

A Participant Observation of the Delivery of Home Care Services to Frail Socially Isolated Older People Receiving Two Different Models of Care Delivery

Stephen Gethin-Jones*

School of Social Work, Care and Community, University of Central Lancashire, UK

*Corresponding author: Stephen Gethin-Jones, School of Social Work, Care and Community, University of Central Lancashire, Harrington Building, HA344, UK, Tel: +44 (0)1772895464; E-mail: sgethin-jones@uclan.ac.uk

Rec date: Dec 21, 2016; Acc date: Jan 09, 2017; Pub date: Jan 11, 2017

Copyright: © 2017 Gethin-Jones S. This is an open-access article distributed under the terms of the Creative Commons Attribution License, which permits unrestricted use, distribution, and reproduction in any medium, provided the original author and source are credited.

Abstract

Purpose: This paper aims to discuss the micro process of care delivery between the home care workers and the older person, with the aim of examining what aspects of the care delivery process improve or impinge on the on the care delivery. In addition to this the paper will consider whether any discernible differences were established between the two models of care delivery.

Design/methodology/approach: This study followed eight homecare workers delivering time and task homecare and an alternative outcome-focused care model. Participant observations were undertaken with the workers who were followed delivering care to 16 older people with 8 older people were selected from each intervention group. In addition to the participant observations 4 follow up interviews were conducted with the homecare workers and 16 follow up interviews were conducted with the participants.

Findings: The key findings were that the model and manner in which homecare is delivered have a profound impact upon the homecare workers and the older person's ability to form a mutually satisfactory caring relationship.

Originality/value: This paper helps to provide insight into how the micro delivery of care process impacts upon the quality of homecare an older person receives.

Keywords: Older people; Homecare; Outcome-focused care

Introduction

Throughout western Europe there has been a decline in the number of older people living within institutional care with a drive to maintain individuals within their own home rather than being placed in expensive residential and what are also perceived to be impersonal settings. These policy decisions over the last 40 years have led to nursing care being moved into community settings, where lone unqualified workers provide the care. This means that in most cases highly isolated housebound adults have the most human interaction with homecare worker making the micro relationship between the two highly significant. The quality of nursing care has been considered in the Francis report [1] which has raised concerns about the nature of caring relationship in the delivery of clinical care. The delivery of homecare has also been the subject of scrutiny by the BBC in a panorama documentary [1] and the subject of a conference convened by the then care minister [2]. The main focus of this debate thus far has focused on nursing training and how care is commissioned by care managers, this study however aimed to focus on the micro relationship in the delivery of care.

The importance of the micro-relationship in care delivery is often lost in the Fordist production line focus on the tasks of clinical care and not on the relationship that is taking place in the unique interaction between the professional carer and the patient. This micro-relationship which is considered by Leece [3] and more recently Lloyd

[4] to be the backbone of the professional carers work is lost. In addition to the views of Leece [3] and Lloyd Tronto (cited in Phillips, 2010:43) offers the concept of the Ethics of Care and presents the view that the micro-relationship between the carer and the cared for is the most important element in the care process, and therefore for truly ethical care to take place the caring relationship must include; attentiveness, responsibility, competence, and responsiveness. Lloyd [5] also presents the importance of trust and compassion in the delivery of care. The micro care relationship with older patients as identified by Twigg [6] is also affected by ageist stereotypes that as we age are physical bodies are less desirable by society and therefore less attention is paid to the care of the older body than that of a younger person, this ageism is therefore unconsciously subsumed by the care worker and impacts on the process of care delivery.

As with the rest of Europe maintaining the individuals' ability to live independently has been the focus of public policy for older people within the UK since the end of the Second World War [7]. However, within the UK the thrust of social care policy for homecare services has been aimed at the promotion of the individuals' physical functional ability. The focus on the physical ability is based on the premise that this would also boost the older adults' quality of life [8,9]. The emphasis on physical functional ability has led to a task-focused approach to the delivery of homecare services to older people. This model divides the activities of daily living [10] into time tasked slots of 15 minutes, which enables private and state providers to cost their services and allow the commissioners of these services to purchase services on behalf of the service user through a process of care

management [11]. This model of care has been successful in enabling individuals to be maintained in their own homes and limit the cost to the state of long-term healthcare provision.

However, research conducted by the Social Policy Research Unit (York University) led by Qureshi et al. [12] and Qureshi and Henwood [13] noted service user and social worker dissatisfaction with the current model of delivery and developed a model of care that was outcome rather than task focused. This model has been piloted in the UK urban local authority and compared against the existing task-focused model. Outcome-focused care is established by an agreement on appropriate outcomes that can be measured by the social worker and the service user, rather than purely agreeing task focused approach based on physical care. Therefore, the two parties' allocate time within which these outcomes could be achieved rather than time slotted tasks. This model allowed the individual the flexibility to bank time which could be used to meet their desired outcomes.

The original model of outcome-focused care arose out of the original research of the Social Policy Research Unit based at York University with the main authors being Qureshi and Henwood [13] whose studies were developed further by Glendinning [14]. Outcome-focused care can be defined thus; Outcomes are defined as the impact, effect or consequences of a service or policy. Outcome-focused services are therefore those that meet the goals, aspirations or priorities of individual service users [14].

For this definition of the outcome-focused care model to be applied in this study meant that the care and outcomes were agreed in consultation with the paid carer the older person and the family and reviewed on a daily basis.

Sample

The sample was purposively selected, with participants being directly recruited by their social workers or district nurses, who acted as the commissioners and gatekeepers to the services. The participants were then randomly selected to either receive the outcome-focused model or the existing provision referred to as time/task. The sample had a mean age of 74 and was 52% female. The participants presented mainly with physical problems whose severity prevented them from living independently without multiple daily visits from either nursing or homecare staff. This meant that 85% would be unable to live independently without high levels of support. The majority of the participants had only limited human contact outside of the profession healthcare staff. No participants were accepted onto the study who were considered to lack capacity [15]. The eight Homecare workers were drawn from a variety of local government and private sector providers.

Data Collection

These observations took place over a four-day period, and involved the researcher accompanying eight home care workers whilst they delivered home care to sixteen service users. Four of the home care workers were delivering the outcome-focused model of care and four were delivering the time/task model of home care. The observations totaled 24 hours. The staff were accompanied by the researcher in their own vehicles, which allowed for the observation of the complete process of care delivery. This observation occurred in a naturalistic setting, and where possible the researcher tried to limit their interaction in the process. The observations took place after the initial semi-structured interview, but prior to the final interview visit. I took

the role as defined in Gold's [16] typology as 'observer as participant'. This involved me accepting that my presence and previous knowledge of both groups would impact upon the objectivity of the observation and that this would have some impact upon the behavior of both groups, and it is that the findings are reported here.

Data Analysis

What do you feel is the most important part of the care you receive?
What makes the delivery of care a positive experience for you?
What aspects of the care you receive make your care experience less positive?

Table 1: Set questions for all participants.

The qualitative themes shown in Table 1 above, were developed from an initial reading of the textual data to provide an overarching structure of codes (theoretical codes established from the questions). These themes were then placed in a priori categories and sub-categories for the remaining data to be analyzed within. This process of coding and template development was dynamic, as the templates were constantly altered because of the analysis of the textual data. The coding structure was developed using a hierarchical process of themes and sub-themes.

This process allowed for the relationship and trends within the data. In addition to the interviews the researcher recorded the length of the conversations between participants and the home care workers. In addition to the length the content of these conversations was broken down into four categories;

- Dialogue predominantly focused on care.
- Dialogue focused on both care and non-related subjects.
- Dialogue focused on topics other than care
- No conversation

Main Study

Both models of care involved the completion of direct care tasks and the provision of intimate personal care. However, the mechanism termed as 'function', (how the care was functionally delivered) operated differently in the way the two models were delivered. The time/task model was totally focused on the completion of tasks in as short a time as possible; therefore, the tasks were done to the individual service user. The outcome-focused tasks were completed as part of a process of care delivery and were done with the individual service user. These tasks were completed within the allocated period which then allowed other social interactions (or tasks) to be completed outside the immediate remit of the care plan. This meant that if the tasks were rushed then they allowed time for other activities. This difference was reflected in the way the staff recorded the care they delivered. On entering homes, the Homecare workers delivering the time/task model normally started by looking at a task card and instructing the service user to get ready for the completion of the tasks and the following introductions were noted when the workers initially entered the properties: "Hiya, I am Becky let's get you washed" or "I'm Michelle, where are your clothes you're wearing today?". In all the cases, no attempts were made to strike up any conversation that was not directly focused on the task, inasmuch that a significant amount of care was delivered in silence, with this leading to a feeling of detachment between those being cared for and the home care staff. This

observation was followed up with staff during the intervening car journeys between visits. Both time/task workers were asked the following question:

I noted that you tend to focus on the task and this sometimes means you don't interact in conversation with the service user much, why is this?

"You have to. These old dears will chat non-stop, they just don't realize you got to get things done, and it slows you down too much."

"You just don't have time to chat and it means you appear less professional chatting, I learnt that when I was a nursing assistant, don't get involved with the patient, keep your distance."

This was very different from the way the care was delivered to the outcome-focused group. The staff always referred to the individual by their first name, and all interactions involved conversations that were not focused around the completion of tasks. Below are some examples of the introductory conversations between the outcome-focused home care staff and the service users:

"Hello Doris how are you, did you see Coronation Street on Sunday?"

"Hiya David it's only me, it's cold today do you need your heating adjusting?"

"Morning Irene what shall we do first today, do you want your breakfast or do you want to get dressed first?"

The focus operating here was about the relationship between the carer and the cared for. Tasks were constantly negotiated, added, or deleted, with a large amount of time focused on general conversation. This did not appear to be an intentional outcome, but a by-product of

the way the care was structured, and they would spend a set time that could only be filled with another activity or conversation. Therefore, the unplanned function was relationship-building. This would appear to shed some light on why the outcome-focused model of care had an impact upon the individual's sense of connection with the homecare staff as opposed to the traditional time/task model. The care being observed appeared to show that there was a connection between the actors that was not present in the observations of the time/task care. This interaction and allowing the older person, who in several cases had no external interaction except with the paid carers, to feel connected, with the outside world.

This observation therefore focused on the development and depth of the social interaction that was taking place between the home care workers and the service users. To measure this the researcher decided to record the length of the conversations between participants and the home care workers. In addition, the content of these conversations was broken down into four categories;

- Dialogue predominantly focused on care.
- Dialogue focused on both care and non-related subjects.
- Dialogue focused on topics other than care
- No conversation

This was achieved using a simple tally system with a tick being given during the conversation for each change of topic and the results are given in Table 2. When a topic was mentioned then a cross was made, and when the topic changed or stopped a further cross was added. These were combined with the start and finish time for the conversation. The total numbers of topics were added together at the end of the conversation and are displayed in Table 2 per each service user. This was completed for five service users in each group.

Participant Group (Conversation over 1 hour period)	Dialogue predominantly focused on care (in minutes)	Dialogue on both care and non-related topics (in minutes)	Dialogue focused on topics other than care (in minutes)	No conversation	Time total of conversation
Time/task	20	05	00	35	25
Time/task	30	07	03	20	40
Time/task	18	07	00	27	23
Time/task	15	10	00	35	25
Time/task	38	00	00	22	38
Outcome/focused	10	15	20	15	45
Outcome/focused	15	10	30	05	55
Outcome/focused	16	8	30	06	54
Outcome/focused	11	10	35	04	56
Outcome/focused	20	06	23	09	51

Table 2: Topics of conversations.

These observations reveal some interesting differences occurring during the social interactions taking place whilst the physical care was being delivered. The outcome-focused group displayed more social interactions not related to the care being delivered than the time/task group. The atmosphere generated during this process felt more inclusive and personal, and generated what felt to the observer as a

more positive attitude and personal feeling to the whole process of care delivery. These findings appear to support the responses of the participants during the second stage interviews. The interaction during the outcome-focused care was more akin to a conversation between acquaintances or neighbors who knew a little information about each other, but did not have the depth of knowledge that would be seen in a

friendship. The process of care delivery therefore differed in content. I observed a variety of different levels of knowledge about the service users. The entire outcome-focused group had been seen consistently over the last eight to ten weeks by the same team of four workers. The level of contact varied greatly amongst the time/task group, with some service users having never met the staff, to the staff having met the service user on more than six separate occasions. Therefore, the fact that workers in the time/task group were seldom allocated the same round of visits meant that the staff tended not to form relationships with the service users. This contrasted with the outcome-focused group who saw it as essential to establish some depth to their social interactions with the service users.

Findings

The need for social interaction beyond the delivery of clinical healthcare tasks

The importance of the non-clinical relationship with the professional careers was the most strongly expressed theme. During the average six-week period the older people had been receiving both models of intervention, they had developed differing links the homecare staff responsible for their care. The outcome-focused group knew the individuals by their first names and knew some personal information about them, such as which soccer teams they liked or their favorite programmers and a little personal information about the professional careers' families. This 'neighbor acquaintance-like' relationship appeared to be highly important for the older patients' sense of connectedness with the care process, and gave them a sense of worth, beyond being just another patient going through the process of being cared for. This personalization of the professional careers enabled the patients to establish their trust in them. This was starkly contrasted against their experience of homecare with the time task model where they had a constant stream of workers with little consistency in who delivered their care. And is summed up by one of the older participants:

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

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

The need for consistent care staff to develop a working relationship

This was a theme that presented in all the interviews and was something that the participants the Outcome-focused care group received consistent care from the same group of workers, as compared to the time/task group who might have a different worker each visit preventing the participant and worker to form any form of micro-relationship outside of the care delivery. This concern about consistency came across in all the interviews, as did the difficulty the constantly changing staff gave the patients in forming a relationship. The impersonal nature caused by this lack of consistency was

Summed up by another patient:

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

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

The need for the older patient to feel they had some control over how their care was delivered

This theme showed that the older patients gave a high value to the care being delivered being explained and discussed with them. They appreciated being asked how they liked the care to be provided and especially if the healthcare assistant or the assistant practitioner discussed how the care could be carried out in the most dignified way. One older patient eloquently expressed this:

'You know that when they are changing your bag (colostomy) that it's not pleasant for you or them and you're embarrassed. It helps when they chat with you as they do it; some workers do it in silence and you can see the disgust on their faces. It makes you feel rotten.'

This gentleman explained that some workers had discussed with him what would be the least upsetting way to carry out this procedure and it was agreed between both parties to complete this task last, so that the older person felt less embarrassed. This theme had a strong thread, throughout that discussion, about how the way care was delivered allowed the older person to feel valued and more of an equal in the care relationship.

Discussion

This study has indicated the importance of three main themes: the need for consistent staff to develop a working relationship, the needs for social interaction beyond the delivery of the healthcare task, and lastly the need for the older patient to feel they had some control over how their care was delivered. The initial factor affecting the ability to build a working relationship, which can then go on to become meaningful to the older person is the consistency of staff. The lack of consistent homecare staff in the traditional task focused model of care examined in this study combined with a lack of emotional interaction by the task focused staff inhibited both the ability to form a relationship and contributed to the older person's sense of powerlessness in the care process. The older people felt that they are subjected to care rather than participate in the care process. Therefore, these findings would support the work of Eliassen [17] whose study found that a lack of consistency and the subsequent poor communication caused by this led to the older person's sense of powerlessness and detachment from the care being delivered. These findings are also supported in this study, where the traditional model also generated the sense of powerlessness and disconnection, whereas the model of outcome-focused care did not. The outcome-focused model enabled consistency and the development of a meaningful relationship has the ability to reduce the sense of disconnect between the older person and the homecare staff.

The second theme of the need for social interaction beyond the care task has been considered in numerous studies within the healthcare arena for some time, and especially in the field of chronic illness, where the potent influence of the care relationship has been established [18,19], with the concept of person-centered care being a central plank of healthcare delivery and policy. Whereas the micro-relationship of care delivery has not been considered in great depth, however Eliassen [17] in his study established that by formally ratifying the older persons lived experience and connecting with them to understand the mutual lived experience shared by them and the homecare worker helped to break down the stereotypical barriers that had led to the sense of powerlessness. Therefore, the workers in this study talking about everyday events outside of the care tasks allowed for the two individuals to interact more as equals and fellow humans and was more person centered. These findings are also supported by the work of Nolan [18] who observed, that person-centered care is an ill-defined concept, with nursing and healthcare staff who provide long-term, intimate care having to struggle with how to clearly define interpersonal relationships that are both professional and meaningful for their patients. Therefore, a deeper and more consistent relationship is required to enable the individual to form a meaningful relationship and to enhance the older person's psychological wellbeing. The final theme; the need for the older patient to feel they had some control over how their care was delivered has been established also in a study conducted by Cloutier [20] this study also identified the need to develop a relationship in order to promote an enabling environment for the older person and to create a relational space within which the care delivery could be agreed, whilst ensuring that the individual relationship between the care provider and the care recipient is the real essence and at the heart of the health care experience.

Limitation and Future Research

This study was small and would have benefited from being conducted on a more ethnically diverse population and over a longer period than was possible. Future recommendations are that a larger study be undertaken, examining the responses of older people from a wider population and a deeper examination of whether the participants' gender has any impact upon what they want from a caring relationship.

Conclusion

The aim of this research was to allow healthcare professionals insight into the micro-relationship occurring when care is provided to older people over an extended period. This limited study has shown that

A deeper and more consistent relationship between HCA/AP and patient is required to enable the individual to form a meaningful relationship and so enhance the older person's psychological wellbeing.

References

1. Francis R (2013) Mid Staffordshire NHS Foundation Trust Public Inquiry. UK.
2. BBC News Education and Family (2013) Minister Norman Lamb Warns of risk of home care scandal.
3. Leece J (2003) The development of domiciliary care; what does the future hold? *Practice: Social Work in Action* 15: 17-30.
4. Lloyd L (2012) *Health and care in ageing societies*. Policy Press, Bristol, UK.
5. Lloyd L (2005) A caring profession? The ethics of care and social work with older people. *Br J Soc Work* 36: 1171-1185.
6. Twigg J (2004) The body, gender, and age: feminist insights in social gerontology. *J Aging Stud* 18: 59-73.
7. Bebbington A, Charnley H (1990) Community care for the elderly-rhetoric and reality. *Br J Soc Work* 20: 409-432.
8. Kutner N, Ory M, Baker D, Schechtman K, Hornbrook M, et al. (1992) Measuring the quality of life of the elderly in health promotion intervention clinical trials. *Public Health Rep* 107: 530-539.
9. Lawton MP (1991) *The concept of the measurement of quality of life in the frail elderly*, Academic Press, San Diego, CA, USA 3-27.
10. Roper N, Logan WW, Tierney AJ (2000) *The Roper-Logan-Tierney model of nursing: Based on activities of living*. Edinburgh: Elsevier Health Science, UK.
11. Challis D, Hughes J, Jacobs S, Stewart K (2007) Are different forms of care management of older people in England associated with variations in case mix, service, and care management, use of time? *Ageing Soc* 27: 25-48.
12. Qureshi H, Patmore C, Nicolas E (1998) Overview of outcomes of social care for older people and carers, Report No. 5, Social Policy Research Unit, University of York, New York, USA.
13. Qureshi H, Henwood M (2000) *Older people's definitions of quality services*, Joseph Rowntree Foundation, New York, USA.
14. Glendinning C, Clarke S, Harre P, Maddison J (2008) Progress and problems in developing outcome-focused social care services for older people in England. *Health & Social Care in the Community* 16: 54-63.
15. Department of Health (2005) *Mental Capacity Act*.
16. Gold RL (1958) Roles in sociological field observation. *Social Forces* 36: 217-213.
17. Eliassen AH (2016) Power relations and health care communications in older adulthood: Educating recipients and providers. *The Gerontologist* 56: 990-996.
18. Nolan MR, Davies S, Brown J, Keady J, Nolan J (2004) Beyond person-centred care: a new vision for gerontological nursing. *J Clin Nurs* 13: 45-53.
19. Robinson C (1996) Health care relationships revisited. *J Family Nurs* 2: 152-173.
20. Cloutier D, Martin-Mathews A, Bryne K, Wolse S (2015) The space between using 'relational ethics' and 'relational space' to explore relationship-building between care providers and care recipients in the home space. *Soc Cult Geogr* 16: 764-782.