6. Together toward trust: understanding interactions between caregivers and receivers during home visits for older people

PART 2/2

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ABSTRACT

Evidence suggests that impact of proactive home visit programs for older people may be influenced by the caregiver-care receiver relationship. To gain insight in the processes that underlie this relationship, we investigated the interaction between Ann, a practice nurse, and Mrs. Peters, an older women participating in a home visit program. We observed during two consecutive home visits, and performed in-depth semi-structured interviews. Our findings indicate that an older person’s grant of authority to their caregiver plays a role in the successful implementation of home visit services. Such a grant of authority has its foundation in a trusting relationship. Ann and Mrs. Peters were able to build a trusting relationship because Ann catered to Mrs. Peters’ needs regarding the relational aspect of the interaction. We conclude that opportunities to increase the overall impact of home visit programs may lie in securing that caregivers meet older people’s relational needs.

INTRODUCTION

When older people become dependent on formal care, they enter a phase in which the medical world plays an increasing role in their day-to-day lives. Between hospital admissions, consultations with physicians and the use of home care services, older people may encounter many different caregivers. Results of studies that investigated the nature and course of encounters between caregivers and care receivers indicate that these interactions play an important role in the care process: they provide a framework for information exchange, negotiation of care and delivery of services; also, they provide the foundation for strategies highly valued by both caregiver and care receiver, such as client involvement and shared decision making [1-7].

Due to the current trend to ‘age in place’, an increasing amount of care for older people is delivered at home [8]. As a result, the location of the caregiver-care receiver interaction has been shifting from the hospital or health care professional’s office to the care receiver’s home environment. Proactive home visit programs for older people, adopted by some countries as national policy, deliberately make use of the home setting as a site of care. The aim of such programs is to prevent loss of autonomy and worsening of disability by initiating the care process before older people express explicit demand [9-11]. However, evaluations of the effectiveness of proactive home visit programs
in systematic literature reviews and meta-analyses yield inconsistent results: some individual studies report positive effects on patient outcomes such as functional status, mental health and perceived social support, while others find no results at all [9;11-14]. So far, this inconsistency remains poorly understood: differences in study design, program characteristics, target populations and context complicate the investigation of what program components contribute to a change in outcomes [9-11;14]. In addition, little information exists about how aspects of the care process (such as implementation, quality of delivery and the extent to which care is tailored) influence program impact.

Literature suggests that success of proactive home visits is influenced by the caregiver-care receiver relationship [15]. For instance, Yamada (2011) found that engaging in a collaborative relationship with a caregiver during a home visit stimulated older people’s willingness to adapt to appropriate health behaviour. Such study findings support the idea that more knowledge about the caregiver-care receiver interaction could increase our understanding of what aspects of home visits have the potential to positively contribute to program impact. So far, however, little is known about the processes that underlie interactions between caregivers who carry out the home visits and older people. Without insight in these processes, the so-called “black box” of home visits remains closed, and policy makers, care professionals and researchers remain in the dark as to how to design and implement effective programs.

In order to open the black box of home visits for older people, we investigated the interaction between an older person and a practice nurse in a home setting. We aimed to gain insight in the processes that took place during this encounter by using a naturalistic case study design. Case studies help achieve a thorough understanding of a single bounded system – in this case the interaction between the practice nurse and the older person – through in-depth engagement with the object of study and analysis of its individual complexity [16]. The case we chose to explore was selected based on its learning potential [17]: we believe that the particularities of this case highlight the intricacies of the interaction between a caregiver and an older person in a home setting, and therefore expose the processes that could help us understand more about how interactions play a role in success of proactive home visits.

In this paper, we present our study findings. To provide a framework for the interpretation and explanation of the empirical data, we apply a theory of ethics of care. To allow for a comprehensive understanding of the case, we describe the characteristics of both the practice nurse and the older person, and give a detailed account (or ‘thick description’) of the events that took
place during the home visit process. In doing so, we hope to contribute to the emerging knowledge about the role of the caregiver-care receiver interaction during proactive home visits for older people.

METHODS

Naturalistic case studies

Naturalistic case studies are used when researchers aim to understand the specifics of a phenomenon in a particular setting for a particular case [17]. As opposed to studies manipulated by the researcher, naturalistic case studies are performed in an everyday, true-to-life environment. Five characteristics distinguish naturalistic case studies from other study designs [17]. First, naturalistic case studies mainly focus on “emic” issues, i.e. topics that were not anticipated in advance but that emerge from the case. While “etic” issues (topics that are anticipated based on the research question or existing knowledge about the phenomenon under scrutiny) may be applied initially to organize the study structure or outline the conceptual framework, emic issues represent unexpected but potentially essential case characteristics, and may therefore be more prominently featured in final research reports. Second, in naturalistic case studies an important role is designated to the case’s specific context. As with all social phenomena, the case and its meaning is constantly shaped by its surroundings; therefore, the study of context enhances our understanding of the case. Third, naturalistic case studies are based on the idea that reality is constructed: all humans actively interpret and make sense of their world, and objective, universal realities do not exist. To take into account this complexity and generate a naturalistic account, it is essential to explore how people give meaning to their world by explicating and analyzing research findings from a range of perspectives. Furthermore, naturalistic case studies aim to produce a holistic understanding of the case. This approach implies researchers assume a case is made up of interrelated and context-dependent events or issues, and that insight in these events and issues help generate a fuller, or “richer”, understanding of reality. Finally, cases are selected not based on their representativeness, but on what exploring their particularities can teach us about the phenomenon that we are interested in. Cases with such ‘learning potential’ often stand out from other cases in terms of complexity and dynamics. While a naturalistic case study
does not aim to achieve generalizability, it is expected that an investigation of a single case’s patterns and processes increases our understanding of a larger issue.

Data collection and analysis

The case study was embedded in the Frail Older Adults Care in Transition (ACT) study, which implemented an integrated care model, the Geriatric Care Model, amongst frail, older people in the Netherlands [18]. The Geriatric Care Model aims to enable ‘productive interactions’ (i.e. collaboration towards achieving a common health or care goal) between activated, informed older people and proactive, prepared caregivers [19]. Older people who participated in the ACT study were offered a program that consisted of a 6-monthly in-home comprehensive geriatric assessment conducted by a nurse practitioner. The interaction between the practice nurse and the older person presented in this case report took place as part of this program.

In order to gain a multi-angled understanding of our case, we used triangulation of methods. Triangulation has been defined as “the combination of two or more rigorous studies, conducted to provide a more comprehensive picture of the results than either study could do alone” [20]. We used participant observation during the first and second home visit to gain insight in the behaviour of the practice nurse and the older person during their interaction. Field notes were based on an observation checklist. Detailed observation reports were written immediately after the observations. In-depth semi-structured interviews with both the older person (one month after the last home visit) and the practice nurse (directly after the home visits) by the first author were used to gain insight in personal histories, beliefs and experiences (see Table 1 for observation and interview topics). Interviews were audio recorded and transcribed. Data was analyzed throughout the study period. In order to focus on issues emerging from the case and to gain contextual understanding, both field reports and interview transcripts were analyzed using narrative analysis.
Table 1
Observation topics and interview topics

<table>
<thead>
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<th>Data collection</th>
<th>Topics</th>
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| **Observations** | - Home visit environment  
- Communication of information  
- Atmosphere  
- Attitude nurse and client  
- Rapport  
- Goal setting  
- Relational dynamics  
- Ways in which practice nurse involves, motivates, stimulates, compliments or reinforces a client  
- Ways in which practice nurse recognizes sources of strength and resilience of client  
- Client response to care advice  
- Assessment outcomes |
| **Interview client** | Recent changes in received care services (e.g. aids, caregivers, medications, treatments)  
- ways in which changes were established  
- attitude client toward changes  
Experiences of client with practice nurse  
- attitude practice nurse toward client  
- extend to which client experienced equality/collaboration in relationship with practice nurse and how this was achieved  
- extent to which client experienced opportunities for autonomous decision making and how this was achieved  
- extent to which client experienced being offered choices and how this was achieved  
- extent to which client experienced control and how this was achieved |
| **Interview practice nurse** | Professional attitude  
- professional beliefs, values, opinions, goals  
- self-perceived competencies  
Evaluation interaction with client  
- rapport and relationship building  
- barriers and facilitators to relationship building  
- own behaviour, attitude and professional functioning  
- priority setting |

**Quality procedures**

Examination of the accuracy of the study process and its outcomes is essential in order to ensure the quality of qualitative research. Three often-used quality criteria are credibility, transferability and dependability [21]. To ensure credibility, the principle concerned with promoting the accurate recording of phenomena under investigation [22], we used data triangulation (see ‘data collection and analysis’). Further, we did member checks by asking both respondents whether they recognized and approved our interpretations [20]. While the practice nurse approved our interpretation, the older person indicated that she would rather not participate in the member check procedure. To achieve transferability, a principle that involves describing findings in a detailed and ‘thick’ way so as to allow others to ‘transfer’
research findings to a different context and interpret them outside of the original research setting [23], we present meaning and context. To ensure dependability, a principle concerned with enabling an accurate repetition of the study, the first author kept a research log in which she reflected on methodological decisions and her own role in the research process. Finally, we aimed to reach intersubjective agreement by performing a two-person (first and second author) analysis of the interview transcripts; results of both analyses were discussed with the research team.

RESULTS

Below, we present a detailed description and critical analysis of two encounters between Mrs. Peters, an older woman living in the community, and Ann, a practice nurse who visited Mrs. Peters at home.

Mrs. Peters

Mrs. Peters is 71 years old. She lives with her 77-year-old husband in a quiet, green suburb of a medium-sized Dutch town. Mrs. Peters has been struggling with poor health her entire life: she lives with asthma, hypothyroidism and atherosclerotic heart disease and suffers from leg pain caused by osteoporosis of the spine. Lately this leg pain has become chronic, which causes Mrs. Peters to be tired most of the day; she complains of a lack of social activities, low energy levels and weight gain. Mrs. and Mr. Peters have no children and do not make use of home care services – so far, Mrs. Peters has been managing daily life with the help of her husband.

Due to Mrs. Peters’ lifelong struggle with illness, she has always been dependent on others. This dependency has influenced Mrs. Peters’ attitude toward care professionals.

You see, I am happy with all the help I can get. And that is caused by all those years of depending on other people. (…)
I have no children. When you have no one, shouldn’t you be counting your blessings when there is someone willing to take care of you? (Interview, Mrs. Peters)
In order to manage her dependency, Mrs. Peters prefers a collaborative relationship with caregivers, but she has not always been able to stand up for herself or voice her opinion. Recently she got in to a conflict with her primary care physician (PCP) about the diagnosis and treatment for her chronic leg pain. After repeatedly requesting further diagnostic tests, the PCP told Mrs. Peters that oral pain medication would be her only option – Mrs. Peters felt dismissed and not taken seriously, and she has not visited the PCP since.

When offered a home visit as part of the ACT study, Mrs. Peters struggles with three issues. First, her chronic leg pain causes physical and social impairment and mental distress. While a pain block (an often-used pain management procedure to treat heavy nerve pains) has helped her before, Mrs. Peters is uncomfortable with treatments that she believes involve toxic chemicals, and has turned away from further procedures. Mrs. Peters is also concerned about the future. Her biggest fear is to lose her husband and be forced to move into a care home. She is contemplating moving to an apartment with care facilities, but realizes that more security in the future also means giving up the familiarity and comfort of her present home. Finally, Mrs. Peters and her husband have been having marital problems for a while, and lately their relationship has become even more strained. These three issues cause Mrs. Peters to worry a lot.

Ann

Animated and with a warm personality, Ann is a fifty-three year old working as a health care professional. In the past ten years, she has worked as a community nurse, a practice assistant and a practice nurse. When asked to rate her involvement in the home visit program, she gives a ten out of ten. She is vocal about her professional philosophy, in which the concepts of trust and involvement play a central role. Ann finds that trust can only be built once a good relationship is established and has clear ideas as to how to approach establishing such a relationship.

A good conversation is pivotal. Trust is built when someone feels understood and empathised with. This can be achieved by paying close attention during a conversation: you want to make sure that you relate to someone, and prevent that she or he starts to feel resistance towards you. (Interview, Ann)
Ann points out that the private home sets the stage for a different conversation than the one held in a doctor’s office: ‘I touch on topics, such as family and intimacy, that are hardly ever discussed with family doctors or specialists. These conversations shake people up, initiate a thinking process. People often thank me afterwards.’ When interacting with clients, Ann prefers an informal approach. It is her belief that in order to relate to a client a nurse practitioner needs to feel engaged. She sees engagement as the key to equality – another condition for a successful relationship – and emphasises that knowledge sharing without involvement could create and unbalanced hierarchy.

The first home visit

When Ann is received in the Peters’ home, the atmosphere is almost formal: Mrs. Peters takes Ann’s coat, and coffee is served from the family’s nicest tableware. Mrs. Peters is reserved and a little guarded; she does not speak much, and when she does her voice is soft. Ann, on the other hand, enters the house chattering, complimenting Mrs. Peters on her house and garden, and trying to make small talk.

Ann uses a structured geriatric assessment instrument to explore Mrs. Peters’ health and care issues. In order to adequately advice and inform Mrs. Peters about ways to target these issues, she also asks about Mrs. Peters’ past, her hobbies and her family. Despite Ann’s efforts, however, Mrs. Peters rejects all of Ann’s suggestions and advice: for instance, she dismisses Ann’s suggestion to get another pain block and responds with silence to Ann’s advice to consider home care instead of moving to a smaller place. In addition, Mrs. Peters remains passive and takes little initiative to ask questions or voice her preferences. When at the end of the assessment Mrs. Peters says that she does not have any care goals, Ann suggests that Mrs. Peters reduces medical drugs intake, finds adequate pain management and increases her activity level. It is unclear whether Mrs. Peters agrees with these goals.

Between home visits

In the weeks after Ann’s visit, Mrs. Peters changes her mind and decides to get another pain block after all. In order to get a referral she has to make an appointment with her PCP, whom she has not visited since the conflict.
In the consultation that follows, Mrs. Peters also talks to the doctor about her marital problems, for which the doctor refers Mr. and Mrs. Peters to marriage counselling.

_The second home visit_

The purpose of the second home visit is to discuss the outcomes of the assessment, which Ann has summarized in a care plan. When Ann enters the house, she thanks Mrs. Peters for receiving her again. During the last visit Ann sat opposite of Mrs. Peters at the table, but this time she sits down next to her and explains why: ‘If you don’t mind, I would like to sit down next to you so we can look at the care plan together.’ Over coffee (Mrs. Peters has remembered how Ann takes hers) Ann explains why an outcome is included in the care plan, asks whether Mrs. Peters agrees with the outcome and advises Mrs. Peters about her options. By making remarks such as ‘if that is something that you would consider’, she offers Mrs. Peters space to give her opinion and make her own choices. Furthermore, Ann motivates (‘you managed, despite everything!’), compliments (‘well done, that took strength!’ or ‘that was a smart thing to do’) and shows engagement (‘I understand’).

As opposed to last time – and to Ann’s surprise – the atmosphere during the home visit is a lot more informal. Mrs. Peters’ attitude has changed from reserved and guarded to more open and at ease, and she responds positively to Ann’s advice and suggestions. Mrs. Peters now says that she has two care goals: she wants to take up social activities and finally decide on whether to move or not. At the end of the home visit, Ann and Mrs. Peters schedule a follow-up visit.

_After the home visits_

When Mrs. Peters is asked about her experiences regarding the two home visits, she mentions she trusts that Ann has the knowledge and competency to inform and advice her: ‘[Ann] is the expert, so I leave it up to her to tell me about the options that I have. I trust that [she knows what she’s doing].’ In addition, Mrs. Peters felt confident to speak up and be vocal about her wants and needs.
Ann gives me a lot of space during our conversation. She does not put pressure on me by telling me to do this or that. I appreciate that space. If Ann would be the kind of person to force her opinion on me, I would not tell her anything. (Interview, Mrs. Peters)

Mrs. Peters emphasises how she feels about the personal aspect of her relationship with Ann. ‘Ann is easy to get on with, to have a conversation with. I feel comfortable around her. (...) I would not be afraid to tell her that a decision [we made] is not working out for me.’ When asked about the future, Mrs. Peters says that since Ann’s visit, she feels someone is looking after her:

Family doctors are always busy, and have little time to spend with their patients. Ann has the time to get to know me. In case something bad happens in the future, Ann knows everything about my situation. This way, I feel more prepared for what is coming. We have no children to take care of us, so we appreciate it. (Interview, Mrs. Peters)

CRITICAL ANALYSIS

Over the course of the two home visits, Mrs. Peters’ attitude changes considerably. During the first visit Mrs. Peters is reserved and quiet: she remains passive, does not set care goals and rejects Ann’s suggestions for treatment or care. However, during the second visit Mrs. Peters is more at ease and opens up. She now accepts Ann’s services, which allows Ann to implement her knowledge and skills: at the end of the second home visit, the issues Mrs. Peters struggled with were brought to the attention of health care professionals and action was taken towards improving Mrs. Peters’ physical, mental and social wellbeing.

Mrs. Peters’ grant of authority

A relationship between a care giver and a care receiver is characterized by a power imbalance: care givers offer services that patients depend on, but cannot provide for themselves. Tronto (2009) argues that the conscious decision
for a care receiver to enter this power relationship – and thus to decide to accept care from a professional – can be understood as a transferral of authority from the care receiver to the caregiver. Since interventions or treatments cannot be started until a care receiver accepts the care offered to them, a care receiver’s grant of authority is an essential condition for care delivery [24].

According to Tronto’s theory, Mrs. Peters’ acceptance of Ann’s services reflects a grant of authority. Understanding why Mrs. Peters grants Ann authority could therefore help us gain more insight in the processes that facilitate the implementation of home visit services. A look at Mrs. Peters’ personal story reminds us that she potentially benefits from accepting support from a caregiver: her back pain is unbearable, she is afraid of becoming dependent on care, and her marriage is under strain. In most care settings, experiencing issues related to health, care or wellbeing can be enough to motivate older people’s decision to enter a care relationship. However, home visits are proactive and optional, which means that they offer services despite the absence of overt demand. An older person who is approached for a home visit might therefore not always feel care is necessary or urgent, even though they could potentially benefit from it. At the same time, home visits ask older people to make an investment: in order to benefit from home visits, older people have to allow caregivers into their personal space, negotiate the home as a site of care, and share personal, often intimate information with someone they may have never met before [25;26]. The absence of urgency and the sacrifices to privacy suggest that, besides potential benefits, other motivators might play a role in the decision to grant a caregiver authority.

Building trust

These motivators might originate in the nature of the caregiver-care receiver relationship. The development of this relationship takes place during the care process, in which Fisher and Tronto (1990) distinguish four phases [27]. In the first phase (‘caring about’), the caregiver recognizes the necessity of care, a process that requires the virtue of attentiveness. In the second phase (‘taking care of’), the caregiver assumes responsibility for the identified care necessity and determines how to respond to it – this requires the virtue of responsibility. The third phase (‘care giving’) is characterized by a direct meeting of care needs, which requires a caregiver to possess the virtue of ex-
pertise. In the last phase (‘care receiving’), the subject of care responds to the care they receive, something that requires responsiveness. The fundamental aspect that connects all the phases of the care process, Fisher and Tronto argue, is trust. This analysis of the care process suggests that the development of caregiver-care receiver relationship is rooted in trust.

Tronto recognizes a strong conceptual link between trust and the act of granting authority: she interprets granting authority as an act of trust [24]. When a care receiver grants their caregiver authority, it insinuates their expectation that their caregiver is reliable and possesses the skills and knowledge required to advice and treat them – the grantor expects that the actions of the care provider will be consistent with the grantor’s needs and demands. If, as we argued earlier, Mrs. Peters indeed granted Ann authority, the relationship between the two women must therefore have been a trusting one. Baier has defined trust in a care relationship as a “reliance on others’ competence and willingness to look after, rather than harm, the things one cares about which are entrusted to their care” [28]. Baier’s definition implies that trust between a caregiver and a care receiver is built on two conditions: a caregiver’s perceived competence and a caregiver’s perceived reliability (a perceived willingness to at all times act in the care receiver’s best interest). It suggests that something must have convinced Mrs. Peters that Ann is reliable and competent enough to meet Mrs. Peters’ specific care needs. To understand how this may have happened, we need to recall Mrs. Peters’ life story, personality and current circumstances.

As we saw earlier, Mrs. Peters’ lifelong dependency on others have made it difficult for her to stand up for herself. It is therefore important for her to receive care in an environment which encourages her to express her wants and needs. Her preferred type of relationship with a caregiver is one in which she and the caregiver work together toward finding solutions for her health and care issues. Ann uses several strategies to meet Mrs. Peters needs for such a collaborative relationship. First, when Ann offers Mrs. Peters advice or information, she is careful not to let her own opinion dominate the conversation: she is clear about the fact that her professional advice is non-obligatory, stresses that interventions are optional, and regularly asks Mrs. Peters about the accuracy of her interpretations and conclusions. Second, during their conversation Ann expresses empathy and engagement. For instance, she regularly acknowledges Mrs. Peters’ emotions and difficult situation, and makes positively reinforcing remarks. Finally, Ann acknowledges Mrs. Peters’ control of her home environment. She makes efforts to be unobtrusive, is polite at all times, and treats Mrs. Peters like a hostess rather than a client.
What we know of Ann suggests that her approach builds on her professional values, philosophy and character. For instance, Ann believes that achieving equality through ‘relating’ to someone is an important condition for a good relationship with a client. This belief causes her to emphasize Mrs. Peters’ autonomy, to express affinity with Mrs. Peters’ life story, and to acknowledge the home visit’s intrusive nature. Ann’s focus on equality through engagement enables a more egalitarian, pressure-free relationship with a client, which corresponds with Mrs. Peters’ need for ‘space’ and collaboration. Moreover, Ann’s warm and easy going personality adds to a friendly and comfortable environment, in which Mrs. Peters is encouraged to take space for herself.

Based on our critical analysis of Mrs. Peters and Ann’s interaction, we argue that whether authority is granted depends largely on a caregiver’s (perceived) ability to meet a care receiver’s relational needs: the needs of a care receiver regarding the relational aspect of the interaction with a caregiver. Ann’s personal and professional approach matches Mrs. Peters’ specific needs regarding the relational aspect of a care relationship, which provides the foundation upon which Mrs. Peters trusted Ann with her authority. Once Mrs. Peters grants Ann authority, she is receptive to advice and options. Ann is now able to start working towards meeting Mrs. Peters’ other, more practical needs by giving tailored advice about social and medical issues and by scheduling a follow-up meeting to discuss further actions.

**Continuing care**

Mrs. Peters says that she feels more secure about the future knowing someone she trusts is aware of her situation and can assist her when she becomes more dependent. This suggests that a grant of authority enables implementation of home visit services in the future. In order to achieve continuity of care delivery, it is essential that the trusting relationship between Ann and Mrs. Peters stays intact. Van Heijst (2005) distinguishes two types of care relationships: a ‘narrow’ relationship, defined as a contract-like agreement between two stakeholders who encounter each other in a care setting, and a ‘qualitative’ relationship, characterized by a mutually valued connection on an emotional level [29]. In order to preserve a care receivers’ grant of authority and enable future home visit services delivery, a shift from a narrow to a qualitative relationship might be necessary.
DISCUSSION

We conducted a case study to explore what happened during the interaction of Mrs. Peters, an older women who participated in a home visit program, and Ann, the practice nurse who visited her at home. When we analyzed the interaction, we noticed that between the first and the second home visit Mrs. Peters's attitude had changed. We interpreted this change as Mrs. Peters’s acceptance of Ann’s services. Using Tronto’s ideas that this acceptance can be seen as a grant of authority (a necessary condition for care delivery) and that an act of granting authority is an act of trust, we showed that there must have been a trusting relationship between Mrs. Peters and Ann.

In order to achieve this trusting relationship two conditions had to be met: first, Mrs. Peters had to perceive Ann as competent, and second, Mrs. Peters had to perceive Ann as reliable. The latter denotes that Mrs. Peters had to believe that Ann had her best interest at heart and was willing and able to meet her needs regarding care and the care process. We learned from Mrs. Peters’s life story that most of her needs involved the relational aspect of the interaction. We also learned that Ann’s actions and attitude during her interaction with Mrs. Peters matched these relational needs. Based on these insights, we concluded that such a match was necessary in order for Ann to implement her services and properly support Mrs. Peters in fulfilling her health and care needs.

Relational needs

Our case illustrates that the services offered by professionals who carry out home visits are likely to be implemented with success only when an older person is accepting of those services. One of the premises upon which older people accept home care services may be the presence of a trusting relationship between themselves and the caregiver. As our findings suggest, a large part of that trusting relationship is built when a care receiver believes that a caregiver can meet their relational needs. Such relational needs, other than medical or functional needs, do not revolve around solutions for problems, but rather around the processes that facilitate the mutual search for solutions and the negotiation of care. Relational needs are highly informed by the care receiver’s identity, life history and personal values. Whether they are met depends on the interplay of characteristics attached to both the caregiver and
care receiver: what the caregiver has to offer personally and professionally needs to complement the care receiver’s very specific and personal relational preferences.

Previous research has recognized the important role of the care receiver’s needs in the development of care relationships that are trusting [7;25;30-32]. Literature furthermore supports our finding that characteristics of both caregiver and care receiver contribute to such a relationship [25;31-33]. For instance, Gantert (2008) writes that since older people are active, rather than passive relationship builders, characteristics of both caregiver and care receiver determine a relationship’s shape and form.

**Countering care**

Since home visits are carried out in the private environment of a care receiver, the compatibility between a caregiver and a care receiver is crucial. Sevenhuijsen (2000) argues that trust cannot be separated from power and responsibility: inherently, any trusting relationship established during the care process is subject to a power dynamic [34]. This means that when a care receiver trusts a caregiver and accepts their care, older people agree to be in a position of dependency. In the institutional setting, older people often do not have a choice but to engage in this power relationship: the urgent health or care demand with which they visit hospitals or physicians necessitate their acceptance of medical services [35;36]. Proactive home visits, however, are voluntary: they offer services without urgent and explicit demand. It is this absence of urgency that gives older people agency over when and where they become dependent. In other words, the home visit context enables them to ‘decide’ when to trust a caregiver and give their grant of authority.

There are different ways in which older people might execute this agency, so-called ‘countermoves’ [37]. For instance, older people can control access to their homes as well as information they are willing to share [7;15]. These countermoves enable older people to reject home care services as long as they are unconvinced that a caregiver is reliable. Therefore, if a caregiver is not able to adequately match their actions and attitude during the interaction with an older person’s relational needs, the home visit process can reach an impasse. Such an impasse is undesirable, since it leads to a situation in which home visits are carried out while their services remain unaccepted, and therefore unimplemented.
The priority paradox

While Mrs. Peters’ relational needs were met over the course of only two home visits, it is possible that some, if not most, caregivers first spend a prolonged amount of time interacting with a care receiver before understanding the complexity of their needs and how they can be met. As in everyday relationships, getting to know someone takes time. However, the reality is that many older people live with multiple chronic conditions, which often demand immediate attention. In these cases the luxury of time cannot be afforded. For instance, due to a limited time frame Ann prioritized discussing medical issues over discussing an issue that she believed to play a significant role in Mrs. Peters’ everyday life. Ann’s case is an example of the paradox that underlies home visits for older people: while home visit services are more likely to be accepted (and to be accepted within a shorter time frame) when caregivers invest time in building and maintaining trusting relationships, caregivers may instead prioritize assessing clinical parameters such as medicine intake, functional status and physical and mental condition over gathering information about a person’s personal priorities and preferences. This hierarchy in the way caregivers set their priorities could result in a situation in which caregivers possess the information and competencies necessary to deliver adequate care, but lack the foundation to implement their services. This paradox may contribute to home visit programs not always achieving the intended results.

Study limitations

Our study contains two possible limitations. First, since data was collected during the first two home visits it is conceivable that a study period that included multiple follow up visits would have yielded more or different information, which could have enhanced our understanding of the case. Second, the fact that Mrs. Peters choose to not participate in the member check procedure may have affected the accuracy with which her perspective is represented.
CONCLUSION

We used empirical evidence to argue that the key to older people’s acceptance of care offered during home visits is a care receiver’s grant of authority. The condition for such a grant of authority is mutual trust between a care receiver and a caregiver. In order to build a trusting relationship, we argue it is pivotal that the caregiver who carries out the home visit meets the older person’s needs regarding the relational aspect of the interaction. As long as a caregiver is unable to do so, an older person may reject the home visit services offered to them by using countermoves. Since older people’s relational needs are largely determined by their personal circumstances and preferences, a caregiver should therefore pay sufficient attention to an older person’s identity, life history and value system, and use that information to adjust her actions and attitude. Finally, we argue that barriers to successful implementation of home visit services might be twofold: caregivers may not all be equally competent at matching their attitude and actions to the relational needs of care receivers, and getting to know an older person well enough to build a trusting relationship requires a time investment the caregiver cannot always make.

In conclusion, elements of the caregiver-care receiver interaction may play a role in the processes that determine home visit program impact. Our findings suggest that opportunities to increase the overall impact of home visits lie in securing that relational needs of older people are met. We therefore recommend that nurses who implement home visits are trained to efficiently gain insight in an older person’s life history and value system, and to successfully tailor their own attitude and actions to match their client’s relational needs.
REFERENCES


