Focus on the micro-relationship in the delivery of care

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Abstract

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- Recent reports have expressed concerns over the quality of care delivery in care settings and the homes of older people. This study
- followed 30 older people who had recently been discharged from hospital and were in the transition from re-ablement services to home care. The study focused on the non-clinical elements of care delivery (interpersonal relationships) and what the older patient felt was important in the delivery of their care.
- This was a qualitative study using semi-structured interviews to gather data on the interpersonal processes involved in the delivery of intimate care to vulnerable older patients. Three key themes were developed as to what the older patient felt was important for good-quality care. These were:
- **The need for social interaction beyond the delivery of clinical**
- **healthcare tasks**
- **The need for consistent care staff in order to develop**
- **a working relationship**

The need for the older patient to feel they had some control

- **over how their care was delivered.**
- **In sum, the patients needed to feel they were working with the**
- **care staff rather than purely having the care done to them.**

Background

The quality of nursing care has been considered in the Francis report (2013), which has raised concerns about the nature of the caring relationship in the delivery of clinical care. The delivery of homecare has also been the subject of scrutiny by the BBC in a Panorama documentary (BBC Panorama, 2013) and the subject of a conference convened by the then care minister (BBC News,2013). The main focus of this debate thus far has focused on nursing training and how care is commissioned by care managers. This study, however, aimed to focus on the micro-relationship in the delivery of care. The importance of the micro-relationship in care delivery is often lost in the Fordist, production-line focus on the tasks of clinical care and not on the relationship that is taking place in the unique interaction between the professional carer and the patient. This micro-relationship—considered by Leece (2003) and, more recently, Lloyd (2012) to be the backbone of the professional carer's work—is lost. In addition to the views of Leece and Lloyd, Tronto (1993) offers the concept of the 'ethics of care' and presents the view that the micro-relationship between the carer and the cared for is the most important element in the care process. Tronto says therefore for truly ethical care to take place, the caring relationship must include: attentiveness, responsibility, competence and responsiveness. Lloyd (2005) also presents the importance of trust and compassion in the delivery of care. The micro-care relationship with older patients as identified by Twigg (2004) is also affected by ageist stereotypes that as we age our physical bodies are seen as less desirable by society and therefore less attention is paid to the care of the older body than that of a younger person, It is possible this ageism may therefore be unconsciously registered by the care worker and impact on the process of care delivery.

Main Study

- This study followed on from a smaller pilot study conducted within a deprived borough of Greater Manchester. This study used a qualitative design (Cresswell, 2009) and was conducted with 30 older adults who were considered to have critical and substantial care needs (Department of Health (DH), 2002). The interviews were analysed thematically (Crabtree, 1999). The study went through the ethics committee of Cardiff University and also the relevant local authority's ethics committee, which had oversight of the project. Setting and sample. The sample was purposively selected, with participants being directly recruited by their care managers (district nurses/social workers), who acted as gatekeepers and chose patients who had recently gone through re-ablement services and were in the transition to homecare. The sample had a mean age of 74 and was 52% female. The majority of the service users experienced physical problems that prevented them from living independently without multiple daily visits from either nursing or homecare staff, with 75% of the sample being housebound. The vast majority of the older people had only limited social contact, with their main human contact being provided by the professional healthcare staff. No patients were accepted onto the research who were considered to lack mental capacity (DH, 2005).

Methods

- The process of data collection involved two interviews. The initial interview was used to explain the research and ensure that the service user was fully aware of the use of the data and give their consent to take part in the study. In addition to the explanation of the project, this interview was designed to gather background data and also establish a relationship between the patient and the researcher. The second interview followed a semi-structured framework, as outlined by Kvale (2009). All the patients were asked the three set questions in *Table 1*. These questions were then examined in order to gain further richness to the data, and allow the patient the opportunity to expand. This free-flowing element allowed the individuals the chance for self-expression and the ability to expand on the experience of having intimate care delivered in their own home.
- **Table 1. Set questions for all patients**
- What do you feel is the most important part of the care
- you receive?
- What makes the delivery of care a positive experience for you?
- What aspects of the care you receive make your care experience
- less positive?

Data Analysis

The qualitative themes were developed from an initial reading of the textual data in order to provide an overarching structure of codes (theoretical codes established from the questions). These themes were then placed in *a priori* categories and sub-categories for the remaining data to be analysed within. This process of coding and template development was dynamic, as the templates were constantly altered as a result of the analysis of the textual data. The coding structure was developed using a hierarchical process of themes and sub-themes. This process allowed for the relationship and trends within the data.

Findings

- *Finding 1*
- **These three themes emerged from the analysis of data:**
- **The need for social interaction beyond the delivery of**
- **clinical healthcare tasks**
- *Finding 2*
- **There is a need for consistent care staff in order to develop a**
- **working relationship**
- *Finding 3*
- **There is a need for the older patient to feel they had some**
- **control over how their care was delivered.**

Results

- **1 The need for social interaction beyond the**
- **delivery of clinical healthcare tasks**
- The importance of the non-clinical relationship with the professional carers was the most strongly expressed theme.
- During the average six-week period the older people had been with the re -ablement service, they had developed
- good links with the assistant practitioners and trainee assistant practitioners responsible for their care. They
- knew the individuals by their first names and knew some personal information about them, such as which football teams they liked or their favourite programmes and also a little personal information about the professional carers' families. This 'neighbourly acquaintance-like' relationship appeared to be highly important for the older patients' sense of connectedness with the care process, and also gave them a sense of worth, beyond being just another patient going through the process of being cared for. This personalisation of the professional carers enabled the patients to establish their trust in them. This was starkly contrasted against their experience of homecare and is summed up by one of the older patients:

'They rush in, do their tasks, change your pads and
things and rush out again, and hardly say a word.
It's like you're an animal and they are just changing
the litter in a pet's cage.'

This sense of disconnect from the care staff and feeling dehumanised by the process was reflected throughout the interviews with the older people.

The need for consistent care staff in order
to develop a working relationship

This was a theme that presented in all the interviews and was something that the patients noted in the transition from re-ablement to homecare services. The re-ablement service had delivered care from a team of 4 regular staff members in addition to other professional staff such as occupational therapists and physiotherapists. The re-ablement teams were mainly made up of assistant practitioners, who had all been homecare workers in their careers. In contrast, the homecare staff tended to be of varying levels of experience and had little further training beyond their initial induction. These are some of the comments of the older people:

'When the other lot were doing it (re-ablement delivering care), you had the same four people coming in and you knew them. Over the six weeks I got to know them and we had some good chats. This lot, you can have two or three different people every day; you just can't get to know them.'

This concern about consistency came across in all the interviews, as did the difficulty the constantly changing staff gave the patients in forming a relationship. The impersonal nature caused by this lack of consistency was

summed up by another patient:

'These people (carers) are doing really personal things to you. It's much more undignified getting
a total stranger to come in and touch your private parts. It's very upsetting.'

The intrusion caused by different staff carrying out their care was reflected in the majority of the interviews that were conducted.

- **3 The need for the older patient to feel they had**
- **some control over how their care was delivered**
- This theme showed that the older patients gave a high value to the care being delivered being explained and
- discussed with them. They appreciated being asked how they liked the care to be provided and especially if the
- healthcare assistant or the assistant practioner discussed how the care could be carried out in the most dignified
- way. This was eloquently expressed by one older patient:
- ***'You know that when they are changing your bag(colostomy) that it's not pleasant for you or them***
- ***and you're embarrassed. It helps when they chat with you as they do it; some workers do it in silence***
- ***and you can see the disgust on their faces. It makes you feel rotten.'***

This gentleman explained that some workers had discussed with him what would be the least upsetting way

to carry out this procedure and it was agreed between both parties to complete this task last, so that the older

person felt less embarrassed. This theme had a strong thread, throughout that discussion, about how the way care was delivered allowed the older person to feel valued and more of an equal in the care relationship.

Conclusions

Nursing and care relationships have been a subject of study within the healthcare arena for some time, and especially in the field of chronic illness, where the potent influence of the care relationship has been established (Nolan et al, 2003; Robinson, 1996), with the concept of person-centred care being a central plank of healthcare delivery and policy. However, as Nolan et al (2003) observed, person-centred care in itself is an ill-defined concept, with nursing and healthcare staff who provide long-term, intimate care having to struggle with how to clearly define interpersonal relationships that are both professional and meaningful for their patients. The majority of the patients in this study had experienced medium-term caring relationships with hospital staff and the re-ablement team. However, none of these relationships had been for more than six weeks and were time-limited. The relationship with the healthcare workers (assistant practitioners) could be for the rest of the older person's life, or until they move into permanent residential care. Therefore, a deeper and more consistent relationship is required to enable the individual to form a meaningful relationship and to enhance the older person's psychological wellbeing.

The aim of this research was to allow healthcare professionals insight into the micro-relationship occurring when care is provided to older people over an extended period. This limited study has shown that older people attribute as high an importance to the non-clinical relational aspects of care delivery as to the physical intervention itself. Healthcare assistants and assistant practitioners, who are the main providers of this level of care, need to consider the importance of general conversation to the building of a trusting and meaningful relationship with the older patient