The Meaning of a Positive Client-Nurse Relationship for Senior Home Care Clients with Chronic Disease

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RÉSUMÉ

Cette étude a exploré la signification d'une relation positive client-infirmière pour les personnes âgées atteintes de maladies chroniques qui reçoivent les soins à domicile. Pour les besoins de cette étude phénoménologique, huit participants âgés de 65 à 86 ont été sélectionnés à partir du Sud-Ouest Centre communautaire d'accès aux soins [or retain as Southwest Community Care Access Centre (SW-CCAC)]? à London, Ontario. Des données narratives ont été recueillies par des entrevues en profondeur capturé sur cassette audio, tout en utilisant un guide d'entretien semi-structuré. L'analyse et l'interprétation des entrevues ont révélé que le sens d'une relation client-infirmière positive de ces personnes âgées englobait deux tendances de sens: *avoir de confort*, et *étant relié au sein de cette relation*. Ces deux modèles ont été contextualisés par être une personne âgée avec une maladie chronique et ont été socialement construits à *travers l'expérience d'avoir créé un rapport positif*. Bien que des recherches supplémentaires sont nécessaires, les connaissances acquises ajouter à ce que l'on sait déjà au sujet de la théorie et la pratique de la promotion de la santé relationnelle pour les personnes âgées vivant avec des maladies chroniques et recevant les soins à domicile.

ABSTRACT

This study explored the meaning of a positive client-nurse relationship for seniors with chronic disease receiving in-home care. In this phenomenological study, eight participants aged 65 to 86 were purposefully selected from the Southwest Community Care Access Centre (SW-CCAC) in London, Ontario. Narrative data were collected through audiotaped, in-depth interviews using a semi-structured interview guide. The analysis and interpretation of the interviews revealed that the meaning of a positive client-nurse relationship for these seniors encompassed two patterns of the meaning: *having comfort* and *being connected* within this relationship. These two patterns were contextualized by *being a senior with chronic disease* and were socially constructed through the relational experience of *co-creating a positive relationship*. Although further research is needed, the insights gained add to what is known about the theory and practice of relational health promotion for seniors living with chronic disease receiving in-home care.

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Within Canada, the population of individuals aged 65 and older is approximately 4.8 million, representing 14 per cent of the total population (Statistics Canada, 2011). As health issues continue to increase with age, seniors are more likely to report chronic conditions and accompanying decline in health status (Statistics Canada). In fact, more than 80 per cent of older individuals who reside at home live with a chronic health condition (Health Canada, 2002), often necessitating in-home care. As a consequence, in-home nursing care to promote the health of older people with chronic illness is an increasingly important consideration.

Health promotion has been generally defined as a process of enabling individuals to increase control over and improve their health (World Health Organization [WHO],

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1986). Health is a resource for everyday living, according to WHO, and has been conceptualized as an experience built through relationships with others, socially constructed from a shared repertoire of intersubjective meanings. Ultimately, health promotion has been theorized to be a relational process (Hartrick, 2002). From a relational perspective, health promotion is the "integral connection of relationships, ethics, and effective practice" (Hartrick-Doane & Varcoe, 2007, p. 193) towards the achievement of salutogenic (Antonovsky, 1985) or health-promoting goals (Hartrick-Doane & Varcoe, 2007). Thus, positive client-nurse relationships have come to be understood as important to overall health and health promotion. This is perhaps particularly so for frail older people with chronic disease who require on-going in-home care from nurses.

But within our current health care system, including in-home care, the primary focus is still on a highly biomedical view, in which cure of disease and/or abnormality takes precedence over promoting health as a resource for everyday living, encompassing client choice, the ability to realize goals, and the ability to gain a sense of control in one's life (WHO, 1986). Given this orientation, the relational aspect of client care is often neglected (Jonsdottir, Litchfield, & Dexheimer-Pharris, 2004).

In recent years, creating meaningful client-nurse relationships for those in need of longer term care in this context has become even more challenging. Dramatic changes in the health care sector, including increased workloads and fewer resources, undermine attention to the client-nurse relationship (Hagerty & Patusky, 2003; Jonsdottir et al., 2004). At the same time, seniors with chronic disease may be caught up in the undermining of client-nurse relationships, as they may all too readily become increasingly dependent upon their in-home care providers for services and care (McWilliam, 2009). This may more readily transpire because the client-nurse relationship structurally is one of unequal power, as nurses have (a) more influence within the health care sector, (b) specialized health knowledge, (c) access to privileged information, and (d) the ability to advocate for their clients (College of Nurses of Ontario, 2006). Thus, clients may experience relationships with nurses that might consequently threaten their optimal independence and, ultimately, their health as a resource for everyday living (WHO, 1986).

Although several studies (Chen, 2003; Gantert, McWilliam, Ward-Griffin, & Allen, 2008; Schoot, Proot, Ter Meulen, & de Witte, 2005) have uncovered clients' perceptions of various aspects of the nature of client-nurse relationships – in particular, barriers and facilitators to such relationships – the majority of research on client-nurse relationships to date addresses only nurses' perceptions of this relationship. What is lacking is research investigating what a positive client-nurse relationship means to seniors who receive in-home care for chronic disease.

The purpose of this study was to explore the meaning of a positive client-nurse relationship for seniors with chronic disease receiving in-home care. Further research exploring the meaning seniors attribute to relationships with nurses, particularly seniors experiencing long-term care for chronic disease, is needed to better understand relational health promotion. Such research may afford nurses, as well as other health professionals, insights into how they might better optimize health while working with senior individuals receiving in-home care for chronic disease.

Literature Review

Using CINAHL, ProQuest, OVID, PsycINFO, and Scopus databases, we reviewed literature related to the client-nurse relationship and relational nursing practice, to older individuals with chronic disease, and to nursing practice within the home care sector by using the following keywords: client-nurse relationship; nurse-patient relationship; relational health promotion; chronic disease; chronic illness; seniors; and home care. The search uncovered literature from the disciplines of nursing, gerontology, medicine, psychology, sociology, occupational therapy, and physical therapy. Specifically, the literature search yielded results between the years 2000 and 2009 published in Canada, Ireland, Sweden, Taiwan, and the United Kingdom.

A number of authors (Forchuk, Westwell, Martin, Bamber-Azzapardi, Kosterewa-Tolman, & Hux, 2000; Sahlsten & Plos, 2009; Williams, 2001) have examined nurses' perceptions and experiences within the client-nurse relationship. Three phenomenological studies in particular have elicited an in-depth understanding about nurses' experiences of relating within the home care context. While these studies afford insights into the nurses' perceptions and experiences, what is less prevalent is research that specifically uncovers the clients' experiences and perceptions of this relationship.

Clients' Views of the Client-Nurse Relationship

Three studies (Chen, 2003; Gantert et al., 2008; Schoot et al., 2005) either directly or indirectly have investigated elements of the client-nurse relationship from clients' perspectives. Gantert et al. and Chen were phenomenological studies; Schoot et al. was a grounded theory study. Another grounded theory study (Miner-Williams, 2007) focused exclusively on connectedness in the client-nurse relationship from the views of both nurses and clients.

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Gantert et al. (2008) explored seniors' (n = 15) perspectives specific to the social phenomenon of *relationship-building* with in-home service providers, and related facilitators and barriers. While senior participants described reluctance to enter into relationships with health care providers, they nevertheless perceived relationship-building as a dynamic process that encompassed *connecting through the larger life context*; *seeking mutual knowing*; *balancing knowledge, status, and authority*; *creating shared patterning*; and ultimately, *building and maintaining bonds.*

In a second, more peripherally relevant phenomenological study, Chen (2003) explored chronically ill seniors' (n = 76) definitions of health and health-promoting practices, uncovering a diverse, multidimensional view of health and related health promotion practices. Specific to relationships, Chen learned that seniors perceived companionship with nurses as important to taking part in health promotion practices.

In a third study, Schoot et al. (2005) conducted a grounded theory investigation of in-home clients' perspectives on client-nurse *interactions*, not relationships per se. In doing so, these researchers described client-centredness as congruence between what clients desired and what they were allowed to do with regard to participation in their care. Schoot et al. also found that clients often valued independence and self-governance in their care and described attentiveness and responsiveness as associated with congruence in care. As these grounded theory findings portray relational elements as a part of client-nurse social interactions, they invite more direct investigation of clients' in-depth experience of relationships.

In another grounded theory study with a sample of 15 nurses and 10 clients, Miner-Williams (2007) explored connectedness in the client-nurse relationship from the perspectives of both nurse and client participants. Miner-Williams found that connectedness in the client-nurse relationship tended to arise through the nurse's meeting the health needs of the client. Two main themes emerged related to connectedness: nurses *meeting the client's needs of the spirit* and *interpreting meaningfulness* of the relationship. The latter was conveyed through the nurses' interpretation of the meaningfulness of the experience for the client. Miner-Williams found that clients wish to be recognized as valued individual persons in their care. This recognition, in turn, was the framework of spirituality, which characterized connectedness with oneself. Although this study exposed the process of connectedness in the relationship, what this relationship meant for clients was not revealed. Revealing the meaning of the client-nurse relationship for seniors with chronic disease may shed light on which aspects of connectedness are most valued in the relationship for this specific population.

These studies (Chen, 2003; Gantert et al., 2008; Miner-Williams, 2007; Schoot et al., 2005), have addressed elements relevant to clients' experiences and perspectives of care relationships, but have not focused specifically on what client-nurse relationships mean to clients. One additional grounded theory study focused on the social interaction process of connectedness, another element of relationship. Miner-Williams' study reflects the mutually shared perspective of nurses and clients together. None of these studies has uncovered what the client-nurse relationship means for these individuals. Gantert et al. highlighted the need to learn more about senior clients' preferences and individuality with regard to care.

Exploring the meaning of a positive client-nurse relationship for seniors receiving in-home care may help to illuminate these preferences. Furthermore, by understanding the meaning of a positive client-nurse relationship from the perspective of seniors receiving in-home care for chronic disease, nurses might better understand what these individuals envision and need with regard to relational health promotion. Ultimately, any insights gained may enable nurses to better optimize health in working with this population.

Methodology and Methods

Design

Interpretive phenomenology was used to explore the *meaning* of a positive client-nurse relationship for older individuals with chronic disease receiving home care services. Phenomenology is the study of essences and the exploration of human experience (Racher & Robinson, 2002). As phenomenological inquiry focuses on the pre-theoretic lived experience that characterizes meaning in our everyday lives, it is non-theoretical in its orientation (van Manen, 1996). Throughout this investigation, a Heideggerian phenomenology approach was taken to interpret the concealed meanings not immediately revealed to direct investigation, analysis, and description (Omery, 1983). Heidegger's concept of *Being-in-the-World* is premised on the assumption that the individual and the world are co-constituted and that an individual makes sense, or meaning, of the world from within existence, not detached or apart from it (Racher & Robinson). Heidegger also argued that time is the essence of being, and that time and space together provide a context that helps to illuminate understanding (McConnell-Henry, Chapman, & Francis, 2009).

Research Question

Understanding the *Being* of something is to recognize the nature or meaning of the phenomenon (Dowling,

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2005), hence, the relevance of Heideggerian phenomenology for answering the research question of this study: What is the meaning of a positive client-nurse relationship for seniors with chronic disease receiving in-home care?

Participants and Setting

Approval for this study was obtained from the Research Ethics Board of the University of Western Ontario. Eligible participants were contacted by Southwest Community Care Access Centre (SW-CCAC) case managers, who served as key informants, providing a list of clients aged 65 and older who met the study inclusion criteria and indicated a willingness to be contacted by the researcher to discuss potential participation in the study.

Purposeful sampling was used to select from amongst participants experiencing the phenomenon under investigation those who would yield information-rich data appropriate to the study (Patton, 2002). A sample of eight senior individuals aged 65 and older living at home with at least one chronic disease was purposefully selected by key informant case managers from the roster of clients receiving home care services for three or more months through the SW-CCAC in London, Ontario. Case managers selected clients assessed as cognitively unimpaired who were able to speak, read, write, and understand English, and were able and willing to participate in a 60- to 90-minute interview, and obtained clients' permission to share their names with the researcher, in keeping with the Privacy of Information legislation. The sample consisted of seven females and one male, ranging in age from 65 to 86 ($\tilde{x}$ = 74). The participants received nursing services from both registered nurses and registered practical nurses one to three times a week, with visits lasting ten minutes to one hour in length. On average, participants were living with two chronic diseases, which encompassed diabetes, cancer, arthritis, emphysema, heart disease, and multiple sclerosis.

Data Collection

Data were collected through audiotaped, in-depth one-on-one interviews with each participant alone in the context of their home environment, using a semi-structured interview guide (see Appendix) by a graduate student nurse researcher (LT). The nurse researcher was not known to the participants prior to the interviews, but the participants were aware that the researcher was a nurse. Demographic data were collected from participants using a demographic information sheet. The time and location of the interview, which lasted approximately 45 to 90 minutes ($\tilde{x}$ = 51 minutes), was arranged to best meet the participants' preferences. During the interview, participants were asked about in-home care relationships and what the client-nurse relationship meant to them personally; they were encouraged to reflect upon and share their personal experiences of this meaning by describing their overall experience of positive relationships with all nurses involved in their care. All interviews were transcribed verbatim. Additionally, the participants' body language, facial expressions, tones of voice, and reactions to research questions were recorded in audiotaped field notes.

Data Analysis

The interpretive analysis approach of immersion and crystallization devised by Spiegelberg (1982) was used to elicit the findings. This reflective process involves reading and re-reading the interview transcripts while simultaneously listening to the audiotaped interviews with the aim of achieving sensitization to the nuances within the text. As patterns and themes began to emerge, the transcribed data were coded to identify categories and sub-categories within the text. These categories and sub-categories were then examined to further identify patterns and themes. Furthermore, themes and associated sub-themes which emerged from the data were crystallized into an integrated, holistic interpretive analysis in an effort to create a sense of the participants' experiences.

Authenticity

The personal, individualistic, and subjective nature of interpretive research precludes objectivity. However, several techniques were used to promote authenticity and applicability of the findings (Angen, 2000; Kuzel & Like, 1991; Lincoln & Guba, 1985). Authenticity was established through member checking, which involved clarifying participants' responses to ensure that their lived experience was understood (Angen; Kuzel & Like), throughout the interview process. Following data collection, member checking also involved returning to select participants from amongst those consenting to a second interview to report preliminary findings and seek further assistance in promoting authentic interpretations of their experiences. Due to the availability of participants within the study's timeline, one participant who had provided particularly in-depth data participated in this process. Authenticity was also promoted by using techniques such as probing to promote *thick description* (Kuzel & Like; Lincoln & Guba) of seniors' experiences of the client-nurse relationship, with the aim of enabling readers to better determine the applicability of the findings to their circumstances. As well, cogency was promoted through on-going peer review of the analyses by the researcher's advisory

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committee. The advisory committee determined whether the interpretation was clear and resonated with their familiarity of the phenomenon under study (Kuzel & Like).

Findings

The findings of this study illuminate the meaning of a positive client-nurse relationship for seniors receiving in-home care for one or more chronic diseases (see Figure 1). For the senior participants in this study, the meaning of a positive client-nurse relationship within in-home care was very much contextualized by *being a senior with chronic disease*. Being a senior with chronic disease was frequently frustrating, for this meant feeling as though one was a chronic problem for those involved in their care.

This negative experience heightened the meaning of a positive client-nurse relationship for seniors with chronic disease receiving in-home care. Specifically, the seniors in this study described positive experiences of *co-creating the client-nurse relationship*. Within this affectively socially constructed experience, the meaning of a positive client-nurse relationship to these chronically ill seniors receiving in-home care reflected two important attributes, namely: *having comfort* and *being connected*. Next, we examine these layers of meaning arising from a positive client-nurse relationship for senior home care clients with chronic disease.

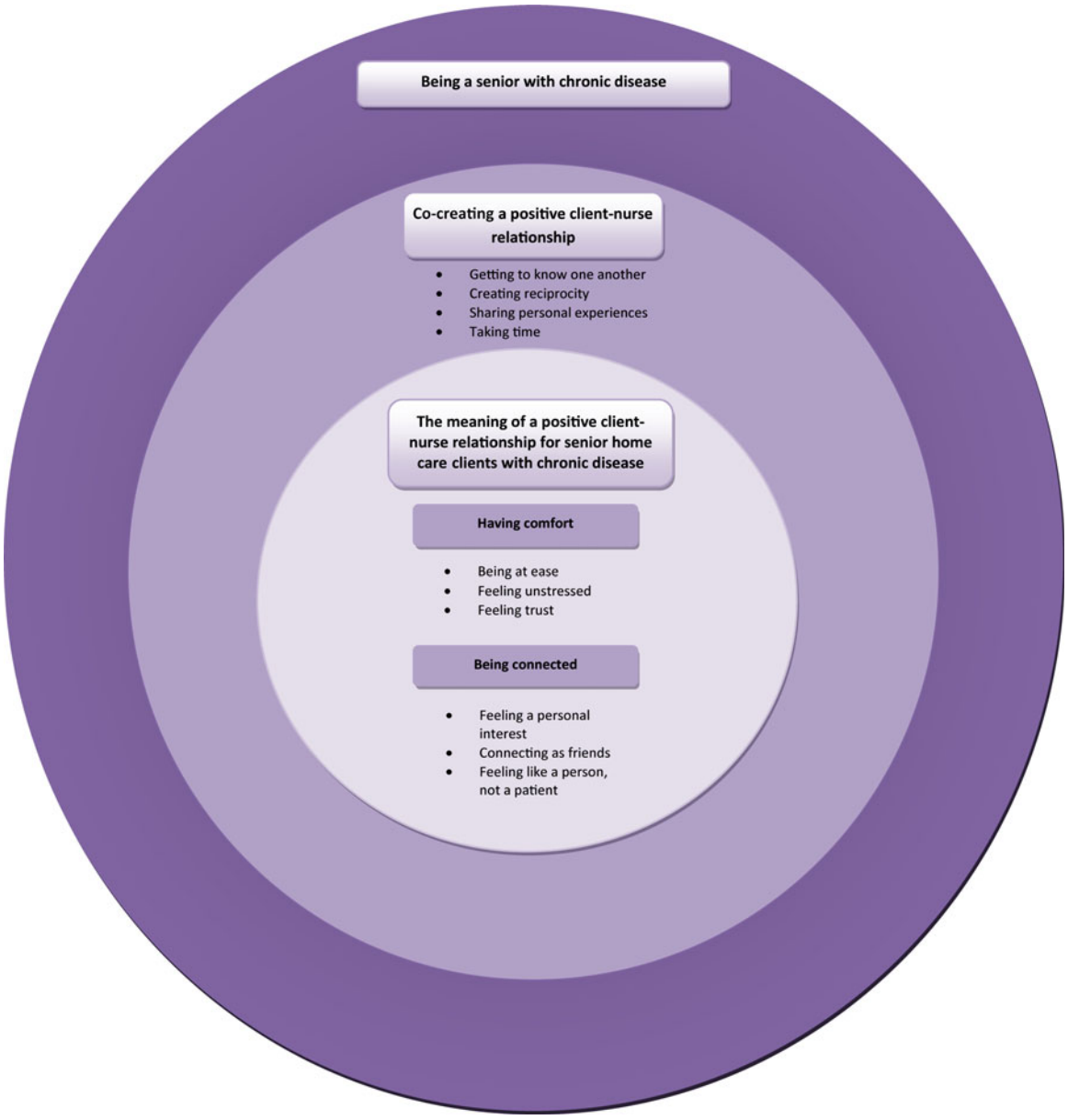

Figure 1: The holistic meaning of a positive client-nurse relationship for seniors receiving in-home care for chronic disease.

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Being a Senior with Chronic Disease

Several participants described their in-home affective experience of relationships as frustrating. Generally, they maintained that nurses providing in-home services generally did not understand what it meant for them to be living with a chronic disease. This experience circumscribed the meaning of positive client-nurse relationships for participants, one of whom portrayed this contextualization as follows:

> Some nurses would come in and look at a patient … as a challenge…. They are going to do everything to fix what's wrong with that patient. If they can make a difference, they would. Others would say, "Okay, this is a chronic problem so we are just going to give mediocre care, because it's a chronic problem that is never going to get better." And that's the problem with listing people with chronic problems.

The same participant expressed frustration with being labelled as having a chronic condition:

> It's very frustrating … to be classified as a chronic problem…. If it's classified as "chronic" and you think you are going to heal, what does that tell you about your thought process and the nurses' thought process? If they don't think they can heal you, they are not going to give you the care you deserve.

Another participant further contextualized the client-nurse relationship with feelings about being referred to as a "patient" with chronic disease. He observed: "I wasn't sick. I had a bodily wound, that's all. Other than that, I was healthy and fine." Similarly, another participant protested: "I don't feel like I'm a chronic problem."

In essence, participants in this study contextualized their accounts of the meaning of a positive client-nurse relationship with stories of frustration and discouragement with how they felt to be treated as a chronic problem and/or patient. Despite the fact that senior participants were living with a chronic disease, many still felt that they were otherwise healthy and expected to be treated as such. Although experiences varied, this overarching experience of in-home care contextualized the meaning of positive client-nurse relationships. In essence, such negative elements of this overarching experience of in-home care heightened the significance of the meaning of positive relationships to them.

Co-creating a Positive Client-Nurse Relationship

Despite this contextualization of *being a senior with chronic disease*, study participants described positive experiences of *co-creating the client-nurse relationship*. *Co-creating a positive client-nurse relationship* included several relational ways of being that were part of the meaning of the client-nurse relationship: *getting to know one another*, *creating reciprocity*, *sharing personal experiences*, and *taking time*. We describe these sub-themes next.

Getting to know one another

Study participants described *getting to know one another* in *co-creating a positive client-nurse relationship*, thereby behaviourly constructing the meaning of the client-nurse relationship. Several participants explained how having the same nurse on a frequent basis created the feeling of greater comfort in the relationship. As one said:

> Well, to me it's really nice if I have somebody I'm very comfortable with, you know? Like after someone has come into your home for 3 or 4 years, you get to know a lot about them. They get to know a lot about you.

Another participant expressed:

> You build up this relationship with this person and you know exactly what they want when they come in … It really is helpful in that sense…. If it's a long-term thing, you get the same [nurse], which is great. Having the same nurse every time, the nurse gets used to you and you get to know the nurse. I think that's one of the big things.

Creating reciprocity

Co-creating a positive client-nurse relationship included sharing a reciprocal connection between client and nurse, which included respecting one another's ideas and opinions in the relationship. One participant said, "I respect her opinions. We have different views, but she doesn't put down my views and I don't put down her views. It has just become a very good relationship."

The same participant revealed:

> The nurse I have – she respects the fact that I'm here waiting for her. So I mean, she'll call and give me a time line. While the other nurses I had that came in, [they] wouldn't call, then showed up anywhere from 8:00 in the morning until 5:00 at night.

Another participant explained:

> So the person [client] has to be able to talk to [the nurse] about the way things are. That's the only way the nurse can help her. If she doesn't have this trust in this person, or if they don't get along that well, then she is not going to have that interaction [a meaningful client-nurse relationship] with her.

Several described the importance of having a reciprocal relationship, one saying:

> It's a two-way street to develop a relationship – it takes two…. The patient has got to be willing to open up and be honest about what's going on with their life and whatever it is that causes them to

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> need home care, and the nurse has to be able to listen and remember.

Another participant stated:

> Clients have to realize that they've got to give and take … you can't just take. A lot of clients expect constantly. They are not the only person that nurse is giving care to.

Yet, another participant noted: "I think it's good when people try on both sides, then it will be okay. It just makes everybody feel comfortable all around."

Sharing personal experiences

A number of participants described how *sharing personal experiences* with the nurse contributed to the meaning of a positive client-nurse relationship. One participant explained how this made her relationship feel "ideal": "Because she shares parts of her life … we have an easygoing relationship. We can talk about what's going on in the news; what's going on in the world, you know?" Another participant said "We laugh and talk about our families and have a really good relationship that way."

Taking time

Participants described nurses *taking time* to care for them as part of *co-creating a positive client-nurse relationship*. One participant revealed:

> She doesn't seem rushed …. She doesn't rush in and say, "Oh that's fine," and away she goes. You know, if they come and they are sort of in a bit of rush, you tend to think, "Oh, I won't bother asking that." She just takes her time and she explains things very well, and therefore, you don't feel as if you are holding her up too much…. She doesn't waste any time, but she doesn't say, "Oh I've got to go now." There's no rushing, she answers everything, and when I go onto a new subject she's right there.

Another participant commented:

> They never make you feel like, "Hurry up, hurry up, I've only got an hour"…. They never look at their watch or make you feel rushed because you're only allotted three-quarters of an hour … They'll just say, "Slow down, relax, don't rush, take your time."

To summarize, for the seniors in this study, co-creating a positive client-nurse relationship through getting to know one another, creating reciprocity, sharing personal experiences, and taking time seemed to socially construct the meaning of a positive client-nurse relationship throughout in-home care for chronic disease.

Within this affective, socially constructed relational context, for the participants in this study, the meaning of a positive client-nurse relationship ultimately encompassed two significant patterns: *having comfort* and *being connected* in the client-nurse relationship, as follows.

Having comfort in the client-nurse relationship

Having comfort in the client-nurse relationship consisted of three elements: *being at ease*, *feeling unstressed*, and *feeling trust*.

Being at ease. For a number of participants, a part of *having comfort* was *being at ease* in the client-nurse relationship. Said one participant: "We have an easygoing relationship, like just basically respect for each other's opinions, you know? If something happens, [she says]: 'What do you think of that?' … If something [else] happens, I say to her, 'What do you think?'"

Another participant observed: "She's very easy to talk to and you don't feel as though you are wasting her time." The same participant described *being at ease* as feeling caring in the relationship, hence, this client-nurse relationship, to her, meant *having comfort*. She said: "She seems like she really cares so I feel comfortable … I enjoy them [nurses] coming and look forward to it. It just makes everybody feel comfortable all around."

Similarly, another client revealed:

> She has the knowledge, she knows what she is doing, and she knows how people feel … It's just not if you're feeling sick – she knows you are at home and there's nobody else in the house but yourself. She's able to talk to you about things and sort of make you feel that there is somebody there looking after you and you don't have to worry because somebody is there, and somebody is coming the next week. And if something is wrong, you can always get in touch with her, too …. I didn't think I would be so at ease.

Another participant commented:

> She helps you to relax. If you have a stranger [come in], you just don't know [how things will go] … you are not relaxed and can't talk the same, either. [Having the same nurse] makes a big difference, I think.

Feeling unstressed. A number of participants expressed how not being stressed was a part of *having comfort* in the client-nurse relationship:

> Stress is very important, especially … when someone is sick. Stress doesn't help. When you have a nurse who is caring and can take command of the situation but runs things by you, saying, "I would like to do this, would you be comfortable to try it?" … They are giving you some respect. [They are saying] that you are intelligent enough to say, "Oh I'm not comfortable with that," or "I am," or, "Let's try it." I think it causes less stress in your life.

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A number of clients described the relevance of *feeling unstressed*. One client articulated:

> If they [the nurses] were rushing me I would really struggle as far as breathing goes, because I can't rush. I would get stressed and then [my] breathing would get worse…. For my health, it means if I'm not stressed, then I'm not struggling with my breathing. So if the relationship was terrible then I would be struggling and stressed and wouldn't want them [the nurses] coming in.

Another client revealed: "I felt a great deal of comfort knowing that someone reliable was coming regularly and they always let me know when. That became comforting and I thought, "Okay, that's one less thing I've got to worry about."

Yet another participant observed:

> It helps your nerves … I mean, you are not worrying about this or about that. You figure, well, these nurses coming will find out what it is. You more or less relax whereas otherwise you would be worried … It helps the nervous system. It helps my nerves. I don't worry about anything. Because you know exactly what's what, and what you have to do, and what have you. She helps you along with that.

Feeling trust. In this study, a few clients also described *feeling trust* as part of the meaning of *having comfort* within a positive client-nurse relationship. One participant said: "I quickly came to trust her, so she could do whatever she wanted to … I knew I was in good hands." Another participant explained: "I feel I can tell her [the nurse] anything that happens … You get to know them [nurses] and they get to know you; you don't mind bringing things out and talking about them."

Being connected

For the participants in this study, a positive client-nurse relationship also meant *being connected* with the nurses providing their in-home care. The following sub-themes further elaborate the meaning of *being connected*, including (a) *feeling a personal interest*, (b) *connecting as friends*, and (c) *feeling like a person, not a patient.*

Feeling a personal interest. A number of participants found meaning in the client-nurse relationship, specifically, *being connected*, through feeling that the nurse had a personal interest. One client explained:

> Most of the nurses that I've dealt with inquire about your personal life and they listen, and then next time you see them that will come up again, you know? And that relationship begins to develop … I wouldn't be as comfortable with a nurse who was just clinical. I want that personal aspect; I think it becomes important in building a good relationship between a nurse and a patient.

Several clients described the significance of *feeling a personal interest*; one poignantly expressed it as follows: "It is much like a human touch …. If I didn't have the nurses I wouldn't know what to do. But to have that, it's like a human touch or human connection … and you need that."

Connecting as friends. Connecting as friends was also a component of being connected. One participant explained:

> It just seemed more than simply nursing care. It was a friend popping in … a young woman that connected…, an attitude of being willing to be a friend and a visitor as well as a professional nurse. She sort of became a friend.

Another participant commented: "I feel I have made a friend, even if it's just for this short time that we have … been seeing each other."

Feeling like a person, not a patient. Ultimately, as one participant was able to articulate, feeling like a person rather than a patient was part of the meaning of being connected:

> She and I connected great … It made me feel good because it meant that I was more than just a wound … I never felt that I was just a patient. The patient needs to be able to be a person, not a patient. I don't remember ever being called a patient by … these nurses.

This participant elaborated further:

> I live alone and I don't have visitors all the time. When someone comes in I like to be able to talk with them and have a human relationship, not just a medical relationship…. She [the nurse] knew me as a person as well as a wound.

In summary, the clients in this study conveyed the in-depth meaning of a positive client-nurse relationship as *having comfort* and *being connected*, shared between client and nurse. These two patterns of the meaning of the client-nurse relationship were contextualized by *being a senior with chronic disease* and socially constructed through the relational experience of *co-creating a positive relationship*.

Discussion

The personal, individualistic, and subjective nature of interpretive research precludes generalizability of the findings (Lopez & Willis, 2004). The data of this investigation were obtained from seniors aged 65 to 86 whose attributes included a diversity of chronic diseases and the predominantly female sex of this subset of home care clientele. All study participants were receiving in-home care services through the SW-CCAC in London, Ontario. The findings reflect these participant

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attributes and cannot be generalized beyond these participants. No attempt was made to undertake data collection and analysis specific to any one age group, gender, or chronic disease, or to differentiate clients' relationships with nurses of different educational levels. The findings may also be limited by the readiness and capacity of participants to convey their experience of the client-nurse relationship. The researcher's interpretation of the participants' experiences also may have been constrained by the context of her own pre-conceived assumptions related to the client-nurse relationship, seniors, and chronic disease and her ability to grasp the meanings that participants conveyed. Nevertheless, these in-depth study findings may have relevance and applicability in other similar situations in which practitioners are providing care to seniors, perhaps particularly within the context of seniors' homes.

Study findings illuminate the meaning of a positive client-nurse relationship as *having comfort* within this relationship, and uncover in greater depth that *having comfort* includes *being at ease*, *feeling unstressed*, and *feeling trust*. This finding supports previous research (Halldorsdottir, 2008; Kolcaba, 2003; Kolcaba & DiMarco, 2005; Nolan, Davies, Brown, Keady, & Nolan, 2003; Yousefi, Abedi, Yarmohammadian, & Elliott, 2009). As comfort is a substantive need throughout life, it is considered an essential component of holistic nursing care (Gropper, 1992; Malinowski & Stamler, 2002). Other research with individuals experiencing palliative care by Kolcaba and Wykle (1997) suggests that individuals who are able to find comfort in their care find it easier to cope, rehabilitate more thoroughly, and are more likely to experience peace. Taken together with these other findings, *having comfort* may be understood to be health promoting when health is understood to be a resource for everyday living.

This study's illumination of the meaning of *having comfort* has important implications for practice in the current context of health care. Once regarded as the central essence of the nursing profession, comfort is now often considered a minor priority within nursing care. Several authors (Malinowski & Stamler, 2002; Wilkin & Slevin, 2003) suggest that the concept of comfort is often neglected within a biomedical approach to health care, where curative strategies are the focus of practice. This technically oriented view of health care often ignores and, indeed, inhibits the relational aspect of client care (Jonsdottir et al., 2004; McWilliam, 2009). As Watson (2009) observes, increased technology, intensity, and bureaucracy of care threaten the nursing function of human caring. Caring is related to comfort (Forchuk et al., 2000; Hudacek, 2007; Kolcaba & DiMarco, 2005; Malinowski & Stamler; Wilkin & Slevin; Yousefi et al., 2009); hence, when human caring is ignored or undermined it can be assumed that comfort is also being ignored (Watson). As a result, relational health promotion is undermined (Hartrick, 2002).

The findings of this study also afford insights into the meaning of a positive client-nurse relationship as *being connected*, illuminated in greater depth as *feeling a personal interest*, *connecting as friends*, and *feeling like a person, not a patient*. This insight is congruent with previous research (Gantert et al., 2008; Halldorsdottir, 2008; McGarry, 2008; McWilliam, 2009; McWilliam et al., 1997; Miner-Williams, 2007; Nolan et al., 2003; Schoot et al., 2005) related to connectedness in the client-nurse relationship. More specifically, several authors (Gantert et al., 2008; Halldorsdottir, 2008; McGarry, 2008; Nolan et al., 2003; Schoot et al., 2005) have found that clients expect to be recognized and valued as a person of worth within this relationship and wish to be understood as an individual human being, apart from their illness. Similarly, other researchers have described the importance of positive relational affect to health (Dale, Savareid, Kirkevold, & Soderhamm, 2010; Gaut & Boykin, 1994; Montgomery, 1993; Segrin & Domschke 2011; Sirri, Magelli, & Grandi, 2010; Wilkin & Slevin, 2003; Wiman & Wikblad, 2003). Inasmuch as positive relational affect is important to health, *being connected*, like *having comfort*, also may be understood to promote health as a resource for everyday living.

This study findings' illumination of the meaning of *having comfort* and *being connected* particularly has implications for both the theory and the practice of relational health promotion. Study findings suggest that in practice, nurses, and indeed, all health and social service professionals, may promote health as a resource for everyday living through consciously attending to co-creating clients' experiences of having comfort and being connected. The initial insights into the importance of these aspects of care also may inform further development of the theory of relational health promotion, identifying in particular elements of relationship that may promote the achievement of salutogenic goals (Antonovsky, 1985; Hartrick-Doane & Varcoe, 2007).

Insight into the meaning of *connecting as friends* in this study also has implications for professional practice. Perceptions about professional boundaries may deter nurses from building relationships in practice which would, in turn, make it difficult to connect with clients. Numerous authors (Gantert et al., 2008; Halldorsdottir, 2008; McGarry, 2008; McWilliam, 2009; McWilliam et al., 1997; McWilliam, Ward-Griffin, Sweetland, Sutherland, & O'Halloran, 2001; Milton, 2008; Moyle, 2003; Oudshoorn, Ward-Griffin, & McWilliam, 2007; Peternelj-Taylor & Yonge, 2003; Williams, 2001) have identified such boundaries in practice. As several authors (Halldorsdottir, 2008; McGarry, 2008; McWilliam et al., 1997; Moyle, 2003) have discussed, nurses have

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been socialized to maintain objectivity in care, often distancing themselves from clients in order to refrain from "over-involvement" in the relationship.

As the findings of this study illuminate, clients' connecting with nurses in a comforting manner constitutes an essential component of the meaning imparted to them by a positive client-nurse relationship. Connecting in such a manner may prove to be difficult if nursing care is consistently being provided at a distance (Moyle, 2003). Providing care "from a distance" clearly makes it difficult for nurses to *connect as friends*, which was meaningful for the senior participants in this study and has also been related to achieving comfort in a positive client-nurse relationship within the context of home care (Yousefi et al., 2009). Connecting with clients in practice becomes further complicated for nurses due to the biomedical model of health care, which places nurses in an authoritative position over their clients, due to their "expert" status, and puts clients in the passive, disempowered position of care recipient (McWilliam, 2009; McWilliam et al., 2001; Milton, 2008; Oudshoorn et al., 2007; Peternelj-Taylor & Yonge, 2003).

Given this reality, with due consideration of the findings of this study, practitioners may be enabled to enhance health promotion by critical reflection on their relationships with clients, continuously questioning whether their assumptions and beliefs about professional boundaries are impeding relational care. However, relational care may constitute a considerable practice challenge. In an ethnographic study with 13 senior clients and 16 community nurses, McGarry (2008) found that, although nurses felt their relationship was a "professional friendship", they often experienced challenges when "policing" their own professional boundaries while trying to initiate and foster health-enhancing relationships with clients. Clearly, as the literature does not convey the precise nature of the meaning of friendship in the context of being a professional friend for a client, this concept requires more in-depth investigation.

Overall, this investigation's insights into the meaning of being connected to older clients receiving in-home care suggest the need for the nursing profession to confront the challenges of connecting appropriately with clients. Developing a more widely espoused knowledge base of how to relate in practice, and how to co-create a mutual understanding of friend, congruent with "professional friendship" (McGarry, 2008) is important if nurses are to enhance health as a resource for everyday living (Hartrick, 2002; Jonsdottir et al., 2004; McWilliam, 2009; McWilliam et al., 2001).

The findings of this study also have implications for professional education. Within nursing education, considerable emphasis has been placed on the science of nursing practice and research (Watson, 2009). This emphasis has shifted our attention away from concepts such as holism and comfort in practice (Dossey, Keegan, & Guzzetta, 2005). In a cross-sectional, comparative-descriptive study with baccalaureate nursing students (n = 120), Khademian and Vizeshfar (2007) found that students perceived practical and cognitive caring behaviours (i.e., assessment and monitoring) as the most important in practice, whereas emotional caring behaviours (i.e., trusting relationship and comfort) were viewed as the least important. This finding was congruent with the research of Kapborg (2000), in which nursing students were found to perceive physical work to be "real nursing". Although Downey (2007) asserted that nursing education has evolved from a behaviourist approach to one that is more humanistic in nature, research to date suggests that nursing education programs continue to fall short in this area.

The insights gained from this study may inform the development of learning experiences for students with seniors who are chronically ill, specifically, experience accompanied by critical reflection assignments designed to nurture understanding of how to build and maintain meaningful relationships with clients. Such educational content may enable nursing students to embrace relational strategies which support empowerment and the promotion of health as a resource for everyday living.

Study findings revealing the participants' expressed frustrations with being treated as a "chronic problem" within the context of in-home care also have implications for practice. Previous investigations (Joachim & Acorn, 2000a, b) have described the experience of stigma amongst people with chronic conditions. In a recent phenomenological investigation, Kaufman (2011) has described how both biomedical approaches to care and individuals' own experience of chronic illness might contribute to the experience of dehumanized care. Several researchers (Chen, 2003; Crawford-Shearer, Fleury, & Reed, 2009; Gantert et al., 2008; McWilliam et al., 1997, 2001) have specifically studied seniors with chronic disease receiving in-home care, but as yet, the experience of being a "chronic problem" has not been explored in-depth in the in-home or any other health care context. With due consideration of the need to be cautious about drawing conclusions from the unique experiences of individuals, and their particular time and space contexts (Thorne et al., 2002), further research that uncovers greater understanding of what it means for seniors to be living with a chronic disease may enable health professionals to understand how to better relate to these individuals in practice and to ultimately promote their health.

Conclusion

This phenomenological investigation was undertaken to uncover the meaning of the client-nurse relationship for seniors with chronic disease receiving in-home care. Findings illuminate that, for these individuals, a positive client-nurse relationship means *having comfort* and *being connected*. The study findings also afford insights further informing the theory and practice of relational health promotion.

The findings of this study accentuate the importance of client-nurse interpersonal interactions which promote comfort and connectedness, thereby constituting meaningful relationships. Yet health care for seniors with chronic disease continues to be very biomedically focused, placing less of an emphasis on relational care needs. Given the current context of health care, the findings of this study may enable decision makers and practitioners of all health and social services to work towards care and service delivery that conveys greater valuing of meaningful client-nurse relationships. As well, the insights acquired through this investigation may inform specific strategies for promoting positive client-nurse relationships, and ultimately, for promoting relational health. Further research is needed to uncover in greater depth the meaning of comfort and connectedness for seniors with chronic disease, thereby further informing the theory and praxis of relational health promotion.

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Appendix

Semi-Structured Interview Guide

Date: _____

Time: _____

The purpose of this study is to gain a better understanding of the meaning of a positive client-nurse relationship for older individuals receiving home care services for chronic disease. There are no right or wrong answers to the questions I will ask you. We simply want to hear about your thoughts, feelings, and experiences, all of which may be valuable in helping nurses to gain insights into how to build positive relationships with people like you. This interview will be recorded. You may refuse to answer any questions and may stop the interview at any time. I also want to remind you that all your answers will be kept confidential. You will never be personally identified in any reports of this study.

First, let's begin with your home care experience in general.

1. Can you tell me a little about your home care experience:
   - What services do you receive?
   - How often do you receive these services?
   - What times of the day do you receive these services?
   - What is your experience of in-home nursing care?
   - What is your experience of relationships with nurses in your in-home care?
2. Please tell me about the positive relationship(s) you have with the nurse(s) who provide care for you:
   - What are these positive relationships like? (Probe for verbal and non-verbal enactment and subjective/ intersubjective affective elements.)
   - How would you describe how you and your nurse(s) relate to one another? (Probe for verbal and non-verbal enactment and subjective/ intersubjective affective elements.)
   - What does each person contribute to the relationship? (Probe for verbal and non-verbal enactment and subjective/ intersubjective affective elements.)
     - How else do you relate to one another?
     - How does this relating process make you feel?
     - How do positive relationships with nurses make you feel?
3. Can you tell me what you think about positive relationships between clients and nurses:
   - What do you think clients expect of their relationships with nurses?
   - Thinking about yourself, what are your expectations of relationships with nurses?
   - What client needs do you think might be met through positive relationships with nurses?
   - How would you describe your needs for positive relationships with nurses?
   - Why do you think positive relationships with nurses might be important to clients?
   - What is important to you about your positive relationships with nurses?
   - What do the positive relationships you have with your home care nurses mean for your health and/or health care?
   - What do the positive relationships you have with your home care nurses mean for you as a person?
4. Can you elaborate more on what makes your positive relationship(s) with nurses meaningful to you:
   - What factors come into play in your relationships with nurses?
   - What would your ideal client-nurse relationship be like?
   - What would your ideal client-nurse relationship feel like?
   - What would this relationship mean to you?
   - How might your current relationships with nurses be better?
   - How do you think nurses and clients might go about making their relationships better?
5. Is there anything about your positive relationship(s) with your home care nurse(s) that you think I haven't asked that you would like to talk about?
6. Do you have any final thoughts you would like to share?

End Time: _____

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