, and separation. Data and records were collected after each visit. The care impressions and expressions were recorded in a field journal to subsequently produce a report based on the concepts, assumptions, the ten elements of the CCP, and the phases of the MCTED.

Data analysis was also grounded on the referential framework of the model, and the study observed the ethical precepts of human research[8]. Research was approved by the research ethics committee of the health sciences sector of the Universidade Federal do Paraná, decision 814.700. The subject signed an informed consent statement.

APPLYING THE MCTED IN THE HOME CARE PRACTICE

The **Initial Contact** phase refers to the first contacts between nurse, patient, and family according to the life stories of each subject[4]. This phase occurred at the outpatient unit and the provided nursing care was inherent in this phase. The continuity of care in the following phases is only possible when the principles, beliefs, and cultures of the subjects are respected and the role of the nurse is fully understood[9].

The **Approximation** phase was initiated in the first meeting. This phase is defined as an evolution in the relationship and where feelings, words, and touch occur. It is also where several issues are addressed and the nurse and patient move toward union[4]. In this phase and in comprehending the home context, the nurse needed to consider external and environmental factors, such as comfort, privacy, and convenience since the setting and energies that emanate from these factors are important coadjutants in reconstruction[10]. All measures to ensure privacy and prevent the presence of strangers were taken so M.G. could feel comfortable.

As advocated by CCP[10], all values, beliefs, and customs were respected. As established in assumption 6 of the MCTED, the nurse offered knowledge, empathy, altruism, respect for beliefs and individuality, sensitivity, and the genuine desire to be in a care relationship to provide home care and apply the theory of TC[3]. These characteristics had to be improved by exhaustively reading the theses that gave rise to the MCTED and its theoretical references[3].

The meeting was initiated by addressing physical aspects and stimulating the teaching-learning process since the care relationship is not merely ethical and scientific; it is also creative, behavioural, professional, and aesthetic[5-6]. This phase required professional scientific and technological knowledge, good interpersonal skills, and the ability to unite scientific and popular knowledge, and technical and sentimental knowledge[11]. The professional must be prepared for the wide range of situations that arise in the context of home care[9], and must unite the various fields of knowledge of the profession. The role of the nurse in HSCT was positive because it confirmed the

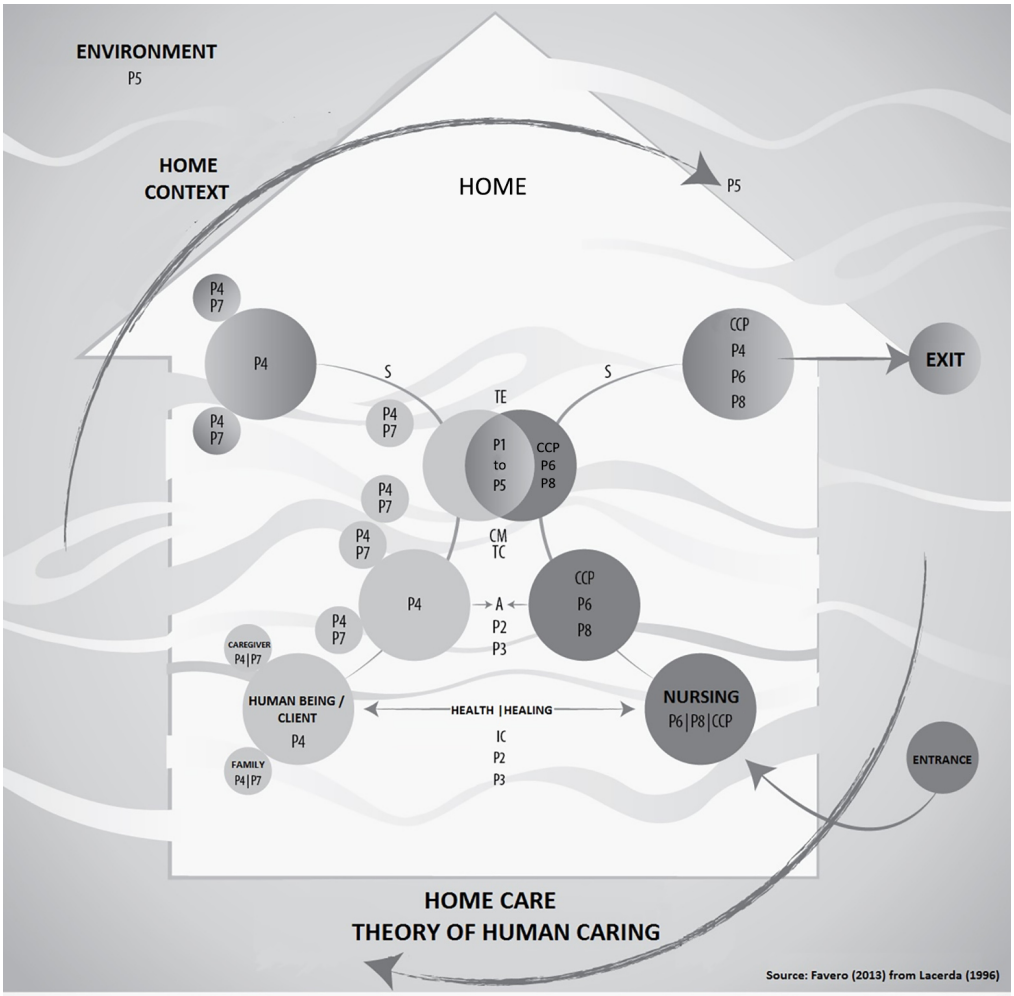

Illustration 1 – Graphical representation of the MCTED of Favero and Lacerda

Source:[3]

care relationship, provided an overview of the illness process, and enhanced problem solving.

Since the patient mentioned fear regarding HSCT, the nurse clarified doubts and creatively included knowledge as part of the provided care. This process afforded a unique experience of teaching and learning that shed light on the unity of beings and of meanings[10], and alleviated the fear and anxiety by resolving queries regarding treatment.

It was possible to notice that the relationship progressed to the **Transpersonal Encounter**, where the nurse and patient are no longer two, but one[12]. The focus of this phase is the spiritual dimension, implemented by therapeutic touch, careful listening, support, and comfort, and encouraging the expression of feelings. Feelings and emotions allow a joint encounter with the real meaning of the experience of caring and of being cared for[7]. The nurse

needs to visualise the world of expressed feelings and make sure that care is not provided without full presence, listening, perception of the other[10, 12], hope, faith, and love in the spiritual approach[7].

M.G. reported emotional turmoil and fear since hospitalization, and reinforced the need to be cared for by other people. She was, however, comforted by her belief in a Supreme Being. Beliefs and subjectivity were stimulated and strengthened, as proposed in the CCP[10]. The nursing care sought to reconstruct the being and enable the generation and enhancement of self-reestablishment, self-growth, self-control, self-recover, and self-awareness[13]. Evolution and overcoming are the targets of this encounter, as well as the use of response and coping mechanisms stimulated by care.

Positive feelings were also encouraged, with the possibility of hospital discharge, since the expression of these feelings is considered a form of treatment[11]. M.G. expected to hear words of motivation, but also expressed and demonstrated strength and confidence. Therefore, there was an exchange between the nurse and patient in which they both taught and learned[11]. At this moment, there was also union between the *selves* that deeply touched the nurse professionally and personally[4] This union triggered a remarkable shift in the lives of both subjects[13] based on the changes in the illness process perceived by the patient and nurse. In other words, the mutual support emerged as a feeling of recovery and strengthening.

The second encounter occurred two days after the first encounter to maintain TC. The **Approximation** phase consisted of addressing physical aspects and providing correlated care guidelines to meet basic human needs[12]. The scope of the **Transpersonal Encounter** emerged rapidly because the TC had already been initiated. The nurse needed to be present, listen, and perceive what the patient said in order to understand the patient's human condition[12].

The subjects mentioned the support of the nursing staff and the appreciation of the patient's sadness. The expression of these feelings was encouraged by creating a setting of reconstitution *(healing)*. Assumption 6 of the MCTED ratifies the crucial role of nurses as the providers of care and affection since it deals with sensitivity and the genuine desire to be in a care relationship as a characteristic of home nursing[3, 12]. Moreover, authentic, responsible, and intentional behaviour, and promoting confidence and spiritual knowledge are characteristics of the professional who provides TC[14]. These characteristics are also developed when applying MCTED and enhanced with each encounter.

Family support, another emerging issue, is considered necessary in care[7]. M.G. mentioned how her children had distanced themselves from her due to her treatment and illness, in terminal stage, and the impossibility of performing daily activities due to the constraints of HSCT. Again, encouraging the expression of negative feelings, comforting, and strengthening the coping mechanisms becomes important at this stage. If feelings are not expressed, they can become internal "prisons". Therefore, their expression brings relief and peace, as perceived in M.G.

The third and last encounter occurred the following day. Again, physical aspects were addressed in the **Approximation** phase. Characteristics of the CCP, such as practicing love and kindness in the context of care awareness, and maintaining the care relationship or trust and care with the one-being-cared-for and her soul, complemented the moment[12].

The **Transpersonal Encounter** was fulfilled. During this phase, the patient mentioned her health status and the chance of cure provided by the transplant, and referred to a Supreme Being. As suggested by the MCTED, her faith was reinforced[10], and the nurse needed to know and honour the expression of those feelings[12]. Of all the CCP elements, element 5 that refers to being present and supporting the expression of feelings was the most present both in this experience and in a previous study[9]. This result can be attributed to the range and diversity of feelings in illness situations.

Many people need faith and hope to guide their existence. Despite the difficulties in addressing spiritual aspects in nursing practice[7], spirituality supports the recovery process. Consequently, the spiritual dimension should be pondered in nursing practice[15] since the role of healthcare professionals is to facilitate the reconstitution of the *self*.

After experiencing the early stages of the care process, the **Separation** phase occurred in the last encounter. This phase represented a maturation of the patient and nurse. Also in this phase, knowledge, force, and energy were strengthened so the patient could better cope with life. Care enabled transformations and re-enactments so that both the nurse and patient could live without dependence and feel renewed and evolved regarding the difficulties of life[9]. The transformation of care through the TC supported healing, wellness, and comprehensiveness[14] since M.G. was notably more confident, prepared, protected, and satisfied.

CONCLUSION

The goal of reporting the experience of applying MCTED to a patient after HSCT was achieved according to

the description of this model. The references that make up the model met the presented health needs. Thus, the MCTED represents a feasible methodological path for applying the elements of the CCP that are crucial for the CT of home nursing. The ability to meet basic human needs, strengthen beliefs, and provide emotional care revealed that the transpersonal approach magnified and deepened the care relationship.

This study contributes to nursing home care by showing that it is possible to apply TC outside the hospital setting and the biological aspect of care. We therefore encourage educational institutions to use this model and other models of care to qualify future professionals and develop new research. The limitation of this study is that the MCTED was only applied to one patient at one service, and the applicability of this model to patients in other healthcare profiles could not be confirmed. We recommend application of this model in other nursing care situations.

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