Optimizing Person Centered Care

A descriptive multiple case-study of the interaction-process between the older person and the home-healthcare nurse during the identification of care-needs

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Background

The progressive ageing of the population of Western countries, associated with the increasing prevalence of chronic comorbidities will engender an increased demand on care-resources[1]. Since 95% of older people live at home, care for older people with chronic diseases will increasingly focus on the care at home; they prefer to stay in their familiar environment[2]. For them 'good' care is of genuine value as they face further health-complications and the loss of possibilities in life[3]. Western governments have an interest in 'good' and cost-effective home-healthcare supporting policies in order to reduce expensive residential 'elder-care'[2,4].

Home-healthcare is nursing care provided at the patient's home by professional home-healthcare organizations or self-employed professionals[5]. It is home-healthcare's mission to support older persons to remain in their own familiar environment for as long as feasible[7,8]. Institutions and professionals providing home-healthcare realize that supporting living at home is about respectfully recognizing one's individuality and uniqueness[8]. Providing care in which 'the person comes first' is known as 'Person Centered Care' (PCC) [6]. It is defined as "a holistic approach to delivering care that is respectful and individualized. It allows the negotiation of care and offers choice through a therapeutic relationship where persons are empowered to be involved in health decisions"[9].

During home-healthcare intake consultations this therapeutic care-relationship is respectively initialized or continued. Unmet needs and existing resources are identified through the interaction between the older person and the nurse. This interaction includes behavioural responding between individuals, both verbally and nonverbally[10]. However it is known, that older persons seldom express their priorities and concerns directly. They tend to express them in a more indirect way, through signals or 'cues' that can be rated in four levels: 1.neutral, 2.giving a hint, 3. direct verbally and 4.expressing an emotion[11]. The nurse should perceive these cues and react appropriately; thereby responding to what is important (effective 'Cue-Responding Behaviour' (CRB)). Thus attentiveness to cues becomes a key attitude of the nurse[12] and should result in adequate responding behaviour: 1. explorative responses: pay attention, listen and 2.acknowledging responses: empathizing, reflecting, confronting and consulting[13]. Being attentive to the fate of 'the other' is related to good care [14]; attentiveness and consequent adequate CRB should produce specific and relevant information to ensure effective nurse diagnosing.[15]

Ideally nurses assess a situation and deliver good care on the basis of scientific knowledge, professional nursing skills, preferences, wishes and expectations of clients and their given

context. It is called 'Evidence Based Practice' (EBP) [16]. However, it has been proven that the recognition of client-input and participation is not always a feature in nursing care practice[17]. Nurses often overlook older persons' social and emotional needs and qualities, focusing predominantly on physical care[18]. Other findings document that Home-Healthcare Nurses (HHN) find it difficult to involve clients and value their input; it requires specific competencies.[8,19,21] Care provision in home-healthcare is often based on what professionals consider to be important for the client; professional expertise reigns supreme. HHNs can think they deliver PCC, but from the older people's viewpoint the involvement and valuing their perspectives, preferences and priorities may be lacking.[21,22,23,24]The opinion prevails that a core skill for HHN is recognizing the relevant but not always directly expressed cues and responding to these cues with effective behaviours[25]. The potential influence of CRB on the quality of client- nurse communication has been described and acknowledged by studies in an inpatient cancer setting[13,26] but not in home-healthcare.

PROBLEMSTATEMENT, AIM AND RESEARCH QUESTION

Effective CRB values older persons' perspectives, preferences and priorities and as a concept it can facilitate the disclosure of older persons' needs and concerns during the intake-consultation.
To this end the current study describes the development of the interaction-process focusing on cue-giving and responding behaviour in home-healthcare nursing. After a systematic and in-depth analysis of client and nurse communication, the insights gained can optimize effective communication and consequently the quality of care. The results can be used to further explore and better understand the concept of PCC in home-healthcare. This study also aims to contribute to PCC-framework building. To address these goals, the following research question was formulated:

'How does the interaction-process between the older person with a chronic disease and the HHN develop during consultations in which care-needs are identified?'

For defined sub-questions see Appendix I.

Method

DESIGN

A multiple case study design was used for this descriptive qualitative study, to gain insight into client-HHN interaction during care needs assessment. It explored the issue in-depth through several cases within a bounded system[27].

SAMPLE

A 'case' was defined as a client-HHN couple and their interaction process during care needs assessment. Three couples (three older clients and three HHNs) were recruited from the study setting, a home-healthcare organization in the northern part of the Netherlands. This setting was selected on the basis of accessibility of the study population: the researcher is employed by this organization. Permission was received from a local manager. Recruitment of clients began by selecting the HHN in each case. Registered Bachelor HHNs were selected 'conveniently' and included on their willingness to participate; the researcher approached them personally. Clients over 65 years having a chronic disease and being in need of home healthcare were included, provided that they were cognitively and physically able to take part. The researcher approached the clients by telephone after the HHN had selected them. All participants received written information about the aim of the study and informed consent was obtained from all study participants prior to study participation. Identifying features were edited out to protect participants' identities. The Regional Scientific Research Committee approved the study procedures (Dnr.13.12150). The study is conducted according to the principles of the Declaration of Helsinki[28].

DATA COLLECTION

Data was collected between January and May 2014.

Data collection methods included personal semi-structured interviews, observations and document review. Method and data triangulation will enhance the credibility and transferability of the conclusions[29]. They were replicated in all three cases. Using this 'replication logic' increased the external validity of this study[30]. As data was collected, preliminary findings were used to guide ongoing data collection[27]; data collection and data analysis alternated. After collecting intake-consultation data in the first case, no suitable case occurred during the following two month. To be able to complete the data collection within the determined period, the researcher decided to include two interim evaluation-consultations.

An interview and observation guide was followed to ensure that all areas were covered and to ensure consistency across the cases[30] (Appendix II).The concepts of PCC and CRB were leading in the construction of the observational and interview guides. One researcher (C.B.) collected all data. She observed the interaction process during the consultations at the clients homes being a 'fly on the wall'[31]. The observations were videotaped and transcribed. The

sequential personal interviews at the client's home and in the office of the HHN were audiotaped and transcribed verbatim. They ranged in duration from 10 to 45 minutes. Variability in interview duration could be attributed to the clients' energy levels and the 'flow' of the interview.

The content of the topic list was amended as the study progressed[27]. 'Constantly comparing' the interview data inspired the researcher to ask less abstract questions. This way especially the older persons felt more encouraged reflecting on their experiences.

ANALYSIS

The analysis unit (case) was composed of a client-HHN couple and their interaction-process during a consultation. The first step in the analysis was to write a case report. Bringing all transcribed data, personal thoughts, reflections, behaviour and context observations plus document reviews together in one 'big picture' was important to achieve a basic understanding of the data. Secondly, the observations were coded inductively to facilitate analysis. Specific themes were found, intertwining the strategy of coding and constant comparison [29,30]. Data was analysed within the constructed categories related to the concept of 'cue-giving and responding'. The researcher used the technique of within-case and cross-case analysis. This provided a case-report of each case and of themes within it (within-case-analysis) followed by a thematic analysis across cases (cross-case-analysis) [29] to examine patterns and differences. By first coding and comparing within cases and secondly across cases, common themes that answered the research questions were identified[30]. The study aims for a thematic description of findings[27], indicating the degree of data-transformation. To provide reliability of the analysis, the researcher and a research-team member independently read and coded the transcripts of case1. This inter-coder agreement ensured the representativeness and rigor of the study[32]. During analysis the researcher used an adjusted version of Quagol[33], a method for grounded theory analysis. All data files were stored 'under lock and key'; data was managed and coded using QDA Minor software. The analysis and the role of the researcher were made transparent by using memos, supporting the verifiability of the research process.

Results

Three older clients and three HHNs agreed to participate. For characteristics see Table 1. The results cover themes linked to the central concept, classified under headings of the sub questions (Appendix I). For detailed results see Table 2 and for quotations see Table 3.

'BIG PICTURE'

The results consisted of detailed key communication elements, motives and related strategic behavioral processes relevant to the disclosure of needs, wishes and preferences during the interaction-process between the older person and the HHN. The HHNs were leading the consultations applying a systematic question initiative based on structured assessment frameworks. The unexpressed goal was to get view on 'the total picture'. They determined the course and content of the conversation always compelled by concerns about the health status and wellbeing of the client, their professional knowledge and responsibilities. They mentioned administrative responsibilities and time management occasionally being at odds with the content of the consultation. The focus was on somatic health problems, documented in individual care plans. Not only problems but also life satisfaction and positive wellbeing were revealed. Overall the older persons adopted a passive attitude. They passively submitted to the nurses' leading role, but when the interaction-process developed the clients felt free to tell their story, giving cues about physical, social and emotional issues. HHNs mostly reacted with verbal and non-verbal attentiveness. They responded to cues adequately: they acknowledged and explored, trying to identify existing resources and individual care-needs. The adequate response to cues sometimes led to a 'chain' of adequate cue giving and responding behaviour between client and nurse. The therapeutic relationship was open and based on trust, but hardly any negotiation was observed. The clients were satisfied; they opined they received good care. They felt they had choice and were empowered to be involved in healthcare decisions that fit their unique situation.

HHN QUESTIONS

All three HHNs asked open directive questions that systematically initiated and systematically shaped the consultations, using different assessment frameworks. Questions that received most attention focussed primarily on somatic health problems: …'*You still have symptoms of dyspnoea, right?'…(N1).*

The nurses mentioned the questionnaires as being helpful to maintain an overview of a wide perspective and not forgetting anything. Within the structure of open directive questions the HHNs posed screening questions to explore a subject.

HHN BEHAVIOUR

The HHNs had a leading role in the interaction-process. They initiated the encounter, they defined the goals and they determined the focus and the proceedings of the interview with their systematic question initiative using an assessment framework. They invited the clients to tell their story and by means of this narrative they culled information in a targeted way:

…'I heard you will take a holiday soon: that's super! (N3)' 'Yes'… (Client tells how she arranged this herself with help of a patient organisation)…, but I worry about my urinary incontinence'… (OP3).

The HHN's displayed a polite and inviting demeanour, showing non-verbal signs of attentiveness. They stimulated clients to talk by 'head nodding' and 'forward leaning'. The nurse showed nearness, involvement, interest and cordiality by gestures and body language and a friendly facial expression. They looked at the clients while listening and also radiated professionalism by inserting their expertise at appropriate moments. All three nurses checked prior knowledge and they expressed their concerns for the health status or situation of the client. They worked on creating or perpetuating a trustful relationship. HHN2 approached the client in dialect to create empathy. Overall, a careful process of attuning needs, priorities, wishes and concerns was observed.

CLIENTS CONCERNS

The clients answered with a range of important issues (concerns) that could be interpreted as a need, a wish or a preference. They will be described ranked by frequency. 'Expressing concern about self' was counted most often in all three cases…*'Well, I worry about the fact that I do not urinate enough the last couple of days'… (OP1).*

This was followed by, 'experiencing functional decline', then 'experiencing pleasure' and in the fourth place featured 'being self-reliant'. The next issue was 'being unique' and then came '(not) feeling safe'. 'Having confidence in professionals' ended in the sixth place, followed by '(not) having a social network'. At the bottom of the list 'surviving' and 'having strength and spirit' were mentioned. All clients expressed their 'satisfaction with (informal) care'. During the interviews afterwards, all clients expressed their feelings of being valued as unique persons receiving 'tailored' care.

CLIENT CUE GIVING

Clients did not take the lead or introduce issues themselves. Four cue levels were identified. Clients mentioned their needs, wishes and preferences by far the most on cue level2: the verbal expression that mentions a worry or concern: *'…they put the meal next to my bed when they leave, but I fall asleep and the next morning I notice I didn't eat at all'… (OP2).*

In frequency this level was followed by cue level0: a neutral expression. Cue level3, a clear expression of emotions, comprised in all cases of laughter by means of body language and intonation of their voice.

HHN CUE RESPONDING

In Case1 the HHN responded to most of the clients 'cues' with acknowledging behaviour. She expressed verbal empathy, reflected on answers, prompted and checked if she understood the message. Almost all the other cues were explored by confirmation, purposive probing and

eliciting and clarifying responses. Three times the HHN responded with distancing behaviour, blocking an important issue with a new question.
In Case2 and Case3 most clients' cues were responded to with exploring behaviour, a few instances more than cues that were acknowledged: …'*OK, that is a very good solution; it is a reference point'… (N3).*
Four times the HHNs responded to with distancing behaviour.

CARE PLAN

The individual care plans consisted of anamneses which reflected the somatic, social and psychological status of the client using the 11 Functional Health Patterns of Gordon[44]. It broadly displayed the discussed matters. In the actual care plan two or three health problems were elaborated with a focus on somatic care needs and risks. Wishes and preferences were added if the HHN and the client assessed them as relevant. Examples of relevant additions included time of visits and working towards independency.

IMPORTANT HHN ISSUES

All HHN advised and informed their clients about issues concerning the organization, payment devices and health status. For the HHNs, organizing and completing administration was an important issue, as was time management. The nurses felt it their responsibility to initiate and provide care that meets professional standards and respects the uniqueness of the client…*'so that I can offer her professional but also personalized care and advice'… (N1).*
In addition they were responsible to do so in a context of organizational and healthcare rules and regulations which, in their view, causes tension. Distancing behaviour, in all cases switching the focus away from the cue, was said to be related to the tension between client- and system-related goals. The observed mix of professional skills, concerns and responsibilities largely determined the course and partly the content of the consultations.

Discussion

The study-results describe the development of the client-nurse interaction-process in home healthcare interviews, focusing on the exciting concept of CRB. They give an empirically based in-depth insight in how client and HHN influence one another in interaction and how this determines the course and content of a consultation.

90% of the clients' cues in this study were responded to with adequate behaviour of the HHN. It created a 'chain' of cue-giving and responding behaviour that led to the disclosure of 'that what really matters' and to client satisfaction with good and PCC.
The larger studies that investigated CRB in client-nurse interaction show an adequate behaviour-rate between 40-50%[13,26,35,36]. In these studies nurses worked in an in-patient

(cancer) setting and it is likely that this sphere conditioned their abilities. Similarly, HHNs may develop skills that equip them to work in a specific context: the clients' home as the space of professional care[37]. Study findings confirm that client needs depend on the context[38,39]and that the dynamics of a therapeutic relationship are strongly influenced by it: home-healthcare is a co-creation, jointly shaped by healthcare professionals, clients and family members, based on a trusting relationship[37]. Spiers[40] shows how all persons involved in home healthcare cooperate by using a variety of communicative strategies to develop a shared understanding about issues such as territory, care needs, preferences, the working relationship and knowledge plus synchronize roles in care. Older people state that the client-nurse relationship in home-healthcare must be one of optimal 'client-participation' being a function of the quality and depth of the client-nurse relationship[41]. If HHNs' collaborative attributes are pivotal than HHNs are, likely more than average, to be attentive to clients' cues resulting in adequate CRB.

Surprisingly, in this study hardly any negotiation is observed i.e. asking consent to one another about process or content[13]. This can be attributed to the elected passive 'nurse knows best'[42] role the client adopts in the observed consultations. Studies show that although older persons expect to be met as unique individuals with personal expectations and needs, many adopt a passive role in relations to healthcare professionals[40,41]. On the other hand, the results reveal that HHNs pursue goals 'that are prescribed by the abstractly formalized rules and value categories of the healthcare system'[42]. These goals are not negotiated with or made transparent to their clients and they visibly create tension. If care needs do not fit the course of nursing care-processes, the danger of distancing behaviour and 'withdrawal' from the interaction with clients exists[42]. Sieger[43] confirms this and advocates a nursing concept based on an understanding- orientated interaction-model that helps to elicit and understand the position of nurses and the way in which they view their clients in professional interactions.

Strength of this study is the captured real-life participant experiences within a home-healthcare context. The observations were vital to understanding the significance of the dynamics of client-nurse interaction and they became sources of evidence. The derived meaning was validated or refuted with personal interviews and document-study. The study has its limitations. The difference in nature between the consultations in the first and the following two cases raises questions about the comparability. HHN2 and HHN3 were able to choose a known client, which could have been of influence on the interaction. The researcher obviates this by giving insight in the study-process and by using 'constantly comparing' during analysis. The purpose of the latter is to describe variation and to indicate in which situations different variations manifest themselves.[27] The sound cross-case patterns that evolved from the three cases suggest that there is substantial similarity in client-nurse interaction regardless of the nature of a consultation.

The researcher, being a HHN herself and part of the organization under study, did not know the participants personally. In order to avoid the interpretation becoming biased, the researcher reflected on possible influences during all study stages.

The findings have implications for home-healthcare practice and research. Effective CRB must become an acknowledged skill of nursing professionals and therefore recognized as an integral part of nursing education and peer review. The profound significance of the CRB-concept opens up a wide item range for follow-up interaction study in home-healthcare nursing.

Conclusion

This study describes the development of interaction and reveals that HHNs' CRB as adequate, because they acknowledge and explore cues, which in turn aids the identification of existing resources and individual care needs. The concept contributes to the understanding of client-nurse behaviour during consultations in clients' homes. Adequate CRB facilitates the disclosure of older persons' concerns in home-healthcare, just as it does in other care-settings. Adequate CRB-HHN skills are necessary to invite clients to share meaningful information, subsequently enabling HHNs and their teams to deliver quality home-healthcare in a person-centered way.

Recommendations

The presented empirical findings cannot be generalized to home-healthcare as a whole; further observational research is needed. Subsequently research must focus on the relationship between CRB and the HHNs persuasion of hidden system- related goals. Training activities in home healthcare teams must focus on cue-responding skills so as to optimize client outcomes. Costly communication training is no option for most organizations. Analyzing videotaped consultations, simulated or real-life, and applying the cue responding concept to colleagues 'observed behaviour can provide a cheap and effective alternative.

Reference list

(1) Colprim D, Martin R, Parer M, Prieto J, Espinosa L, Inzitari M. Direct admission to intermediate care for Older adults with reactivated diseases as an alternative to conventional hospitalization. JAMDA 2013;14: 300302.

(2) Holroyd A, Dahlke S, Fehr C, Jung P, Hunter A. Attitudes toward aging: implications for a caring profession. J Nursing Education 2009 Jul; 48(7):374-380.

(3) Cingel M. Compassion in care: A qualitative study of older people with a chronic disease and nurses. Nursing Ethics 2011 Jun; 18(5):672-685.

(4) RIVM. <http://www.nationaalkompas.nl> Volksgezondheid Toekomst Verkenning, Nationaal Kompas Volksgezondheid, Bilthoven versie 4.11. Accessed 28 March, 2013.

(5) Kerkstra A, Hutten J. Organization and financing of home nursing in the European Union. J Adv Nurs 1996; 24(5):1023-1032.

(6) Kitwood T. Rethinking Aging: Dementia reconsidered. “The person comes first". 1st ed. London: Open University Press; 1997.

(7) Innes A, Cox S, Smith A, Mason A. Service provision for people with dementia in rural Scotland: difficulties and innovations. Dementia 2006;5(2):249-70.

(8) Eloranta S, Routasalo P, Arve S. Personal resources supporting living at home as described by older home care clients. Int. J Nursing Practice 2008 Aug;14(4):308-314.

(9) Morgan S. A Concept Analysis of Person-Centred Care. J. Holistic Nursing 2012; 30(1):6.

(10) Bensing J, Zandbelt L, Zimmermann C. Introduction. Sequence analysis of patient-provider interaction. Epidemiol Psychiatr Soc. 2003b Apr-Jun; 12(2):78-80.

(11) Butow P, Brown R, Cogar S, Tattersall M, Dunn S. Oncologists’ reactions to cancer patients’ verbal cues. Psycho Oncology 2002; 11(1):47-58.

(12) Higgs J, Titchen A, Practice knowledge and expertise in the health professions. Oxford: Butterworth-Heineman; 2001.

(13) Uitterhoeve R, Leeuw J de, Bensing J, Heaven C, Borm G, Mulder P de, Achterberg T van. Cue-responding behaviours of oncology nurses in video-simulated interviews. Journal of Advanced Nursing 2008; 61(1):71-80.

(14) Vorstenbosch J, Zorg een filosofische analyse. Amsterdam: Nieuwezijds; 2005.

(15) Benner P. Van beginner naar expert, excellentie en invloed in de verpleegkundige praktijk. Maarssen: Elsevier Gezondheidszorg; 2006.

(16) Achterberg T van, Schoonhoven L, Grol R. Nursing Implementation Science: How Evidence-Based nursing requires Evidence-Based Implementation J of Nursing Scholarship 2008; 40(4):302-310.

(17) Florin J, Ehrenberg A, Ehnfors M. Patient participation in clinical decision-making in nursing: a comparative study of nurses’ and patients’ perceptions. Issues in Clinical Nursing 2005 1498-1508.

(18) Farrell C, Heaven C, Beaver K, Maguire P. Identifying the concerns of women undergoing chemotherapy. Patient Education and Counseling 2005; 56(1):72-77.

(19) Eloranta S, Arve S, Routasalo P. Multi-professional collaboration promoting home care clients' personal resources: perspectives of older clients. Int. J Older People Nursing 2008 Jun; 3(2):88-95.

(20) Malterud,K. Hollnagel,H. Witt,K. Gendered health resources and coping: a study from gereal practice. Scandinavian Journal of Public Health 2001; 29:183-188.

(21) Eloranta S, Arve S, Isoaho H, Routasalo P. Home care from the perspective of older clients and their professional carers. Archive of Gerontology Geriatrics 2010 Sep-Oct; 51(2):180-184.

(22) Eloranta S, Arve S, Routasalo P. Multi-professional collaboration promoting home care clients' personal resources: perspectives of older clients. Int. J Older People Nursing 2008 Jun; 3(2):88-95.

(23) Roe B, Whattam M, Young H, Dimond M. Elders' perceptions of formal and informal care: aspects of getting and receiving help for their activities of daily living. J Clinical Nursing 2001 May; 10(3):398-405
(24) Oudshoorn A. Power and empowerment: critical concepts in the nurse-client relationship. Contemporary Nurse J. Nursing Profession 2005; 20(1):57-66.
(25) Eide H, Quera V, Graugaard P, Finset A. Physician-patient dialogue surrounding patients' expression of concern: applying sequence analysis to RIAS. Social Science& Medicine 2004; 59(1):145-155.
(26) Uitterhoeve R, Bensing J, Dilven E, Donders R, deMulder P, Achterbert T. Nurse-patient communication in cancer care: does responding to patient's cues predict patient satisfaction with communication. Psycho-Oncology 2008
(27) Boeije H. Analysis in Qualitative Research. 1st ed. London: Sage Publications Ltd; 2010.
(28) Declaration of Helsinki. Ethical principles for medical research involving human subjects. J Indian Med Assoc. 2009; 107(6):403-405.
(29) Creswell JW. Qualitative inquiry and research design: Choosing among five approaches. 2nd ed. London Thousand Oaks Sage Publications Ltd. 2007
(30) Yin, R. Case Study Research: design and methods 5 th ed. London Cosmos Corporation Sage Publications Ltd. 2014
(31) Martin B, Hanington B, Universal Methods of Design. 1st ed Beverly: Rockport Publishers; 2012 (31)
(32) Morse J, Field P Qualitative Research Methods for Health Professionals. 2st ed. Thousand Oaks: Sage; 1995
(33) Dierckx de Casterlé B, Gastmans C, Bryon E, Denier Y. Quagol A guide for qualitative data analysis. International Journal of Nursing Studies 2012; 49 (2): 360-371
(34) Uitterhoeve R, Leeuw J de, Bensing J, Heaven C, Borm G, Mulder .de, Achterberg T.van. Cue-responding behaviours of oncology nurses in video-simulated interviews. Journal of Advanced Nursing, 2008; 61(1): 71-80.
(35) Wilkinson S. Factors which influence how nurses communicate with cancer patients. Journal of Advanced Nursing, 1991; 16(6):677-682
(36) Heaven C.M., Maguire P. Training hospice nurses to elicit patient concerns. Journal of Advanced Nursing, 1996; 23(2): 280-286.
(37) Lindahl B, Lidén E, Lindblad B-M. A meta-synthesis describing the relationship between patients, informal caregivers and health professionals in home-care settings. Journal of Clinical Nursing, 2010; 20: 454-463.
(38) Hancock K, Chang E, Chenoweth L, Clarke M, Carroll A, Jeon YH. Nursing needs of acutely ill older people. J Advanced Nursing 2003; 44(5):507-516.
(39) Basset C. Nurses' perception of care and caring. International J Nursing Practice 2002; 8:8-15.
(40) Spiers J. The interpersonal context of negotiating care in home care nurse-patient interactions. Qualitative Health Research 2002;12: 1033-1057.
(41) Millard L, Hallett C, Luker K. Nurse-patient interaction and decision-making in care: patient involvement in community nursing. J Adv Nurs 2006 Jul;55(2):142-150.
(42) Glasdam S, Hendriksen N, Kjaer L, Praestegaard J. Nursing Inquiry 2013; 20: 329-340.
(43) Sieger M. In discourse: Bourdieu's theory of practice and habitus in the context of a communication-orientated nursing action model. J of Advanced Nursing 2012; 68(2):48
(44) Gordon, M. Nursing Diagnosis: process and application. 1994 Philadelphia: Mostby.

Tables

Table 1: Sample Cases: 3 Client-HHN Couples

Case	Client	HHN
1		
Gender	Female	Female
Age in years	83	32
Illness	COPD/DM type II	
Years of Experience		10 years as Registered Nurse with a Bachelor of Nursing Degree of which 6 years as HHN
2		
Gender	Female	Female
Age in years	80	56
Illness	Arthritis/COPD	
Years of Experience		29 years as a Registered Nurse without a Bachelor of Nursing Degree 9 years as a registered Nurse with a Bachelor of Nursing Degree as HHN
3		
Gender	Female	Female
Age in years	88	57
Illness	Heart failure	
Years of Experience		22 years as a Registered Nurse without a Bachelor Degree of Nursing 6 years as a Registered Nurse with a Bachelor of Nursing Degree as HHN

Table 2: Scheme Results

Study Questions	Case 1	Case 2	Case 3
What does the HHN do to find out what care the older person needs?			
- What kind of questions does the HHN ask to find out what care the older person needs?			
Form:			
Open directive question	16	3	18
Screening question	50	27	2
Summarizing question	3	0	2
Negotiating question	4	0	2
Closed directive question			1
Question and answer			2
- How does the HHN behave in order to find out what care the older person needs?			
Clinical reasoning	4	0	1
Touching	0	2	0
Interpreting	0	2	0
Checking prior knowledge	1	1	1
Verbally expressing worry	11	3	0
Facial expression and body language:			
Gesticulating	x	x	X
Non-verbal attention: Showing nearness, involvement, interest and cordiality	X	X	X
Looking in the eyes	X	X	X
Using professional knowledge and experience	X	X	X
Creating a trustful relationship	X	X	X
What needs, wishes and preferences does the older person introduce? (cues)			
Concern/Functional decline	5	5	10
Expressing concern about self	17	13	12
Need and wish/Being self-reliant	7	4	4
Concern/being satisfied with (informal)care	1	9	4
Need and wish/feeling safe	7	2	3
Preference/ experiencing pleasure	6	5	8
Preference/being in need of help	2	0	2
Wish/surviving	2	2	1
Need/having social network	5	3	3
Concern/expressing joy or worry about (grand)children	2	1	0
Preference/being unique	9	4	1
Preference/having strength and spirit	3	1	2
Concern/having confidence in professionals	5	4	3
Preference/being cognitively intact	1	1	0
Concern/ being ashamed	1	1	0
Preference/standing up for yourself	0	1	0
Concern/appointing disadvantage of receiving care	0	0	1
Expressing concern about partner	7	0	0
How does the older person introduce needs, wishes and preferences?			
Cue level 0 neutral expression	47	32	37
Cue level 1 expression that hints at worry or concern	0	2	6
Cue level 2 expression that mentions worry or concern	95	60	50
Cue level 3 clear expression of emotion (laughing)	8	5	10
Does the HHN recognise the needs, wishes and preferences? If so, how?	X	X	X
How does the HHN respond to the needs, wishes and preferences of the older person [verbal and behavioural]?(cue responding behaviour)			
Exploring (clarifying, eliciting, purposive probing. confirming)	45	27	26
Acknowledging (prompting, expressing verbal empathy, reflecting, checking)	54	17	24
Distancing (blocking, switching focus, premature advise, inappropriate reassurance)	3	4	4
Are needs, wishes and preferences of the older person described in the client-care plan? If so, how?	X	X	X
What needs, wishes and preferences does the HHN introduce that are of interest for the client, organisation or self?			
Informing	27	8	10
Advising	15	4	5

Table 3: Personal Interview and observation quotations

Themes	Illustrative Quotes
HHN questions	Routinely questioning: *'Yes, a list of questions that I have to answer'(Case 1OP)* Total picture: '*By doing the intake you get the complete picture and this way you can identify relating problems, anticipate and having to take action on it either sooner or later in the care process' (Case 1 N)*
HHN behaviour	Leading role of the HHN: '*At one point, when I noticed we wandered off , I thought we have to return to the intake interview.'(Case 1N)* Creating trust: *'Yes, I always try to create trust during the interview'(Case 2N)* Verbally expressing worry: *'Her weight does worry me; it is on the edge of being critical'(Case3N)*
Introduced needs, wishes and preferences client	Experiencing pleasure: *(About going on vacation) 'Yes, ha, ha, ha, but if I don't go now than it will not happen anymore; if I stay in this chair than nothing will happen. You will miss the fun'(Case3OP)* Being cognitively intact: *'I said to my general practitioner I was fortunate in one thing. I said: My body is not functioning at all, but my head still works fine, and that is very important '(Case2OP)* Feeling safe: '*Safety, yes…I could do it myself but I am still a bit unstable.'(Case1OP)*
Cue-giving	Cue level 1: *(Being short of breath)'Yes, please, close that book(client care plan)now…'(Case2OP)* Cue level 2:*'I can manage quite well, but I have to do it in small steps. As soon as I start moving, I get short of breath.(Case3OP)* Cue level 2:'*It was terrible, this itchiness from my toes to my upper back. My skin was red, I looked like a leper'(Case1OP)*
Cue-responding	Exploring: *'no, but before admission, you didn't sleep well either?'(Case1N)* '*do you want me to ask T. to bring along some samples, or shall I drop them by myself…'(Case 3N)* *'Ok, your home help comes twice a week now, this initially was once, wasn't it?'(Case2N)* Acknowledging: '*No, no. Yes, you must feel safe here in your own environment(Case1N)* *'Oh, sure, fortunately. It is very important that you have people in your neighbourhood that you get along well with'(Case2N)* '*OK, that is a very good solution, it is a reference point'(Case3N*) Distancing: '*Yes, but that is something we cannot do much about' (Case1N)* *(reaction after client told about a crash she had with her scoot mobile)'But you did not fall at home or in the garden?'(Case3N)* *(reaction after client talked about tiredness while taking a shower)'Ok, but you like it very much.'(Case2N)*
Introduced issues of HHN	Inform: *(about a personal alarm system)'..so that you know about its existence. I leave this folder here with you, it is always good to talk about it as a precaution.(Case1N)* *(about medication)'you get your medication from a'baxter-system'.(Case2N)* *(about self-management) 'we always check what clients can do themselves and if you need us more often then you can phone us'(Case3N)* Advise:*(about gaining weight)'I don't know if T. told you, but nowadays you can buy 'building blocks', small tartlets that contain proteins and nutrients. In the supermarket, deep frozen.(Case3N)* *(about general practitioner)'It is very important that you have a good relationship with your general practitioner, you don't have to be friends but the relationship must be trustful.'(Case1N)* *(about grips for safety)'but we can change that so that you can get grips on the first floor too for your own safety'(Case2N)*

Nederlandse samenvatting

TITEL

Optimalisering van Persoonsgerichte Zorg:
Een multiple-case studie die het interactieproces beschrijft tussen de oudere zorgvrager en de wijkverpleegkundige tijdens het inventariseren van zorgbehoeften.

ACHTERGROND

Zelden uiten oudere zorgvragers voor hen belangrijke onderwerpen rechtstreeks; ze geven hints of signalen. Om zorg te kunnen geven die respectvol is en die past bij de uniciteit van een persoon, zullen wijkverpleegkundigen alert moeten zijn op deze hints.

DOEL EN ONDERZOEKSVRAAG

Dit artikel beschrijft het interactieproces tussen client en wijkverpleegkundige, met als doel het optimaliseren van effectieve communicatie en kwaliteit van zorg. Onderzoeksvraag: 'Hoe verloopt het interactieproces tussen de oudere zorgvrager en de wijkverpleegkundige tijdens het inventariseren van zorgbehoeften?'

METHODE

In deze multiple case-study, uitgevoerd van januari tot mei 2014, werden drie klant-verpleegkundige consulten bij de klant thuis geobserveerd. Ze werden op video opgenomen en geanalyseerd met behulp van het concept 'cue- giving- en responding'. Natijd werden de respondenten apart geïnterviewd en werden de zorgplannen geanalyseerd. Drie case-rapporten gaven inzicht in het totaal plaatje en werden ook gebruikt voor de within-case en across-case analyses.

RESULTATEN

Dit onderzoek beschrijft interactieprocessen tussen client en wijkverpleegkundige. Met behulp van het concept cue-giving- en responding geeft het inzicht in hoe cliënten en wijkverpleegkundigen elkaar in dat proces beïnvloeden.

CONCLUSIE

Wijkverpleegkundigen hebben adequate cue-responding vaardigheden. Ze erkennen en onderzoeken hints, zodat ze krachbronnen en zorgvragen ontdekken. Het concept draagt bij aan de kennisontwikkeling omtrent client-en verpleegkundig gedrag in de thuiszorgcontext.

Dit stelt thuiszorg-professionals in staat kwalitatief goede, persoonsgerichte thuiszorg te leveren.

AANBEVELINGEN

Bij intercollegiale toetsing van gedrag door middel van videotapes van echte- of gesimuleerde client-gesprekken, kan het cue-responding concept behulpzaam zijn. Vervolgonderzoek zal zich moeten richten op de relatie tussen cue-responding gedrag en het nastreven van verborgen doelen door verpleegkundigen, die gerelateerd zijn aan zorgsystemen en zorgmodellen.

SLEUTELWOORDEN

Client-wijkverpleegkundige interactie , thuiszorg, ouderen, persoonsgericht, multiple casestudy.

English Abstract

TITLE

Optimizing Person-Centred Care
A descriptive multiple case-study of the interaction-process between the older person and the home-healthcare nurse during identification of care-needs.

BACKGROUND

Older persons in healthcare situations seldom express directly important personal topics; they give cues or signals instead. Home-healthcare nurses should be attentive to these cues in order to be able to deliver care that is respectful and individualized: person-centred care.

AIM AND RESEARCH QUESTION

This paper describes client- nurse interaction in home-healthcare with a view to optimize effective communication and consequently quality of care. Research question:
'How does the interaction-process between the older person with a chronic disease and the home-healthcare nurse develop during the identification of care-needs?'

METHOD

In this multiple case-study, conducted from January to May 2014, three client-nurse consultations in the clients' homes were observed. They were videotaped and analysed for cue-giving and responding behaviour. Afterwards, respondents were interviewed separately and care-plans were reviewed. Three case-reports gave insight in the big picture and facilitated within and across-case analysis.

RESULTS

This study describes the client-nurse interaction-processes. Using the concept of cue-giving and responding as an analytical grid, it provides an empirically based insight in how clients and home-healthcare nurses influence each other in that process.

CONCLUSION

Home-healthcare nurses have adequate cue-responding skills. They acknowledge and explore cues, which in turn aids them to identify resources and individual care-needs. The concept contributes to the understanding of client-nurse behaviour during consultations in clients' homes and it enables home-healthcare professionals to deliver quality, person-centred, home-healthcare.

RECOMMENDATIONS

Using videotaped consultations (simulated or real) the concept of cue-responding can be of assistance in peer appraisals of professional behaviour. Follow-up research must focus on the relationship between cue-responding behaviour and hidden system-related goals that nurses pursue.

KEYWORDS

Client-nurse interaction, home- healthcare, older people, person-centred, multiple case-study.

Appendices

Appendix I- Defined sub-questions

1. What kind of activities does the HHN undertake to find out what care the older person needs?
    - What kind of questions does the HHN ask to find out what care the older person needs?
    - What kind of behaviour does the HHN demonstrate in order to find out what care the older person needs?
2. What needs, wishes and preferences does the older person introduce? (concerns)
3. How does the older person introduce needs, wishes and preferences [verbal and behavioural]? (cues)
4. Does the HHN recognise the needs, wishes and preferences? If so, how?
5. How does the HHN respond to the needs, wishes and preferences of the older person [verbal and behavioural]? (cue responding behaviour)
6. Are needs, wishes and preferences of the older person described in the client-care plan? If so, how?

Appendix II- Interview and observation guide

INTERVIEW GUIDE

	Verpleegkundige	**Oudere**
Eerste algemene vraag	Kunt u/kun je mij vertellen wat u meemaakte tijdens het intake interview, kunt u/je beschrijven wat er gebeurde?	Kunt u/kun je mij vertellen wat u meemaakte tijdens het intake interview, kunt u/je beschrijven wat er gebeurde?
Cues and concerns	Gaf de oudere in jouw beleving hints of signalen of sprak hij/zij z'n bezorgdheid uit?	Hebt u in het gesprek een onderwerp door laten schemeren zonder het duidelijk uit te spreken?
Wensen en voorkeuren	Heeft de oudere volgens jou eigen wensen en voorkeuren ingebracht? Hoe deed de oudere dit? Wanneer was dit verbaal, wanneer was dit non-verbaal? Hoe herkende je die inbreng?	Hebt u in het gesprek naar uw mening eigen wensen en voorkeuren ingebracht? Ervoer u genoeg ruimte om dat te kunnen doen? Wat maakt dat u dit wel of juist niet ervoer?
Resultaat	Wat is volgens jou het resultaat van dit gesprek? Ben je tevreden over het resultaat, wat had volgens jou anders gemoeten (resultaat, gedrag communicatie)?	Wat is naar uw mening het resultaat van dit gesprek? Bent u er tevreden mee, is er in uw ogen iets dat anders had gekund (resultaat gedrag, communicatie)?
Cue responding behavior	Hoe vind je dat je reageerde op de eigen inbreng van de oudere?	Vond u dat de verpleegkundige ruimte gaf voor uw verhaal, vond u dat

		zij goed luisterde, dat zij inging op uw inbreng. Hoe vond u haar bejegening?
Voorkennis	Heb je voorkennis over de leefsituatie van de oudere en het ziektebeeld, welke en in welke mate speelt de voorkennis mee die je al hebt over de patiënt van een verwijzer of van het CIZ?	Hoe is het voor u om professionele zorg thuis te krijgen, wist u hier van te voren al iets over? Had u verwachtingen t.a.v. de verpleegkundige (gedrag, communicatie)
EBP	Heb je een professionele standaard in je hoofd als je een intake gaat doen? Zo ja, welke? Kun je zonder je zorg bril naar een zorgvrager luisteren? Vind je dat een zorgvraag altijd om een zorgantwoord vraagt? Door wat wordt het antwoord bepaald?	Is er naar uw mening een ander antwoord mogelijk op uw zorgvraag dan een zorgantwoord?
Bestaand zorgaanbod organisatie	Ga je uit van een bestaand zorgaanbod, regels, routes, afgesproken grenzen in je organisatie? Hoe veel speelruimte, ruimte om buiten de box te denken en handelen ervaar je en neem je doorgaans?	Wat weet u van de organisatie die de zorg aanbiedt, wat verwacht u van deze organisatie?
Gedrag	Wat heb jij de oudere zien doen, hoe gedroeg hij/zij zich?	Wat hebt u de verpleegkundige zien doen, hoe gedroeg ze zich?
Communicatie (verbaal/non-verbaal)	Hoe vond je de communicatie verlopen, welke houding nam je aan en hoe reageerde de oudere daar volgens jou op?	Wat vond u van de manier waarom de verpleegkundige communiceerde (met u sprak en wat vond u van haar houding daarbij)?
Uniciteit	Wat in dit gesprek is volgens jou het centrale uitgangspunt?	Wat moet er in een gesprek als dit gebeuren om u het gevoel te geven dat u en uw leven centraal staan?
Laatste vraag	In relatie tot wat we besproken hebben: is er iets dat nog toegevoegd moet worden, iets waarvan u vindt dat het belangrijk is om in dit onderzoek mee te nemen?	In relatie tot wat we besproken hebben: is er iets dat nog toegevoegd moet worden, iets waarvan u vindt dat het belangrijk is om in dit onderzoek mee te nemen?

OBSERVATION GUIDE

Oudere

1	Het uitdrukken van een hint die bezorgdheid aangeeft of een voor de cliënt belangrijk onderwerp
2	Een expliciet geverbaliseerde bezorgdheid of een voor de cliënt belangrijk onderwerp
3	Een direct geuite emotie

Verpleegkundige

Functie		
1	Explorerend gedrag	Aandacht geven
		Luisteren
2	Erkennend gedrag	Inleven
		Spiegelen
		Confronteren
		Navragen
3	Afstandelijk gedrag	Feitelijke verheldering
		Ongepaste geruststelling
		Voortijdig advies
		Focus verleggen
		Blokkeren
		Afwentelen
Vorm		
1	Directieve vraag	
2	Screening	
3	Onderhandelen	
4	Samenvatten	