

The Importance of Trust in Successful Home Visit Programs for Older People

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Abstract

Outcomes of proactive home visit programs for frail, older people might be influenced by aspects of the caregiver–receiver interaction. We conducted a naturalistic case study to explore the interactional process between a nurse and an older woman during two home visits. Using an ethics of care, we posit that a trusting relationship is pivotal for older people to accept care that is proactively offered to them. Trust can be built when nurses meet the relational needs of older people. Nurses can achieve insight in these needs by exploring older people’s value systems and life stories. We argue that a strong focus on older people’s relational needs might contribute to success of proactive home visits for frail, older people.

Keywords

aging, case studies, ethics / moral perspective, health care primary, older people

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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 might interact with 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 the exchange of information, the negotiation of care and delivery of services, and are the foundation for strategies highly valued by both caregiver and care receiver, such as client involvement and shared decision making (Florin, Ehrenberg, & Ehnfors, 2006; Lyttle & Ryan, 2010; McCormack, 2001; Millard, Hallett, & Luker, 2006; Paavilainen & Åstedt-Kurki, 1997; Schoot, Proot, Meulen, & de Witte, 2005; Spiers, 2002). As a result of the current trend to “age in place,” an increasing amount of care for older people is delivered at home (Wiles, Leibing, Guberman, Reeve, & Allen, 2012). Caregiver–care receiver interactions are therefore 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 (Huss, Stuck, Rubenstein, Egger, & Clough-Gorr, 2008; Liebel, Friedman, Watson, & Powers, 2009; Stuck, Egger, Hammer, Minder, & Beck, 2002). 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, whereas others find no results at all (Elkan et al., 2001; Hoogendijk, 2016; Huss et al., 2008; Marek & Baker, 2006; Markle-Reid et al., 2006; Stuck et al., 2002). 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 (Huss et al., 2008; Liebel et al., 2009; Markle-Reid et al., 2006). In addition, little information exists about how aspects of the care process (such as

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implementation, quality of delivery, and the extent to which care is tailored) influence program impact.

Literature suggests that success of proactive home visits might be influenced by the caregiver–care receiver relationship (McNaughton, 2000). For instance, Yamada et al. (2011) find that engaging in a collaborative relationship with a caregiver during a home visit stimulated older people’s willingness to adapt to appropriate health behavior. 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, policy makers, care professionals, and researchers remain unclear as to how to design and implement effective programs.

To deepen our understanding of how collaborations between nurses and clients might occur during proactive home visits, we performed a naturalistic case study. Case studies help achieve a thorough understanding of a single bounded system through in-depth engagement with the object of study and analysis of its individual complexity (Merriam, 2009). We investigated and analyzed the interaction between an older woman and a practice nurse during two consecutive home visits that took place as part of a program that aimed to implement the Geriatric Care Model (GCM), a comprehensive care model for frail, older people in a primary care setting (Muntinga et al., 2012). To allow for a comprehensive understanding of the case, we describe the characteristics of both the practice nurse, Ann, and the older woman, Mrs. Peters, and give a detailed account (or “thick description”) of the events that took place during the home visit process. We use narrative analysis to construct the story of the interaction, and employ a theory of ethics of care to interpret our findings. In doing so, we hope to contribute to existing knowledge about the caregiver–care receiver interaction and its contribution to outcomes of comprehensive care interventions for frail, older people in primary care.

Method

The GCM

Based on the Chronic Care Model (Bodenheimer, Wagner, & Grumbach, 2002), the GCM aims to improve quality of care and, subsequently, frail older people’s quality of life by enabling productive interactions between activated, informed older people and proactive, prepared care professionals (Muntinga et al., 2012). A central component of the GCM is a proactive home visit program carried out by practice nurses. In the Netherlands, practice nurses provide chronic and social care services to primary care patients through guideline-based interventions and organizational activities (Landelijke Huisartsen Vereniging, 2004). Every 6 months,

frail older people receive an in-home comprehensive geriatric assessment (CGA) and a tailored care plan. Based on the CGA results, practice nurses explore older people’s health and care needs, provide information about available and suitable care options, and actively involve older people in their own care process. At all times, older people’s own preferences and goals determine care actions and agreements.

Study Design

The case study was embedded in the 2-year frail, older Adults: Care in Transition (ACT) study (2011–2013) that implemented the GCM among 35 primary care practices in two regions in the Netherlands by means of a stepped-wedge randomized controlled trial (RCT; Muntinga et al., 2012). The ACT study was approved by the ethics committee of VU University Medical Center. All study participants signed an informed consent form.

We used a naturalistic case study design. Naturalistic case studies are used when researchers aim to understand the specifics of a phenomenon in a particular setting for a particular case (Abma & Stake, 2014). As opposed to studies manipulated by the researcher, naturalistic case studies are performed in an everyday, true-to-life environment. In the case of this study, this environment is the home of one of the 1,147 frail, older people who participated in the ACT study.

Four characteristics distinguish naturalistic case studies from other study designs (Abma & Stake, 2014). First, naturalistic case studies mainly focus on “emic” issues, that is, issues that were not anticipated in advance but that emerge from the case. Whereas “etic” issues (topics that are anticipated based on the research question or existing knowledge about the phenomenon under scrutiny) might be applied initially to organize the study structure or outline the conceptual framework, emic issues represent unexpected but potentially essential case characteristics. 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. Finally, 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 (Abma & Stake, 2014).

Selecting the Case

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 (Abma & Stake, 2014; Simons, 2015). Although the primary aim of a case study might not be to achieve generalizability, it is expected that by focusing on context and particularity, an investigation of a single case's patterns and processes increases our understanding of a larger issue and helps us apply knowledge generated from large sample evaluations (Simons, 2015).

Data for this case study were collected as part of a multiple case study, for which a researcher (M.E.M.) followed three practice nurse–older person “couples” during the home visit process. Practice nurses were recruited by means of convenience sampling; their participation depended on their individual work schedule and willingness to contribute to research activities. At the time of recruitment, the researcher had met each of the participating practice nurses once before. To collect data for the three case studies, she joined the practice nurses on a randomly selected first home visit to a new client.

Observations and interviews as described in this article were carried out for all three encounters. However, Ann and Mrs. Peters's case stood out from the other cases in terms of complexity and dynamics. The choice to present their case in this article was therefore based on its learning potential: The particularities of Ann and Mrs. Peters's encounter, characterized by its richness and tension—the unexpected outcome—help us understand more about the processes that underlie the caregiver–care receiver relationship during proactive home visits for older people, and the role of this relationship in the outcomes of such visits.

Data Collection

To gain a multi-angled understanding of our case, we used triangulation of methods (Morse, 2003). We used participant observation during the first and second home visit to gain insight in the behavior of practice nurse and client during their interaction. The observations lasted approximately 75 (first home visit) and 60 (second home visit) minutes. Using an observation guide, we focused on the following domains: environmental information (i.e., characteristics of the home environment, persons present during the home visit, location of persons in the room), atmosphere (i.e., formal/informal, cooperative/non-cooperative), interaction process (i.e., giving and receiving information, involvement of client in care process, emphasis on client's needs and preferences, attention for client's value system or life story, emphasis on client's self-determination, delivery of care options, client's response to advice), and home visit outcomes (i.e., care goals formulated, agreements made). Detailed observation reports were written immediately after the observations.

Semistructured interviews with both the older person (20 days after the last home visit) and the practice nurse (directly

before the first home visit) by the researcher were used to gain insight in personal histories, beliefs, and experiences (see Table 1 for observation and interview topics). The interviews lasted 48 and 25 minutes, respectively. Interviews were audio recorded and transcribed. In addition, several informal conversations took place between the researcher and the practice nurse before and after the home visits, during which the researcher made notes.

We used the pseudonyms “Ann” and “Mrs. Peters” to protect respondent confidentiality. Both Ann and Mrs. Peters signed informed consent statements consenting to the use of their stories for the purpose of this case study.

Data Analysis

To focus on issues emerging from the case and to gain contextual understanding, both field reports, interview transcripts and reports of informal conversations, were analyzed using interpretative narrative analysis. Interpretative narrative analysis can be defined as “a technique that seeks to interpret the ways in which people perceive reality, make sense of their worlds, and perform social actions” (Riessman, 2008, p. 11). Simply put, the objective of narrative analysis is to identify a story in a data set to answer *how* and *why* questions (Riessman, 2008; Ziebland, 2013). To understand why and how the particular events that characterized our case occurred, we constructed the story of the interaction between Mrs. Peters and Ann. We paid attention to the structure of their accounts, as well as the way in which both women allocated meaning to their interaction.

The analysis was carried out by M.E.M. and K.V.L. separately. First, the researchers familiarized with the data by reading and rereading the documents, and identified preliminary themes and subthemes that emerged from the data. Subsequently, the researchers formulated labels, which they systematically applied to the data, and arranged and rearranged the data according to emerging themes. The researchers then compared their analyses and decided on final themes. Finally, a third researcher (T.A.) critically reviewed an analysis scheme that involved all themes and subthemes.

Despite our analytic choices, we recognize that any qualitative inquiry project is in its essence a failed project (Jackson & Mazzei, 2013), because endeavors to capture individuals' true experiences and selves are unavoidably bound by the subjectivity of the research setting (Jackson & Mazzei, 2013; Josselson, 2011). From the outset, we therefore accepted that the data and “truths” we sought out to collect as part of this project would be based on partial, incomplete reconstructions of meaning shaped by our own methodological and theoretical perspectives. As a consequence of this position, we aimed not to work within a priori defined theoretical framework, but rather to “plug” the narrative of Mrs. Peters and Ann into our thinking of the care process, to understand how power dynamics and relational aspects of proactive

Table 1.

Data Collection	Topics
Observations	<ul style="list-style-type: none"> • Home visit environment • Communication of information • Atmosphere • Attitude nurse and client • Rapport • Goal setting • Relational dynamics • Ways in which nurse involves, motivates, stimulates, compliments, or reinforces a client • Ways in which nurse recognizes sources of strength and resilience of client • Client response to care advice • Assessment outcomes
Interview care receiver	<p>Recent changes in received care services (e.g., aids, caregivers, medications, treatments)</p> <ul style="list-style-type: none"> • Ways in which changes were established • Attitude care receiver toward changes <p>Experiences of care receiver with nurse practitioner</p> <ul style="list-style-type: none"> • Attitude nurse practitioner toward care receiver • Extent to which care receiver experienced equality/collaboration in relationship with nurse practitioner and how this was achieved • Extent to which care receiver experienced opportunities for autonomous decision making and how this was achieved • Extent to which care receiver experienced being offered choices and how this was achieved • Extent to which care receiver experienced control and how this was achieved
Interview nurse practitioner	<p>Professional attitude</p> <ul style="list-style-type: none"> • Professional beliefs, values, opinions, goals • Self-perceived competencies <p>Evaluation interaction with Mrs. Peters</p> <ul style="list-style-type: none"> • Rapport and relationship building • Barriers and facilitators to relationship building • Own behavior, attitude, and professional functioning • Priority setting

caregiving and receiving might underpin a care interaction in the home setting (Jackson & Mazzei, 2013).

Quality Procedures

To ensure credibility, we used data triangulation. In addition, we performed member checks by asking both respondents whether they recognized and approved our interpretations (Morse, Barrett, Mayan, Olson, & Spiers, 2008). Although the practice nurse approved our interpretation, the older woman 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 (Lincoln & Guba, 1985), we present meaning and context. To ensure dependability, a principle concerned with enabling an accurate repetition of the study, the researcher who collected the data 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 multiperson analysis of the interview transcripts and observation reports.

Reflections on the Authors’ Positions

The positions of the researchers might have sculpted the knowledge generated with this project in several ways, because the professional and personal backgrounds of qualitative researchers decide the angle of investigation and the framing of findings (www.qualres.org). M.E.M. and T.A.A. work in the field of care ethics, which determined the theoretical constructs inherently available to us (what Jackson & Mazzei, 2013, call “the theory in ourselves”), thus informing how we read the transcripts and constituted the narrative. In addition, the social locations of the researchers who analyzed the data (female-identified cisgender, White, able-bodied, younger professionals working in an academic environment) and the perspectives associated with those locations are likely to have shaped our interpretations of Mrs. Peters’s and Ann’s complex experiences, values, and contexts during data analysis.

Results

Below, we describe the characteristics of, and the interaction between, an older woman, Mrs. Peters, and the practice nurse, Ann. We then critically analyze these findings from an ethics of care framework.

Mrs. Peters and Ann

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 with the help of her husband. Because of Mrs. Peters's lifelong struggle with illness, she has always been dependent on others. This dependency has influenced Mrs. Peters's 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)

Mrs. Peters says that as a result of being dependent on others, she finds it difficult to stand up for herself.

I do think that I lack power of my own, which makes people walk all over me. . . . Many [people] have walked over me, I gave them a finger and they took the whole hand. . . . I cannot deal with fiery people, they make me shut down and think "whatever." . . . I avoid conflict situations, I have experienced enough of those in my life. (Interview, Mrs. Peters)

As a result, she prefers care professionals who give her space to form her own opinions: "If someone very opinionated would be sitting across from me, I would not say a word." When asked about whether it is important for her to make her own decisions, she says that she prefers to work together with a care professional and make decisions together.

Well, I do not think that you can just say "I want this and that," I do not expect that. . . . I do not need that autonomy. . . . I hope I can co-decide, let me put it that way, I like that better. No, not [deciding] by myself, not me, me, me, not at all. But co-deciding, that works, for me anyway. (Interview, Mrs. Peters)

She says that if she does not experience a connection with a care professional, she would not continue to see them.

I assume that [care professionals] are well-educated and I expect that they can judge human nature and have some insight into my character. When there is a connection [with a care professional] then I am fine, of course. But if I do not feel a connection . . . I want someone else.

Although Mrs. Peters says she tends to avoid conflict as a result of her difficulties claiming space for herself, she has experienced a conflict with her primary care physician (PCP) about the diagnosis of her chronic leg pain and its treatment. After repeatedly requesting further diagnostic tests, the PCP told Mrs. Peters that oral pain medication would be her only option. Feeling dismissed and not taken seriously, Mrs. Peters has not visited the PCP since.

At the time that she is offered a home visit as part of the ACT study, Mrs. Peters is struggling with three issues. First, her chronic leg pain causes physical and social impairment and mental distress. Although 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. One of her biggest fears is to lose her husband and be forced to move into a care home. "To be all alone, phew. I am strong and try my best, but that I cannot do. When I see [care homes] on television, all those people together in a room, it frightens me." She is therefore contemplating to move to a small 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 marital problems, which have been increasing in the last couple of months. These three issues cause Mrs. Peters to worry every day.

Ann is a 53-year-old health care professional. She is animated and has a warm personality. In the past 10 years, she has worked as a community nurse, a practice assistant and a practice nurse. When asked about her sense of involvement in the ACT study home visit program, she says she feels 100% involved. 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 essential. Trust is built when someone feels understood and empathized 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 to relate to a client, a caregiver needs to feel engaged. She sees engagement as the key to equality—another condition for a successful relationship—and emphasizes that knowledge sharing without involvement could create an asymmetric relationship.

The Encounter Between Mrs. Peters and Ann

When Ann first contacts Mrs. Peters over the phone about arranging a date and time for a home visit, she is met with reluctance: Mrs. Peters does not seem eager to receive the practice nurse at home. In response, Ann proposes that Mrs. Peters takes her time to consider the visit, and emphasizes that a visit will only happen on Mrs. Peters’s terms. Mrs. Peters accepts this proposal, and when Ann calls again a week later, Mrs. Peters agrees to the home visit.

When Ann is received in the Peters family’s home for the first home visit, the atmosphere is almost formal: Mrs. Peters takes Ann’s coat, and coffee is served from the family’s nicest coffee pot. Mrs. Peters appears guarded and slightly tensed: She does not speak much, and when she does, her voice is soft. Ann is cheerful but polite, and tries to break the ice by making small talk. She thanks Mrs. Peters for receiving her and compliments her on her house and garden, then waits for Mrs. Peters to invite her to sit down at the table. The CGA that Ann uses to explore Mrs. Peters’s health and care issues is web based, and therefore, Ann uses a laptop. Although this creates a barrier between care professional and client, Ann continues to make eye contact with Mrs. Peters and explains why she asks certain questions. In addition to asking questions about health-related topics, as the assessment instrument requires, Ann also inquires about Mrs. Peters’s medical history, her hobbies, and her family. When she learns that Mrs. Peters has been through a lot medically and personally, she reacts to this by saying “you are strong” and “you do not give up!” to which Mrs. Peters responds affirmatively.

Mrs. Peters tells Ann that she wants to continue to make her own choices, but that this is becoming increasingly difficult. Toward the end of the assessment, Ann asks whether Mrs. Peters has any care goals. When Mrs. Peters says that she does not have any, Ann suggests that Mrs. Peters reduces medical drugs intake, finds adequate pain management and increases her activity level, and explains why and how this could improve Mrs. Peters’s situation. She advises Mrs. Peters to get another pain block, and to first consider home care before deciding to move to a smaller place with care facilities. When Mrs. Peters responds negatively to Ann’s suggestions (by avoiding a direct response or explaining why the suggestions do not work for her), Ann drops the issue and quickly moves on to other topics. Upon leaving, Ann thanks Mrs. Peters for her time. Afterward, she remarks that Mrs. Peters asked no questions or mentioned any goals, needs, or preferences. She believes Mrs. Peters held back,

and that there was “no relationship of mutual trust yet” between her and her client.

In the weeks after Ann’s first visit, Mrs. Peters has a change of heart and decides to get another pain block after all, as Ann suggested. To get a referral, she has to make an appointment with her PCP, whom she has not visited since their conflict. During the consultation with the PCP, Mrs. Peters also talks to the doctor about her marital problems, for which the doctor refers Mr. and Mrs. Peters to marriage counseling.

Three weeks after the first home visit, Ann visits Mrs. Peters for the second time. The purpose of the second home visit is to discuss the assessment results, which Ann has summarized in a care plan. When Ann enters the house, she acknowledges the voluntary character of the visit by telling Mrs. Peters “thank you for having me again.” Although during the last visit Ann sat opposite of Mrs. Peters at the table, 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 to Mrs. Peters what she wrote in her care plan and why, regularly asks Mrs. Peters about the accuracy of her interpretations and conclusions and advises Mrs. Peters about her care options.

As opposed to the first home visit—and to Ann’s surprise—the atmosphere during the second home visit is a lot more informal. Mrs. Peters’s attitude has changed from guarded and tensed to more open and at ease, and she responds positively to Ann’s advice and suggestions. She even reflects on her and Ann’s relationship and its importance for Ann’s work: “There has to be a mutual connection, otherwise you [Ann] cannot do your work properly.” One of the assessment results involves oral pain medication intake, which Ann had suggested to reduce. However, because Mrs. Peters is scheduled for a pain block, she expects not to be dependent on oral pain medication anymore, and together Ann and Mrs. Peters decide to leave the medication as it is. Mrs. Peters also says she has two care goals: She would like to pick up her social activities again, and finally decide whether to move or not. Ann offers to help give Mrs. Peters some insights and information about her options, and Mrs. Peters accepts.

Throughout the second home visit, Ann uses several interactional strategies. She verifies that care plan content reflects Mrs. Peters’s experiences and is clear about the fact that her professional advice is not obligatory. For instance, she adds to her advice remarks such as “if that is something that you would consider.” In addition, Ann continuously emphasizes that decisions are made together and expresses empathy and engagement. For instance, she regularly acknowledges Mrs. Peters’s difficult situation (“you managed, despite everything!”), makes positively reinforcing remarks (“well done, that took strength!” or “that was a smart thing to do”), and shows engagement (“I understand”). At the end of the home visit, Ann writes down the names and websites of care organization. Mrs. Peters asks, “You will be back, won’t you?” They make an appointment for a follow-up consultation.

Mrs. Peters's Experiences With the Home Visits

When Mrs. Peters is interviewed about her experiences with Ann's two visits, she mentions she trusts that Ann has the knowledge and competency to inform and advise 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 says she feels confident to speak up and express her needs and preferences to Ann.

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 emphasizes 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 believes that 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. 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

Our findings suggest that over the course of the two-visit encounter between Ann and Mrs. Peters, something unexpected happened: Mrs. Peters's attitude changed. Although at the outset Mrs. Peters is passive, does not set care goals, and rejects Ann's suggestions regarding treatments or care, during the second visit Mrs. Peters is more at ease and responsive to Ann's advice. At the end of their encounter, the issues Mrs. Peters struggled with were brought to the attention of health care professionals and action was taken toward improving Mrs. Peters's physical, mental, and social well-being. Below, we employ an ethics of care framework to deepen our understanding of the relational dynamics between Ann and Mrs. Peters.

Mrs. Peters's Grant of Authority

A relationship between a caregiver and a care receiver is characterized by a power imbalance: Caregivers 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 transferal of authority from the care receiver to the

caregiver. Because 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 (Tronto, 2009).

According to Tronto's theory, Mrs. Peters's 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's 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 well-being 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 think 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: 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 might have never met before (McGarry, 2009; Pickard & Glendinning, 2002). 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. 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 (Fisher & Tronto, 1990). The third phase ("care giving") is characterized by a direct meeting of care needs, which requires a caregiver to possess the virtue of expertise. In the last phase ("care receiving"), the participant of care responds to the care he or she receives, 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 (Tronto, 2009). 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 advise 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 (1986) defines 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” (p. 259). 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's specific care needs. To understand how this might have happened, we need to recall Mrs. Peters's life story, personality, and current circumstances.

As we described earlier, Mrs. Peters's lifelong dependency on others has made it difficult for her to stand up for herself. It is therefore important for her to receive care in an environment in which she feels safe, and in which she experiences the space to express her needs and preferences. 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. Our data show that Ann was able to provide this type of relationship: Throughout the visits, she used several strategies that can contribute to a collaborative relationship. 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's autonomy, to express affinity with Mrs. Peters's life story, and to acknowledge Mrs. Peters's control of her own home environment. Ann's focus on equality through engagement enables a more egalitarian, pressure-free relationship with a client, which corresponds with Mrs. Peters's need for “space” and collaboration. Moreover, Ann's warm and easygoing personality adds to a friendly and comfortable environment, in which Mrs. Peters is encouraged to take space for herself.

Based on our 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 matched Mrs. Peters's specific needs regarding the relational aspect of a care relationship, which provided the foundation upon which Mrs. Peters granted Ann authority, and trust was built. Once a trusting relationship had been established, Mrs. Peters was receptive to Ann's advice and suggestions. From

that moment on, Ann was able to start working toward meeting Mrs. Peters's 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 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 trusting relationship might also enable implementation of home visit services in the future. To achieve continuity of care delivery, it is therefore essential that the 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 (van Heijst, 2005). 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 naturalistic case study to explore what happened during the interaction of Mrs. Peters, an older women, and Ann, the practice nurse who visited her at home. When we analyzed data, we noticed that at the time of 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 argued that there must have been a trusting relationship between Mrs. Peters and Ann.

We learned from Mrs. Peters's life story that most of her needs regarding care and the care process 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 for Ann to implement her services and properly support Mrs. Peters in meeting 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, and that one of the premises upon which older people accept home care services might 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 (Gantert, McWilliam, Ward-Griffin & Allen, 2008; McGarry, 2009; Millard et al., 2006; Spiers, 2002; van Kempen et al., 2012). Literature furthermore supports our finding that characteristics of both caregiver and care receiver contribute to such a relationship (Gantert et al., 2008; Hupcey & Miller, 2006; McGarry, 2009; Millard et al., 2006). For instance, Gantert et al. (2008) write that because 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

Because home visits are carried out in the private environment of a care receiver, the compatibility between a caregiver and a care receiver is crucial. Care ethicist 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. 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 (Scannell, Gillies, Biordi, & Child, 1993; Wendt, 1996). 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 (Agich, 2003). For instance, older people can control access to their homes as well as information they are willing to share (McNaughton, 2000; Spiers, 2002). 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 interactional strategies during the interaction with an older person's relational needs, the home visit process can reach an impasse. Such an impasse is undesirable, because it leads to a situation in which

proactive home visits are carried out while their services remain unaccepted, and therefore unimplemented. In addition, countermoves might increase the time it takes for a care professional to gain insight in an older person's value systems and life story and adjust their interactional strategies, time a care professional might not always have.

Study Limitations

Our study contains several limitations. First, because data were only 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. In addition, it would have provided us with information about whether saturation had been reached. Second, the fact that Mrs. Peters chose to not participate in the member check procedure might have affected the accuracy with which her perspective is represented. Third, because the in-depth interview with Mrs. Peters took place 20 days after the last home visit, it might be that Mrs. Peters's recollection of the events and experiences was inaccurate or incomplete.

Finally, rapport between Mrs. Peters and the researcher might have been affected by the researcher's professional relationship with the practice nurse. In her field notes, the researcher reflects on this issue as follows:

How do I give the respondent space to give her true opinion about the practice nurse without impacting the integrity of their relationship? . . . The only option is to carefully explain my reason for asking [Mrs. Peters about her opinion of the practice nurse], and assure [Mrs. Peters] that I will not share her answers [with Ann].

Potential rapport issues might have resulted in socially desirable answers from Mrs. Peters.

Conclusion

In this article, we analyzed the interaction between a practice nurse and an older person during a proactive home visit. Based on our analysis, we argue that the key to older people's acceptance of care offered during a proactive home visit is a care receiver's grant of authority. A condition for such a grant of authority is mutual trust between a care receiver and a caregiver. 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 might reject the home visit services offered to them—for instance, by using countermoves.

Opportunities to increase the overall impact of proactive home visits might therefore lie in care providers' efforts to meet the relational needs of older people. Because relational needs are largely determined by their personal circumstances

and preferences, we posit that caregivers who carry out proactive home visits should pay sufficient attention to older people's identity, life history, and value system, and use that information to adjust their actions and attitude.

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