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Nurse-elderly client relationship in home-care

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Abstract

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Home-care services have the purpose of helping clients in the daily activities they are no longer capable of performing, with the final aim of making it possible for them to live comfortably at home for as long as possible. Because of the special environment in which home-care takes place, there are reasons to believe that the relationship between nurses and patients is composed of specific elements that are interesting to analyse. Moreover, when it comes to elderly patients who have difficulties in moving outside their house, nurses might hold an almost more important social role, in addition to being health-care professionals.

The purpose of this thesis is to describe the nurse-elderly client relationship in home-care setting, taking into account all the peculiarities of this environment. For this reason, systematic literature review was conducted. The articles were retrieved by searching on two complementary databases, Laurea Finna and EBSCOHost, in order to maximise the amount of results. The articles were first selected using pre-determined criteria, which can be summarised as full-text English language articles published in 2006 or later. Subsequently, titles and abstracts were analysed and only those articles that were relevant to the topic were selected for thorough review. This led to a total of 15 articles to be examined.

Findings were finally summarised into four groups: client perspective, nurse perspective, specific elements of relationship, and technical aspects of home-care. These categories, however, are partially overlapping, and it was not possible to discuss one without mentioning the others. Briefly, home-care special setting changes the balance in the therapeutic relationship and empowers the client, but at the same time elderly patients, due to their physical problems and loneliness, are more dependent on nurses from the social point of view. For future studies, it would be interesting to compare home-care with other types of long-term care settings, or examine nurse-client interactions in short-term home-care.

Keywords: Nurse, Elderly client, Nurse-elderly client relationship, Home-care

Laurea-ammattikorkeakoulu **Tiivistelmä**

Laurea Otaniemi
Degree Programme in Nursing

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Hoitaja-iäkäs asiakas-suhde kotihoidossa

Vuosi 2016 Sivumäärä 47

Kotihoidolla autetaan asiakkaita päivittäisissä toiminnoissa, joita he eivät enää kykene suorittamaan. Tavoite on se, että asiakkaat saavat elää kotona mahdollisimman pitkään. Koska kotihoito tapahtuu erikoisessa ympäristössä, on ehkä syytä sanoa, että hoitaja-potilas-suhteessa on ainutlaatuisia ja mielenkiintoisia ominaisuuksia. Sen lisäksi, vanhusten liikkuminen kodin ulkopuolella on usein rajoitettua, joten sairaanhoitajilla on tärkeä sosiaalinen rooli.

Tällä opinnäytetyöllä kuvailen hoitajan-iäkäs asiakas-suhteen kotihoidossa, ottamalla huomioon tämän ympäristön erikoisvaatimukset. Tämä selvitin systemaattisen kirjallisuuskatsauksen avulla. Artikkelit löytyivät kahdesta toisiaan täydentävästä tietokannasta: Laurea Finna ja EBSCOHost. Näin oli mahdollista saada mahdollisimman laaja otos. Kriteerit, joiden mukaan valitsin artikkeleita päätin etukäteen. Käytin englanninkielisiä artikkeleita, jotka on julkaistu vuoden 2006 lähtien ja joiden koko teksti on saatavilla. Sen jälkeen, luin otsikoita ja tiivistelmiä ja valitsin vain aiheeseen liittyviä artikkeleita. Tutkin perusteellisesti 15 artikkelia.

Tulokset voidaan jakaa neljään eri ryhmään: asiakkaan näkökulma, hoitajan näkökulma, ainutlaatuiset suhteeseen-liittyvät ominaisuudet ja kotihoidon tekniset puolet. Nämä ryhmät ovat kuitenkin osittain päällekkäisiä, joten ei ole mahdollista puhua vain yhdestä ryhmästä kerrallaan. Lyhyesti, kotihoidon erityinen ympäristö muuttaa tasapainoa hoitaja-asiakas-suhteessa ja valtuuttaa asiakasta. Samalla, iäkkäillä potilailla on vaivoja ja he ovat yksinäisiä, joten he ovat riippuvaisempia hoitajista sosiaalisesta näkökulmasta. Tulevaisuudessa olisi mielenkiintoista verrata kotihoitoa muihin pitkäaikaishoidon tilanteisiin ja tutkia hoitaja-asiakas suhdetta lyhytaikaiskotihoidossa.

Keywords: Hoitaja, Iäkäs asiakas, Hoitaja-iäkäs asiakas-suhde, Kotihoito

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1 Introduction

Humans exist both as individuals and in connection to the people and the environment surrounding them. Human beings are constantly influenced by these relationships on the biological, cognitive, moral, and spiritual level. When the nature of these connections is good, a person will feel safe and will be more likely to develop. On the contrary, a dysfunctional relationship can cause feelings of isolation and sickness. As nurses, we relate with ourselves, our clients and their families, our colleagues, and the community. For the professional relationship to be successful, the nurse should be able to experience the client's point of view and communicate this understanding. At this point, it is important to remember that patients' values, ideas, and feelings depend largely on their age, education, gender, and life experiences. This means that there is no magic formula to use with everybody, and this is why it is important to implement client-centred care. Duffy (2014) reports a study by the Picker Institute (1993), where clients themselves had identified the most important characteristics of good and safe care. The patients reported needing: respect for their views and needs, coordination and continuity of care, clear education, physical comfort, emotional support, and involvement of the family. While some of these points are more practical (physical comfort intended as relief from pain can be achieved by medicines), many of them focus on the nurse's ability to relate with clients, which seems therefore to be an essential aspect of client-centred care.

An effective relationship should have a balance of power between the nurse and the client: if the health-care professional is perceived to have too much control, the patient might be afraid of speaking and communication will be impaired. When the nurse-client relationship is efficient, the patient will feel cared for, which is even more important today than in the past, especially considering that many elderly clients are lonely and their families are scattered throughout the country, or even the world (Duffy 2014). Related to this last point, one of the most important health-care services when it comes to older patients is home-based care. One of the goals of this type of aid is to support clients in those areas of their lives they can not take care of. In the city of Helsinki, home-care provides support with basic care, medical procedures and medicines, gives the possibility to receive meals at home, and helps with security services and assistive devices (Helsingin kaupunki 2016).

The aim of this thesis was to the describe the therapeutic relationship between nurses and elderly clients in a special environment like that of a patient's home. For this purpose, literature review was used, in order to summarize and discuss what is known about this topic.

2 Theories and concepts

2.1 Nurse

Registered nurses can be found in all health-care settings: from hospitals to health centres, going through home-care, and elderly homes. Registered nurses can also work in schools, prisons, shelters, and be present at sporting events. Their job is versatile and rich in responsibilities. Registered nurses, for instance, perform health checks, administer medicines, carry out wound care, and counsel and educate patients. Moreover, they have a coordinating and supervising role when it comes to dealing with other health-care professionals, and a duty to perform research and keep themselves updated (American Nurses Association 2016). To work as a registered nurse in Europe, a bachelor degree is needed. In Finland this requires three and a half years of studies, for a total of 210 credits. In total there are more than 80000 registered nurses in Finland, which means slightly more than ten nurses for a thousand people, and four nurses for every medical doctor (Finnish Nurses Association ND).

There are several other types of nurses. For instance, advanced practice registered nurses have also a master's degree, and more clinical competences compared to a regular registered nurse, therefore their job has a wider scope. Practical nurses, instead, have a more basic education, and help patients in primary aspects of their care, like bathing and feeding. Licensed practical nurses, however, can perform some of the registered nurses' tasks (American Nurses Association 2016). In this thesis, the term "nurse" has been used to indicate licensed practical nurses, registered nurses, and advanced practice registered nurses. However, it does not include home-support workers or personal care attendants, who have a shorter learning path (Academy Canada 2016) and therefore do not have as deep health-care-related knowledge.

2.2 Elderly client

Even though in Finland the term "client" is more often used when talking about home-care (Helsingin kaupunki 2016), in this thesis the words "client" and "patient" have been used as synonyms. Unfortunately, there is not a univocal definition of patient; the term can be explained as somebody who is receiving health-care, or has received or will receive it (MedicineNet.com 2016). Indeed, the Nurse and Midwifery Council, as reported by Griffith and Tengnah (2010), uses a wide definition of patient so that both direct and indirect contacts with health-care professionals are included. In this thesis, client is used with the widest scope.

This work is focusing on elderly clients, so it is important to clearly define what an older person is. However, even in this case, there is no clear definition of the concept. Most developed

countries assume that elderly people are above 60 or 65 years of age, because, indeed, there is a relationship between calendar and biological age. However, this is not necessarily true for people with different background living in different regions and environment (World Health Organization 2016). In Finland, elderlies are defined as people over 65 years of age, which, in 2013, were almost one fifth of the total population (Finnish Nurses Association ND). In this thesis, however, people over 60 years old were considered elderly, since source articles were written in several countries that might not have the same definition of older person as Finland.

2.3 Nurse-client relationship

According to the MOT Oxford Dictionary of English (2016), a relationship is the way in which two or more people or things are related, or the state of being connected. Except in very special cases, for instance when it comes to unconscious patients, a nurse and a patient always interact, and therefore connect, during their encounters. Relationships between nurses and clients have been analysed in depth by Hildegard Peplau (1991), who describes therapeutic relationship as composed by four phases: orientation, identification, exploitation, and resolution. Figure 1 shows that these phases are partially overlapping and last throughout the whole healing process.

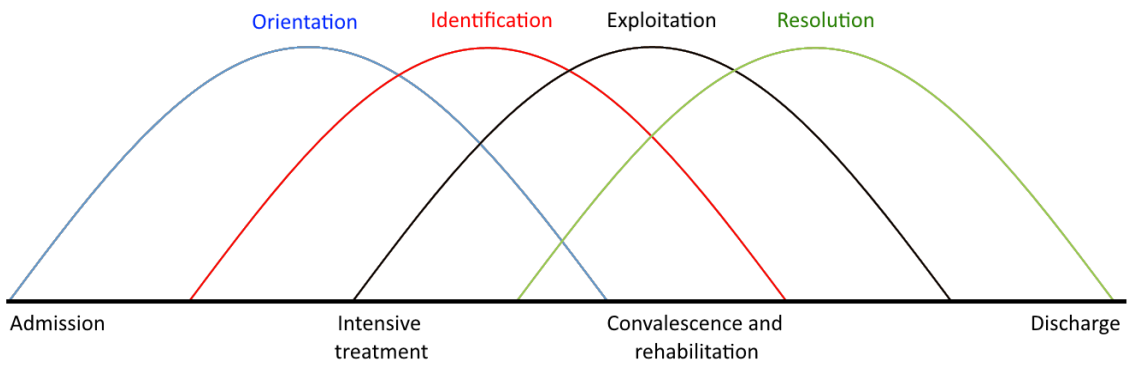


Figure 1. The four phases of the therapeutic relationship are overlapping. Peplau (1991) focuses on a hospital setting in her description, so certain aspects might differ in home-care.

The orientation stage starts with the patient seeking professional help due to felt need, that is: the patient understands that he or she is sick. During this phase, therapies are started, but the educational aspect of nursing should not be forgotten: the client knows that something is wrong, but he or she might not know what the problem is and needs guidance. For the nurse it is important to try to understand from patient's behaviour and questions what advice is needed. Patients themselves, however, might not be able to express exactly their feelings and needs, and nurses should strive to make this possible by being open, welcoming, and not judgemental.

The orientation phase is necessary for patient's full participation to the caring process and to integrate sickness in their life, and is followed by the identification stage. During identification, after the patient is oriented to his or her disease, he or she will respond to people who seem to offer the needed help. People might react in different ways during this phase: some patients who had negative experience of interpersonal relationships might not believe that somebody is accepting them, and might isolate themselves, try to be unreasonably independent and not ask for help. At the opposite extreme are patients who think all the help is given and only call for the nurse without trying to improve themselves. The nurse-patient relationship should aim at developing personality, so ideally, patients should explore their feelings, which could help them become less vulnerable to the situation. It is understandable that people might experience mixed feelings during this phase, but nurses can not know what patients are thinking without clear communication, which is therefore essential (Peplau 1991).

The exploitation phase arises at the overlapping of identification and resolution stages. During the third phase, patients are using in full all the services needed, and the requests they have for nurses might increase. However, at the same time, they are redirecting themselves towards new goals, like that of going home. When this happens, the fourth, and last, phase starts. Ideally, the resolution stage begins after the patient is healed, and consists in cutting the ties born during the therapeutic relationship. However, this is a psychologic process, which might not start so straightforwardly. For instance, a patient who has already been discharged could come back several times for no apparent physical reason. This could be an indication that something went wrong: all four phases should be correctly resolved for the process to be successful (Peplau 1991).

Peplau's description shows that the therapeutic relationship between nurses and clients is a very complex one. It is clear how, in order to develop a positive connection with patients, nurses should be able to take care of several important issues. For instance, nurses should be empathic and respectful of patients' ideas; they should be able to educate, to guide, and to give emotional support. At the same time, they should work ethically, without crossing professional boundaries. This is in line with what mentioned in the introduction about the study by the Picker Institute (1993), as reported by Duffy (2014). However, Peplau's work concerns mostly hospital patients, and the situation might be different in home-care. To gain further insight on this matter, this thesis work analyses 15 articles related to the nurse-elderly client relationship in home-care. Through a systematic literature review the therapeutic relationship is analysed from both the point of view of the health-care provider and of the client, in order to reveal aspects peculiar to this special environment.

2.4 Home-care

Home-care refers to the delivery of health-related services at a client's home. This type of aid is aimed at disabled people who are over 18 years old, convalescent patients, clients suffering from long-term illnesses, and elderly. The goal of home-care is to support these categories in the daily activities they can not perform on their own and, therefore, to make it possible for them to live as normal life as possible at home. In Finland, home-care nurses help clients not only with medications and medical procedures, but also with basic care. Through home-care it is also possible to gain access to other services which, however, are not directly controlled by the home-care organization. These include receiving groceries or ready meals at home, renting of a security system and of assistive devices (Helsingin kaupunki 2016). To access home-care in Finland the client or a close relative has to call the local coordinator and agree on a preliminary meeting. During this encounter the real resources and needs of the patient are discussed, in order to draw a personalized care plan, which is updated throughout the duration of the therapeutic relationship (Helsingin kaupunki 2015).

3 Purpose of the study and research question

The purpose of this study is to describe the relationship between nurses and elderly clients in home-care setting.

This study asks the following question:

- What are the components of the nurse-elderly client relationship in home-care?

4 Methodology

4.1 Systematic literature review

A systematic literature review should always be performed when several empirical studies on the same research question have been published. It aims at answering the research question by collecting data fitting specific criteria, which are defined before the search starts. The methodology used for this type of literature search should be clear and reproducible, and the findings should be assessed for their validity. The results are then synthesized and presented systematically (The University of Edinburgh 2013).

The literature search is determined directly by the research question, which should be clear and focused, univocal, concrete, and relevant. Systematic review of studies on topics related to the research question makes it possible for the researcher to develop his or her initial ideas or theories from which the research question derives. As a consequence, the research process itself becomes clearer and the researcher has a better understanding of what should be addressed and how in order to answer the research question. During the whole process, however, it is important to remember that the purpose of literature review is not that of giving the researcher a fixed theoretical stance, but that of developing ideas and building the basis to conduct his or her study. In other words, the approach to qualitative research should be open-minded, but informed (Ritchie and Lewis 2003).

4.1.1 Data search and inclusion criteria

Several keywords were identified for this search: home-care, nurse, elderly, client, relationship. Synonyms used were: community care or domiciliary care for home-care, older for elderly, patient for client, and interaction for relationship. While some of the words might not be perfect synonyms of the main search terms (for instance interaction is only a small part of a relationship), it was noticed during a preliminary search that authors had been using those keywords with the same meaning, and they were therefore used during this phase. In each search, the keywords were connected through the Boolean operator “and”. Each search was then repeated substituting keywords with their corresponding synonym(s). Searching with fewer than four keywords was considered too unspecific due to the number of articles retrieved even after filtering. The data search process was conducted between the 18th of June and the 3rd of July 2016. The search engines used were Laurea Finna and EBSCOHost because Laurea Finna retrieves articles from many of the journals Laurea has a subscription to, with the exception of those included in EBSCOHost (Laurea Finna ND). By using complementary search engines, the results are supposed to be as complete as possible. A preliminary search was limited to full-text, peer-reviewed articles in English published in 2006 or later. These

minimum eligibility criteria ensured that the results were up-to-date (published in the last ten years), reliable (peer-reviewed), easily understandable by all readers (in English), and contained all the relevant information (full-text). The titles and abstracts of the articles were then screened, and only those that looked relevant for the research question underwent initial review. Reasons for discarding articles in this first step are summarized in Figure 2. The total number of articles complying with the minimum eligibility criteria and of those selected for more thorough review is summarized in Table 1.

Database / Keywords	Laurea Finna	EBSCOHost	Total number of articles	Discarded articles	Articles for thorough review
Home-care Nurse Elderly Client Relationship	165	106	271	261	10
Home-care Elderly Client Relationship	250	392	642	625	17
Home-care Nurse Client Relationship	189	546	735	715	20
Nurse Elderly Client Relationship	244	229	473	464	9
Total	848	1273	2121	2065	56

Table 1. Data search process. The number of articles in each cell refers to the articles found using the listed keywords or their synonyms reported in the text. Total number of articles refers to the entire number of articles found after applying the minimum eligibility criteria. Discarded articles were rejected after reading their abstracts, leaving only relevant articles for thorough review.

The 56 articles selected for detailed study were first screened for duplicates before reviewing the remaining articles. The inclusion and exclusion criteria for this second part of the search are included in Figure 2.

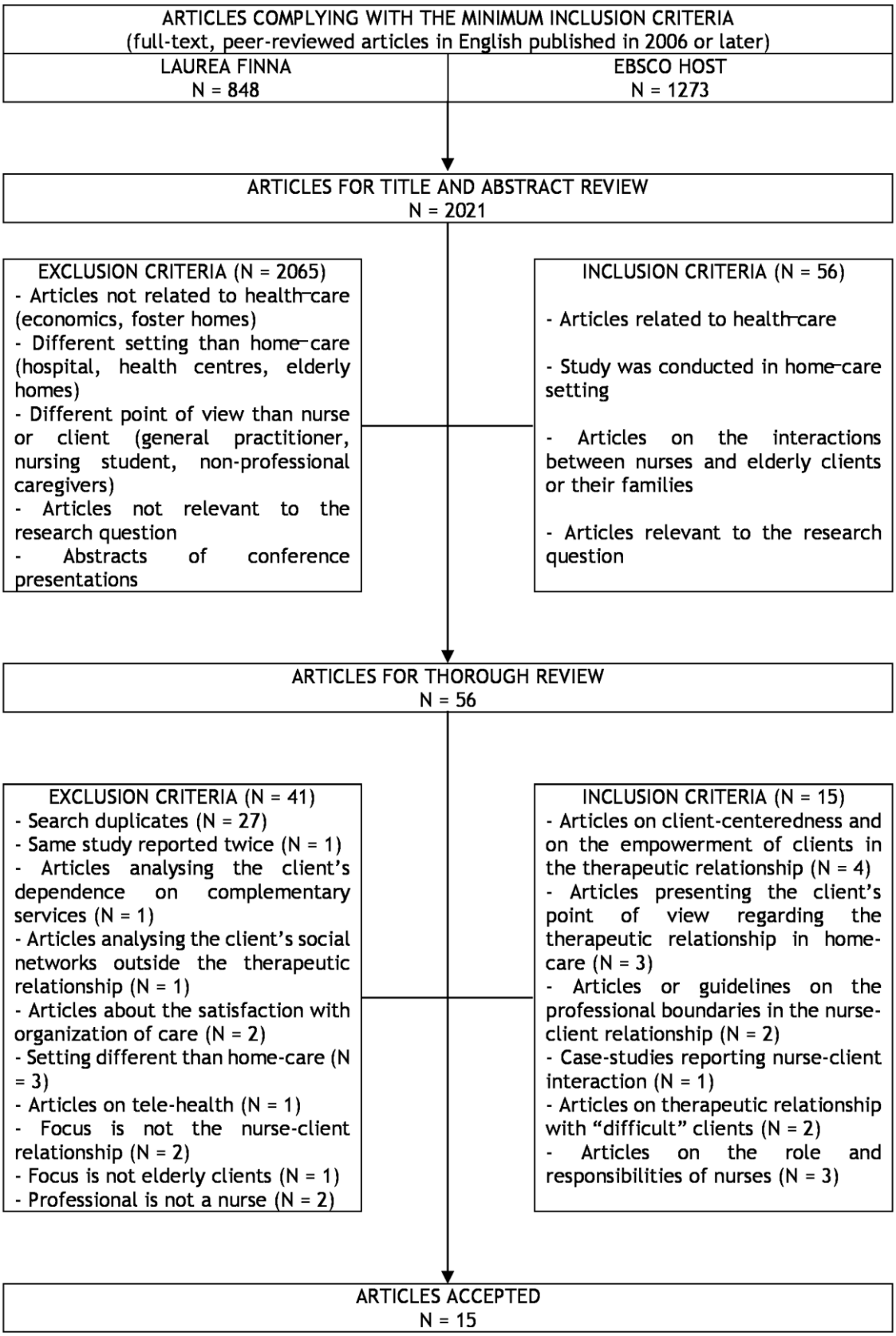


Figure 2. Data selection process.

4.1.2 Data appraisal

Critical appraisal of the articles was performed with the goal of finding strengths and weaknesses of the studies. Instructions for appraisal were retrieved through the Equator Network Online Wizard (ND) in order to find appropriate guidelines for each of the different types of studies. In total ten articles reported qualitative studies, one a quantitative study, two included both qualitative and quantitative results (in both cases only the qualitative part was appraised because the quantitative part was not relevant to this thesis), and one was a case-report for which modified guidelines had to be used. These modified guidelines were needed since no optimal appraisal instrument was found, so the closest one was used, taking into account that some requirements were not applicable. Finally, one article was a summary of a code of conduct and therefore was not evaluated. The following guidelines were used:

- CARE: Case Reports guidelines (Riley, Gagnier, Kienle, Moher, Plotnikoff, Shamseer and Barber 2013). These guidelines were thought for clinical case reports and included requirements that were not suitable for the reported observation, such as pharmacological and follow-up information. Therefore, the non-applicable points were not included in the scale for evaluation of the article. As a result, the final scale was composed of 25 items instead of the original 30.
- SRQR: Standards for Reporting Qualitative Research (O'Brien, Harris, Beckman, Reed and Cook 2014). These guidelines were used to evaluate qualitative articles and the qualitative parts of mixed-methods studies.
- STROBE: Strengthening the Reporting of Observational Studies in Epidemiology (von Elm, Altman, Egger, Pocock, Gotzsche and Vandenbroucke 2007). STROBE guidelines were used to evaluate the only purely quantitative article included in this study.

Because of the differences in focus, methods, and design, the results were difficult to compare and, consequently, the search for shared themes more complicated. However, the articles were rich in information on the nurse-elderly client relationship in home-care. Most of the studies failed to mention how the sample and its size were chosen. Other points that were often lacking were the documentation of ethical approval, grant source and declaration of possible conflicts of interests. Despite these weaknesses, the overall quality of the articles was sufficient for their inclusion in this thesis work. The studies were graded from A (very good) to E (very poor) based on how many of the items reported in the guidelines were present in the articles. For the modified CARE guidelines, grading was as follows: 0-5,5: E; 6-10,5: D; 11-15,5: C; 16-20,5: B; 21-25: A. For SRQR guidelines, 0-5,5: E; 6-9,5: D; 10-13,5: C; 14-17,5: B; 18-21: A. For STROBE guidelines, 0-4,5: E; 5-9,5: D; 10-14,5: C; 15-19,5: B; 20-23: A. A summary of the process can be found in table 2.

Study	Guidelines	Grade	Notes
Brown, D., McWilliam, C., Ward-Griffin, C. 2006. Client-centred empowering partnering in nursing. J Adv Nurs. 53 (2), 160-8.	SRQR	19,5/21 A	Qualitative study
Cheng, W.L., Lai, C.K. 2010. Satisfaction Scale for Community Nursing: development and validation. J Adv Nurs. 66 (10), 2331-40	SRQR	19,5/21 A	Mixed methods study. Appraisal was performed on the qualitative part.
Corbett, S., Williams, F. 2014. Striking a professional balance: interactions between nurses and their older rural patients. Br J Community Nurs. 19 (4),162-7.	SRQR	16/21 B	Qualitative study
Doherty, M., Thompson, H. 2014. Enhancing person-centred care through the development of a therapeutic relationship. Br J Community Nurs. 19 (10), 502, 504-7.	Modified CARE	22/25 A	Case-report
Griffith, R., Tengnah, C. 2013. Maintaining professional boundaries: keep your distance. Br J Community Nurs. 18 (1), 43-6.	Not evaluated	Not evaluated	Summary of guidelines by the Nurse and Midwifery Council
Hautsalo, K., Rantanen, A., Astedt-Kurki, P. 2013. Family functioning, health and social support assessed by aged home care clients and their family members. J Clin Nurs. 22 (19-20), 2953-63.	STROBE Statement	18/23 B	Quantitative study
Holmberg, M., Valmari, G., Lundgren, S.M. 2012. Patients' experiences of homecare nursing: balancing the duality between obtaining care and to maintain dignity and self-determination. Scand J Caring Sci. 26 (4), 705-12.	SRQR	18,5/21 A	Qualitative study
Liveng, A. 2011. The vulnerable elderly's need for recognizing relationships – a challenge to Danish home-based care. J Soc Work Pract. 25 (3), 271-83.	SRQR	14/21 B	Qualitative study
Lucas, S. 2013. The missing link: district nurses as social connection for older people with type 2 diabetes mellitus. Br J Community Nurs. 18 (8), 388, 390-7.	SRQR	17,5/21 B	Mixed methods study. Appraisal was performed on the qualitative part.
McGarry, J. 2009. Defining roles, relationships, boundaries and participation between elderly people and nurses within the home: an ethnographic study. Health Soc Care Community. 17 (1), 83-91.	SRQR	18,5/21 A	Qualitative study
Michaelsen, J.J. 2012. Emotional distance to so-called difficult patients. Scand J Caring Sci. 26 (1), 90-7.	SRQR	18,5/21 A	Qualitative study
Millard, L., Hallett, C., Luker, K. 2006. Nurse-patient interaction and decision-making in care: patient involvement in community nursing. J Adv Nurs. 55 (2), 142-50.	SRQR	18/21 A	Qualitative study
Roberts, A., Philip, L., Currie, M., Mort, A. 2015. Striking a balance between in-person care and the use of eHealth to support the older rural population with chronic pain. Int J Qual Stud Health Well-being. 2, 10, 27536	SRQR	19/21 A	Qualitative study
Schoot, T. Proot, I., Legius, M., ter Meulen, R., de Witte, L. 2006. Client-Centered Home Care: Balancing Between Competing Responsibilities. Clin Nurs Res. 15 (4), 231-54.	SRQR	18/21 A	Qualitative study
Witsø, A.E., Eide, A.H., Vik, K. 2011. Professional carers' perspectives on participation for older adults living in place. Disabil Rehabil. 33 (7), 557-68.	SRQR	17,5/21 B	Qualitative study

Table 2. Data appraisal. Different guidelines were used depending on the type of study. Abbreviations: CARE = Case Reports guidelines (Riley et al. 2013); SRQR = Standards for Reporting Qualitative Research (O'Brien et al. 2014); STROBE = Strengthening the Reporting of Observational Studies in Epidemiology (von Elm et al. 2007).

4.1.3 Data analysis

The literature search retrieved 15 articles containing information that should be sorted and organized. For this purpose, inductive content analysis was chosen. This process requires first familiarizing with the articles and their contents, and then pinpointing concepts under which to sort the data. In order to categorize the data, recurring themes have to be identified; these are subsequently grouped under broader main themes, which makes the data manageable. Once the main themes have been defined, the material should be read again in order to catalogue the data and, in case, refine the main themes. Therefore, this process is not straightforward but requires going back first to the raw data and then to the resulting framework in order to optimise the process. Once the data has been sorted, it is possible to focus on the different subjects in order to analyse them and synthesize the results (Ritchie and Lewis 2003). An example of the outcome of the process is reported in Figure 3. The complete analysis process is reported in Appendix 1.

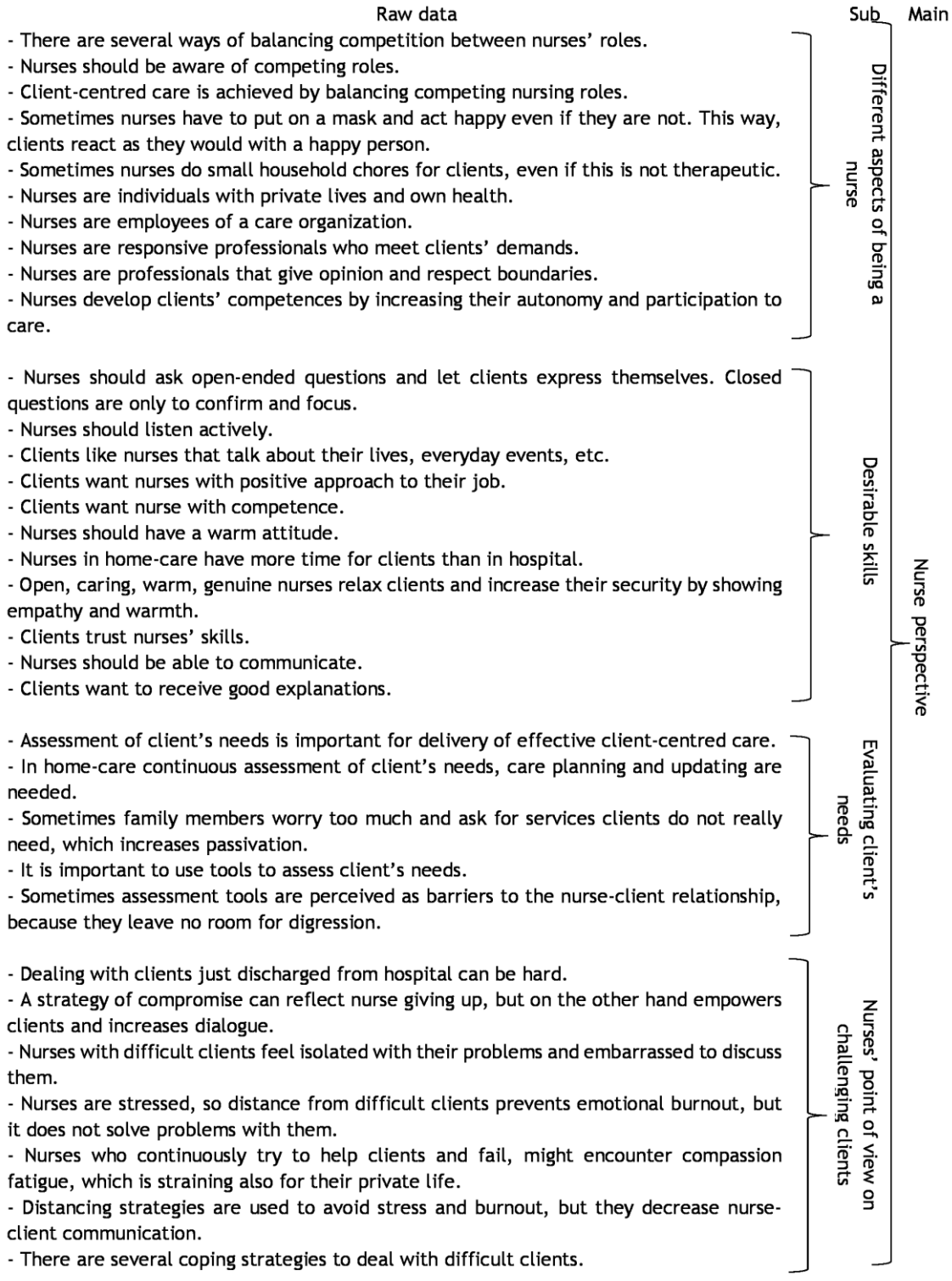


Figure 3. Data analysis for nurse perspective. Sub refers to sub-categories, main to the main category Nurse perspective.

5 Systematic literature review findings

The purpose of this the study was to answer the question: what are the components of the nurse-elderly client relationship in home-care? Keeping this objective in mind, 15 research articles were examined. The findings were divided into four main categories: client perspective, nurse perspective, specific elements of relationship, and technical aspects of home-care. Figure 4 shows the connections between main and sub-categories.

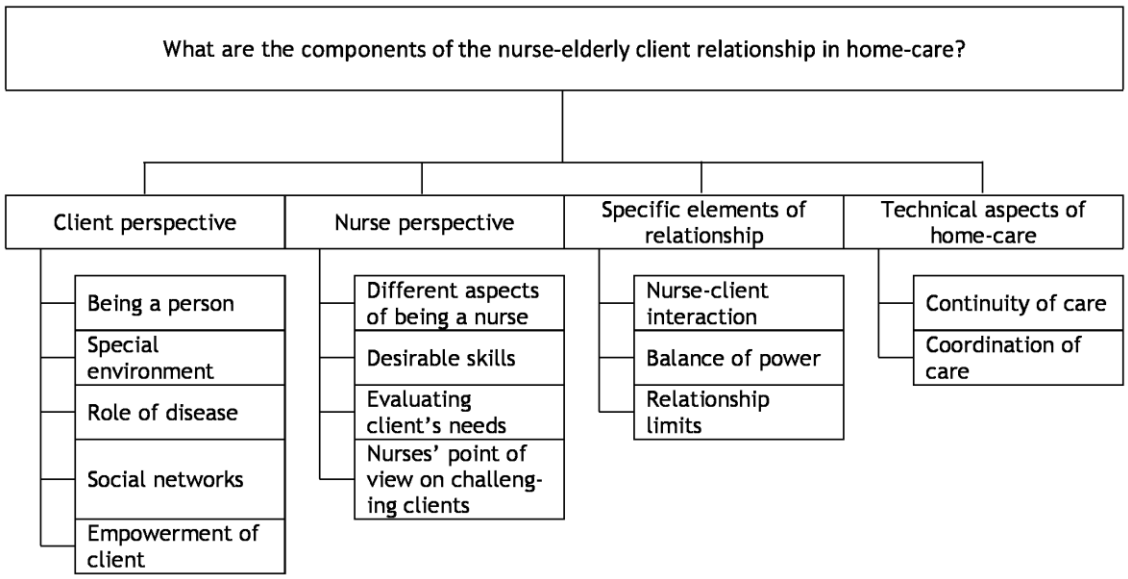


Figure 4. Summary of literature review findings.

5.1 Client perspective

5.1.1 Being a person

Home-care seems to be more person-oriented compared to hospital care (McGarry 2009). There are many types of clients in home-care, with various diseases and distinct personalities. Each of them is different, and nurses have been observed to change their behaviour based on the patient, rather than on his or her specific illness (Millard et al. 2006). Home-care clients themselves have expressed the need to be identified through the lives they had, rather than through their disease: although they know they need help, they do not want their weakness to be the only thing nurses focus on (Liveng 2011, Holmberg et al. 2012). Home-care patients want to feel as unique individuals, and want their encounters with the nurse to be personal (Holmberg et al. 2012). Most of the clients, in fact, do not feel cared for if nurses ask only health-related questions (Corbett and Williams 2014), they want to be paid interest to, talked to, and listened actively to (Holmberg et al. 2012). Sharing personal information with patients has been shown to increase trust in the therapeutic relationship and makes cli-

ents feel more valued, which increases their psychological well-being (Corbett and Williams 2014).

In addition to being paid attention to, home-care patients consider important that nurses respect their values, feelings, and individuality. Only by knowing what the client wants, it is possible to develop a trusting relationship and to preserve patients' right to autonomy. Related to this, it has been mentioned that nurses try to make their patients to take part in the care process, but, sometimes, clients want to remain passive. They mention, as reasons for this behaviour, tiredness or pain (Cheng and Lai 2010, Holmberg et al. 2012, Millard et al. 2006, Roberts et al. 2015). Some clients have also mentioned that they have not let in nurses who did not treat them as they had requested (Holmberg et al. 2012). This is sometimes a difficult situation for the nurse, who has to find a balance between doing what the patient wants and doing what he or she really needs (Liveng 2011).

The third point clients consider important is time. While it has been reported that home-care clients are not as bound by hospital routines as in a ward (McGarry 2009), organization and duration of visits still seems to be an issue. Having to wait for a nurse to come, maybe even for hours, decreases patients' control over their everyday lives. For instance, if they want to take care of small house chores, clients often wait for after the nurse's visit before starting those (Witsø et al. 2011). Clients do understand that nurses might be late for a visit, but at the same time find it disrespectful when the delay is too long. They also understand that nurses have many patients to take care of, but clients want their own time with the health-care professional and think work-related phone calls should be avoided during visits (Holmberg et al. 2012). In addition, nurses should not show time-related pressure during visits or complain about their workload, so that clients do not feel like they are a burden (Hautsalo et al. 2013, Holmberg et al. 2012).

5.1.2 Special environment

As already mentioned, home-care is more person-oriented than hospital care (McGarry 2009). There are several reasons for this, including the fact that home, as a context, allows a better understanding of clients (Brown et al. 2006, McGarry 2009). Moreover, being at home, in a familiar environment, increases security, independence, and self-esteem of patients. Sense of integrity and privacy are also preserved (Holmberg et al. 2012). Clients living at home experience also decreased professional barriers and an increased sense of reciprocity. They might for instance start giving suggestions on aspects not related to the therapeutic relationship, as if the nurse was an acquaintance instead of a professional (McGarry 2009). Because of this type of setting, which is more relaxed and familiar for patients, also development of a nurse-client relationship is facilitated (Doherty and Thompson 2014). Patients are aware that the

home environment is a special one, and demand that nurse value their homes and ask for permission before doing things such as opening drawers, even when it is to get medicines for them. Most nurses seem to be aware of this need, and consider themselves as guests when they are visiting clients in their homes (Holmberg et al. 2012).

5.1.3 Role of disease

It can be argued that, especially for elderly clients with chronic diseases, illness is a part of their lives and they are used to it (McGarry 2009). However, patients want to be identified through their interests and the life they lived, rather than by their weaknesses. They also want to be responsible for their own life choices as much as possible, despite their problems. Clients find it important to manage to balance self-determination and dignity with the need for care, and they want to be respected as human beings, despite their increased needs (Holmberg et al. 2012, Liveng 2011).

Roberts et al. (2015) studied the role of pain in the interaction between nurses and their patients. They report that elderly clients often experience chronic pain. Pain is a very common symptom of various diseases, and it has been estimated that about one seventh of the population of United Kingdom suffers from it. Unfortunately, pain comes with repercussions both on the physical and psychological aspect of health. For instance, it is one of the causes of social isolation, it can cause depression, and of course decreases life quality. One of the main findings of the study was that pain affects communication levels, both with nurses and relatives or friends.

5.1.4 Social networks

Elderly home-care clients are often isolated due to migration of their families, worsening of their health, and, in some rural areas, difficult access to public transportation. Because of these difficulties, nurses' visits play also a social role in the lives of their patients. Visits connect clients to the outside world, and studies have found out that patients consider this social aspect as important as good care (Corbett and Williams 2014, Lucas 2013, Roberts et al. 2015). However, sometimes home-care nurses do not understand the importance of the social role they play. Their connection to their clients is fragile, and often patients are afraid of being discharged, even when they are self-sufficient, indeed because of the role nurses have in their lives (Lucas 2013). Clients like to share information about relatives and family activities, to talk about what happened in their community or discuss the news, but also to chat about common topics, like the weather. Because patients still want to participate in events outside their homes, but often can not, the social role of home-care nurses enables elderly clients to still be part of the community (Corbett and Williams 2014, Witsø et al. 2011).

5.1.5 Empowerment of client

According to the MOT Oxford Dictionary of English (2016), empowerment is the act of giving someone the power to do something, to make him or her more confident and stronger, able to control his or her own life and rights. Given this definition, it is understandable that home-care has been described as client-empowering (Holmberg et al. 2012). However, empowering clients does not mean that nurses have to give up all of their power, nor that patients are supposed to do everything on their own without nurses' help. Often empowering comes as the result of finding a compromise between what the client wants and what he or she really needs: nurses give up some of their authority to increase dialogue and increase clients' power (Brown et al. 2006, Michaelsen et al. 2012).

Empowering is essential for client-centred approach, and in home-care context, it often means to involve clients in the caring process, to give them positive feedback in order to increase their self-esteem (Brown et al. 2006, Doherty and Thompson 2014). Indeed, in home-care there is the implicit assumption that patients want to take part in care planning, and several studies have reported that clients are willing to be part of the process and even instruct new nurses on how to take care of them (Cheng and Lai 2010, Holmberg et al. 2012, Millard et al. 2006). However, empowerment is not a clear process: sometimes nurses think that certain interventions will increase patients' involvement in the care process, but actually end up passivating clients (Witsø et al. 2011). Moreover, nurses should value patients' individuality and right to decision-making: some people do not want to be involved in their care and assume on purpose a passive role (Holmberg et al. 2012, McGarry et al. 2010, Millard et al. 2006). In addition, it should be taken into account that empowering is not only clients' participation in the care plan: patients want to regain functionality and independence, but this takes time, which often nurses do not have, and effort, and is even harder when clients' energy is decreased (Witsø et al. 2011).

5.2 Nurse perspective

5.2.1 Different aspects of being a nurse

That of home-care nurses is a multi-faceted job. Besides being a social link to the outside world (Paragraph 5.1.4) and working to empower their clients (Paragraph 5.1.5), nurses sometimes find themselves doing small house chores for their patients, even when there is no therapeutic reason for it. They can for instance collect the client's mail or toss their trash (Roberts et al. 2015). Nurses have sometimes to be also actors and actresses, and act happy and calm even when they are not. This way, clients react as they would to a cheerful person,

are more comfortable and prone to talk, which has a beneficial effect on the therapeutic relationship (Michaelsen 2012).

Schoot et al. (2006) have studied in detail the various roles assumed by nurses in home-care. Firstly, nurses are responsive professionals who meet clients' demands and are responsible for respecting clients' autonomy and uniqueness, and who have to be present. Secondly, they are critical professionals: they give informed opinions, set professional boundaries, and develop effective care and efficient time division. Thirdly, nurses are developers of patients' competences who empower clients and apply the principle of beneficence. Fourthly, nurses are individuals: they have their own private lives and health to take care of. Lastly, they are employees of the health-care organization, who have to be efficient, productive, and contain costs. Patient-centred care is achieved by balancing these competing roles, of which nurses should be aware. For instance, nurses can not always be present and divide time fairly at the same time; similarly, deliver of evidence-based care often clashes with clients' autonomy. Nurses have several ways of balancing these responsibilities. These strategies can be classified based on how aware the nurse is of the competing roles, on how much responsibility the nurse is taking, and on how committed to clients' demands the nurse is. A nurse who is aware of these contrast and decides to respect patient's autonomy, doing only what the client wants, is defined as pleasing. A dialoguing nurse is aware, takes responsibility and tries at the same time to meet client's needs. In this case the nurse explains the various options to the patient and tries to make him or her understand why a certain choice would be better. A directing nurse is not aware of the competing roles, but takes responsibility and has a dominant role. Another type of directing nurse is the one who is aware of the colliding roles but chooses to assume a dominant role out of beneficence. A detaching nurse is not aware of clients' vulnerability and acts in a task-oriented way. In other cases, detaching nurses are aware of the situation they are in, but the client's demands can not be respected. Therefore, the nurse acts in what he or she thinks is the only possible way. However, this last solution leads to moral distress.

5.2.2 Desirable skills

It has been reported that home-care nurses have more time for their patients than hospital nurses (McGarry 2009), which suggests that the relationship they form is also different. Several studies have investigated what clients need in a home-care nurse in order to have beneficial therapeutic interactions. Patients need nurses who are technically competent and able to communicate. They generally trust nurses' caring skills, but often suggest that nurses should be able to explain and communicate (Cheng and Lai 2010, Hautsalo et al. 2013, Holmberg et al. 2012). Client also want to be actively listened to (Cheng and Lai 2010), and it is recommended that, in order to let patients express themselves, nurses ask mostly open-

ended questions. Yes-and-no questions should be used only to confirm what the patient said and to focus. In order for the client to relax and feel secure in the therapeutic relationship, nurses should show openness and warmth, and be caring and genuine (Doherty and Thompson 2014). Moreover, patients do not want to feel like they are a burden for the nurse, so they hope to meet professionals with a positive attitude towards their job (Hautsalo et al. 2013). Finally, as already mentioned in Paragraph 5.1.4, nurses play an important social role, and clients want to talk with them about their lives and families, and comment and share opinions on daily events (Holmberg et al. 2012).

5.2.3 Evaluating client's needs

Assessing clients' needs is important to develop a functional therapeutic relationship and delivery of efficient client-centred care (Doherty and Thompson 2014). Because clients and their needs evolve continuously, constant assessment is needed, and patients' care plans should be updated accordingly (Hautsalo et al. 2013). Moreover, sometimes clients' relatives worry too much and ask for services that patients do not really need, which might cause passivation (Witsø et al. 2011). In order to properly assess clients' needs, it is therefore important that the health-care professionals use specific tools. One example is the Northern Ireland Single Assessment Tool (NISAT), which is based on the idea that elderly clients with multiple needs require inputs by different types of professionals (Doherty and Thompson 2014). However, sometimes assessment tools are perceived as hindrances because they do not leave room for digressions or deepening of certain issues (McGarry 2009).

5.2.4 Nurses' point of view on challenging clients

Dealing with patients just discharged from the hospital might be hard at times, for instance because of unclear instruction and insufficient information on the client's needs (Brown et al. 2006). However, there is no univocal definition of "difficult patient". What is problematic for one nurse might not feel so for another one. Some examples include clients who do not comply with instructions, who ask too many questions or interrupt too often, and patients who have addictions or are overweight. Nurses with difficult clients feel isolated and are embarrassed to talk about their problems (Michaelsen 2012). Understandably, when a nurse tries continuously to help a patient but fails, he or she might encounter compassion fatigue and burnout, which pose a strain on private life (Doherty and Thompson 2014). Michaelsen (2012) has described several coping strategies that nurses may use to deal with such patients. When adopting a persuasive strategy, nurses expect that patients would comply to the instructions, either because they accept the professional's advice or after being threatened. An avoidance strategy can be implemented both psychologically (emotional distance) and physically (asking a colleague to deal with the patient). This strategy (which has also been described by Roberts

et al. 2015) prevents stress-derived emotional burnout, but decreases communication between nurses and clients and does not solve their problems. A third strategy consists in finding a compromise between the first two. Nurses who compromise know that the patient will not comply, but have not adopted an avoiding strategy. While compromising might reflect that a nurse has given up, it also opens up possibilities by empowering clients and increasing dialogue. Therefore, from a situation of compromise, the relationship might evolve in different directions with time.

5.3 Specific elements of relationship

5.3.1 Nurse-client interaction

Some of the elements of a nurse-patient relationship might be cultural. For instance, clients in China tend to adopt a more submissive role than in Europe (Cheng and Lai 2010). However, there are universal components that are worth mentioning. A functional therapeutic relationship is client-centred and needs honesty, listening, questioning, and providing information and support (Doherty and Thompson 2014, Holmberg et al. 2012). However, light-hearted discussions are common in home-care, and clients like nurses who talk about their lives and discuss everyday events. Some clients have also mentioned that they prepare beforehand to the visit to decrease the burden on nurses and to have more time to chat (Holmberg et al. 2012, Roberts et al. 2015, Witsø et al. 2011). Sharing personal information is not considered therapeutic, but it increases nurses' understanding of their clients and improves the relationship by making patients feel more valued and increasing their self-esteem (Corbett and Williams 2014). Moreover, social interactions between nurses and clients have been shown to reduce the intrinsic differences that are part of therapeutic relationships, and indeed home-care nurses have often said that they learn from their clients (McGarry 2009). The same is true for non-verbal communication, and nurses often use both clinical and non-clinical touch when interacting with their clients. Nurses also know that being talkative will increase the client's involvement (Roberts et al. 2015). Because of the diminished boundaries, and of a more relaxing environment, dialogue and holistic care are improved (Doherty and Thompson 2014, Millard et al. 2006). This said, it is clear that the nurse-client relationship in home-care is a multi-sided and complex one, and therefore it is often misinterpreted by other health-care professionals (McGarry 2009). In addition, because of its complexity, this relationship can not function properly if nurses disconnect psychologically (see Paragraph 5.2.4). A different case is, of course, when nurses put on purpose distance between them and their patients to avoid over-attachment (Corbett and Williams 2014).

Roberts et al. (2015) briefly explore the role of eHealth in the nurse-patient relationship. This study takes into account the possibility of using internet for communications between nurses

and elderly clients in rural areas, where the possibility of travelling is decreased. While this is an interesting possibility, it encounters several problems. For instance, the internet connectivity in remote areas is often not sufficient for a good communication. Moreover, the use of technology requires a computer literacy that the elderly population might not have. In addition, clients need to take responsibilities for several aspects of their care, and not everybody might be willing to do so. Lastly, this type of intervention would greatly reduce the physical presence of the nurse, diminishing further the already limited social network of patients.

Other studies mention other aspects of the relationship. For instance, sometimes clients are confused about their role and on whom they should talk about their illness, mixing the nurse's and the doctor's functions (Michaelsen 2012).

5.3.2 Balance of power

As in all therapeutic relationships, the power balance in home-care is unequal and shifted towards the nurse (Brown et al. 2006). However, while nurses are aware of their dominant position, they tend to consider themselves as guests at clients' homes (Holmberg et al. 2012). Certain types of non-verbal behaviour, such as sitting at the same level as the patient, leaning towards the client while talking, keeping comfortable eye contact, and smiling or touching the patient's arm, contribute to decrease differences between home-care nurses and their clients (Doherty and Thompson 2014). Also the special setting in which home-care takes place moves the balance slightly towards the client, compared to other types of nurse-patient relationships (McGarry 2009). In home-care, clients do not want to completely surrender to the nurse: they want their wishes to be respected, to maintain their independence, and to influence the way they are taken care of (Cheng and Lai 2010, Holmberg et al. 2012, Liveng 2011). Negotiations on treatment are often part of home-care, and nurses often have to try to find a balance between following patients' wishes and performing their tasks (Liveng 2011, McGarry 2009). Clients have been observed to use their power: they want nurses to respect their preferences and limits, and they want them to ask for permission before doing things such as opening drawers, even when it is to get the medications that patients need (Holmberg et al. 2012, Roberts et al. 2015). For home-care clients, having the possibility to control their own lives is important: they do not want to wait too long for the nurse to arrive, because it affects the control they have, and do not want nurses to intrude in the way they live (Liveng 2011, Witsø et al. 2011).

Nurses should try to find a balance between treating clients' diseases and being with their patients (Brown et al. 2006), and this means also involving clients in the planning of care and act accordingly. Millard et al. (2006) talk about five different approaches to the therapeutic relationship in home-care. Nurses using a completely involving approach are open and inter-

acting, and focus on the patient including him or her in the care process. They would for instance ask clients about their needs and what time do they want the visits to be. Sometimes, however, nurses use a partially involving approach, where they may focus on the client's wishes or on the care task during the same visit. As an example, they would take care of a client's wounds without asking his or her preferences, but would then ask on what day they would like the following wound care visit. Other nurses involve patients only when forced, meaning that they start with a non-involving approach but have to include the client when he or she asks for alternative ways of completing a care task. Non-involving nurses might be acting covertly or overtly. In the first case, the nurse focuses on treating the client without asking his or her opinion on any matter; in the second, the nurse takes care of the task and excludes the client, even when he or she has challenged the nurse. Interestingly, the study reports that the same nurse might behave differently with clients with the same care needs.

5.3.3 Relationship limits

The concept of professional boundaries is used to define what is appropriate and what is inopportune in the relationship between professionals and clients. Several authors, including Corbett and Williams (2014), Griffith and Tengnah (2013), and McGarry (2009), have pointed out that these boundaries are blurred in home-care. Home-care clients have decreased professional constraints and increased sense of reciprocity. They might for instance try to help nurses if they sense there is some problem (McGarry 2009). Patients like to talk about relatives and family activities, to discuss community news and common topics, and do not feel cared for as individuals when nurses do not ask them anything personal (Corbett and Williams 2014). For these reasons, nurses often use the concept of "professional friendship" to describe their relationship with clients (McGarry 2009).

The guidelines of the Nursing and Midwifery Council, as reported by Griffith and Tengnah (2013), state that a therapeutic relationship should focus only on the client's care needs and nurses should not give patients any information related to their private life. However, this is not always possible, especially in rural contexts where patients and nurses might already know each other or have common acquaintances (Corbett and Williams 2014). While unclear borders decrease objectivity, it is also true that their crossing is not necessarily unprofessional. Sharing personal information is of course not therapeutic, but it helps nurses to understand their patients. It is up to the nurse to use his or her judgment and find a balance (Corbett and Williams 2014).

Of course, certain ways of crossing boundaries are never acceptable. For instance, a nurse should not accept gifts from clients. An even more serious matter is that of sexual activity, which includes also telling dirty jokes. Nurses should never have intimate relationships with

clients, even when the therapeutic process has ended. This is because patients are still considered vulnerable, and nurses have a dominant role, which might have an effect on the client's perception of the relationship (Griffith and Tengnah 2013).

5.4 Technical aspects of home-care

5.4.1 Continuity of care

Home-care clients receive the visits of many nurses, often several times per day. One of the main concerns of patients is to have the same nurse as often as possible (Hautsalo et al. 2013, Holmberg et al. 2012). This, and increased time to dedicate to visits, would have a positive effect on the therapeutic relationship (Corbett and Williams 2014). However, this is often not possible due to time and money constraints, and to organizational decisions. For instance, from another point of view, staff rotation is necessary to prevent over-attachment to clients (Brown et al. 2006, Corbett and Williams 2014). On the other hand, to maintain accountability, it is desirable to have a dedicated primary nurse who is responsible for the patient's care plan and visits him or her when on duty (Hautsalo et al. 2013).

5.4.2 Coordination of care

It has been reported that home-care nurses have more time to take care of clients than hospital nurses (McGarry 2009). However, nurses have complained that they lack time for listening properly to patients and to coordinate the multidisciplinary work that would be needed with certain types of clients (Doherty and Thompson 2014). Patients, from their point of view, have mentioned the need for increased flexibility of services. This would include the chance to receive longer visits, the possibility to influence what time nurses are coming, and the opportunity to request extra contacts when needed (Cheng and Lai 2010, Hautsalo et al. 2013, Holmberg et al. 2012).

Home-care patients want holistic care. They have asked for the possibility to participate in the planning of their care, to have good quality and accessible health records, and for increased cooperation between nurses and relatives (Cheng and Lai 2010, Hautsalo et al. 2013). In addition, clients have often demanded that more services become available. They would for instance need somebody to go with them to the hospital (Cheng and Lai 2010, Hautsalo et al. 2013).

6 Discussion

As well described also by Schoot et al. (2006), home-care has the purpose of helping clients to live at home for as long as possible. The focus of this type of service has slowly switched from disease management to client-centeredness, and participation and autonomy of patients are becoming more and more important. In addition, care should be effective and efficient. As an example, Roberts et al. (2015) report that by 2035 more than one fourth of the population of Scotland will be over 75 years of age. This amount is not going to be equally distributed throughout the country, but it is estimated that the majority of the elderly population will be living in the countryside. Since world population is becoming increasingly older, especially in the more industrialized countries, the demands on health-care and social services are destined to grow. The purpose of this study was to use systematic literature review to analyse the therapeutic relationship between nurses and elderly clients in the context of home-care.

Articles for the systematic review were searched on Laurea Finna and EBSCOHost. After discarding the articles that did not meet the eligibility criteria or were not related to the research question, 15 studies were selected for in-depth reading and analysis. This study aimed at answering the following question: "What are the components of the nurse-elderly client relationship in home-care?". Four themes emerged from data analysis: client perspective, nurse perspective, specific elements of relationship, and technical aspects of home-care. These themes, however, overlap partially and it is not possible to talk about one of them without mentioning the others.

That of home-care is a special environment, possibly the one where the care delivered is as close as possible to being holistic. Clients are in a familiar location, surrounded by their own possessions, the atmosphere is more relaxed, and patients feel more secure. For all these reasons, the relationship between nurses and clients is different compared to a hospital (Brown et al. 2006, Doherty and Thompson 2014). Often patients deal with nurses as if they were acquaintances, and nurses have talked about "professional friendship" to describe this situation (McGarry 2009). This leads to three important matters: firstly, home-care tends to be very person-oriented, secondly, power balance is not as shifted towards the nurse, and, lastly, professional boundaries are somewhat blurred in this setting.

Person-oriented care in this case means more than just having personalized plans for clients. Patients want to be, first of all, considered as people. They have their weakness and diseases, most of them chronic, but that is not what should characterize them. Clients want to be seen through their interests, the lives they have lived, and want their homes to be respected (Liveng 2011, Holmberg et al. 2012). They want nurses to have time to listen to them, not only when they need to discuss health-related issues, but also when chatting about their daily

lives and families. As mentioned, this is probably due to a different atmosphere, but the other reason why patients need this type of interaction with nurses is isolation. Most home-care clients are elderly people who have a very limited network, usually due to their illness. Daily nurses' visits are often their only connection to the outside world (Corbett and Williams 2014, Witsø et al. 2011).

An important element in the nurse-client relationship is power balance. Power is always shifted towards the nurse, who is in a dominant position. In home-care, however, both context and type of relationship influence this equilibrium, making it more equal (McGarry 2009). Several studies (Cheng and Lai 2010, Hautsalo et al. 2013, Holmberg et al. 2012, Liveng 2011) have reported that clients express the will to influence the care they receive and to remain independent. While they understand that there might be problems and nurses can be late, patients object that this decreases the control they have over their lives. This is true even when clients are elderly who spend most of their days at home. Patients want for instance to be able to influence length and timing of visits. This, and other types of negotiations, are often part of the nurse-client relationship in home-care, and nurses have to find a balance between client's wishes and needs and health-care organization resources. Home-care patients, therefore, retain a certain amount of control. Nurses seems to be aware of this, since they often report feeling like guests. How much power patients have, however, still depends on the nurse's behaviour. As described by Millard (2006) and Schoot et al. (2006), nurses might act differently with different clients, even when they have the same care needs. A pleasing nurse, or one who adopts an involving approach, will give more power to patients, compared to those nurses who choose not to involve them, even after clients try to gain some control by challenging the professional.

With these premises, it is easy to understand why professional boundaries are not clear in home-care. While guidelines reported by Griffith and Tengnah (2013) are apparently precise, the situation in real life is not straightforward. For instance, often clients like to small talk over a cup of coffee during visits (Schoot et al. 2006, Witsø et al. 2011). This possibly breaks several of the guidelines, as nurses should not accept presents nor disclose personal information (Griffith and Tengnah 2013). However, one could argue that for elderly clients with a limited social network this is actually a care need. Moreover, sharing personal information helps to get to know clients and increases their self-esteem (Corbett and Williams 2014). In these situations, it is up to nurses to use their professional judgment to make sure the boundary crossing is somehow limited and justified.

Because of such a complex relationship with clients, home-care nurses have to be able to find a balance between being with patients, completing care tasks, and respecting clients' autonomy. Ideally, nurses should not just be technically skilled, but they should behave in a way

that empowers patients and makes them feel cared for. Interestingly, though, at least two studies (Millard et al. 2006, Schoot et al. 2006) report that nurses can adopt very different behaviours, even with clients with the same care needs. The articles do not report any clear explanation for this phenomenon, but most probably several factors are involved. For instance, when dealing with a difficult patient, nurses might choose to follow a more dominant approach, purposely avoiding client's involvement, in order to take care of the patient's problem without interruptions or discussions. Another possibility would be to behave in a pleasing way and doing only what the client wants, to avoid conflict. Another factor is related to time constraints (Doherty and Thompson 2014): nurses might choose a non-involving approach when the visit has lasted too long or when they have many clients left to visit. A third factor is that nurses are human beings: while they should always behave professionally, it might be that they are experiencing burnout or simply do not get along well with that specific patient. Finally, there is the possibility that nurses know if and how much the client wants to be involved in their care process and act more dominantly with people who want to remain more passive.

7 Trustworthiness

Cohen and Crabtree (2008) report Lincoln and Guba's (1985) evaluative criteria for trustworthiness of qualitative research. A reliable study should be credible, transferable, dependable, and confirmable. In other words, findings should be truthful, applicable in other contexts, consistent and repeatable, and not biased. There are several ways to improve these characteristics, in order to produce a better study.

Credibility requires prolonged engagement, persistent observation, triangulation, peer debriefing, negative case analysis, referential adequacy, and member-checking. Prolonged engagement necessitates that authors spend enough time learning the phenomenon. In this case, articles and books about nurse-client relationship were read before starting the thesis process. In addition, the author has a one-year experience as practical nurse in home-care. Persistent observation is what gives depth to a study, and is achieved by drawing from several sources. In this study, out of 2021 articles respecting the minimum search criteria (full-text, peer-reviewed articles in English published in 2006 or later), 15 articles were chosen through a process described in Paragraph 4.1.1. The number of articles ensured that data was collected from different sources, while still being relevant to the topic of this thesis. Triangulation requires using multiple methods to improve understanding of the phenomena. In this case, triangulation of sources is a result of persistent observation: by using different articles, it was possible to observe consistency of results between studies conducted in different settings. Peer debriefing consists in exposing the research to a peer with no conflicts of interests in order to uncover researcher's biases. This was achieved by presenting the study during thesis meetings, and by discussing it with teachers, other students, and an opponent. Negative case analysis requires studying contradictory data, until an explanation for these can be found. In the literature analysed, contrasts were mostly related to clients wanting power compared to patients that are more passive. This can be easily explained keeping in mind that every person is different and there might be several reasons for their less active behaviour, as discussed also by other authors (Millard et al. 2006, Roberts et al. 2015, Witsø et al. 2011). Referential adequacy consists in excluding part of the data from the analysis to come back to it after developing preliminary results. By analysing the initially excluded data, one can confirm the validity of the findings. However, referential adequacy is problematic in qualitative research, since it is difficult to guarantee that the excluded data can be left over without compromising the analysis and at the same time is representative (Onwegbuzie, Jiao and Bostik 2004). This step was therefore skipped. Member checking requires testing data and conclusions with the members of the groups from which the original data came. This was not applicable in this case, since data was generated by means of a literature review.

Transferability is ensured by describing the phenomenon in detail, in order to have a way to evaluate its validity in other contexts. This process is known as thick description, while thin description is a superficial account. The articles retrieved describe the setting rigorously, and studies conducted in different countries found similar results. So the findings seem to be transferable between nations. However, the papers have a limited scope: the relationship between nurses and elderly clients in home-care. Many of the findings are heavily dependent on the home-care context and on the fact that patients are over 60 years of age, so they can not be used to describe the relationship that develops in a hospital setting or with young clients.

To ensure that the findings are repeatable and consistent, that is, to establish dependability, it is recommended to have an external audit. This is basically an external researcher who examines the research process and evaluates if the data support the conclusions. Of course by doing so, the external audit gives also important feedback related to the research. The limitation is that sometimes data is not interpreted the same way by somebody who is not as immersed in the study and this can cause confusion, rather than being of help. For this thesis process, teachers and an opponent carry out the function of the external researcher.

The aforementioned external audit is of course important also when it comes to confirmability. Of course, also triangulation, which was mentioned in relation to credibility, is needed to increase lack of bias. Another important instrument is the audit trail, which is basically the description of the research process. This is reported in detail in Paragraph 4.1 and in its subordinate paragraphs. Shortly, after defining the minimum eligibility criteria and keywords and synonyms, complementary search engines were used to retrieve useful articles. The abstracts and titles of the articles were then screened in order to filter out the studies that were not related to the topic. At this point duplicates were omitted and the articles remaining were read to choose the ones to be used for the review. Data from these studies was analysed to find main themes and subcategories, in order to present the results in a precise and logic way. A final important characteristic is reflexivity: the researcher should be aware of his or her preconceptions and influences on the study. To increase reflexivity, often researches are conducted by more than one investigator, but this was not possible in this case. Instead, a reflexive diary was used. This type of journal contains entries related to methodological choices and the reasons behind them, and can be useful for researchers when it comes to uncovering personal preconceptions and biases.

8 Ethical considerations

Clinical and biomedical research are continuously gaining importance. Consequently, the theme of ethical issues in such studies is becoming more and more relevant. However, the problem of ethics in systematic literature reviews is rarely taken into account. This is probably due to the fact that this type of research does not draw directly from human subjects, but is the result of a secondary study. However, as Vergnes, Maechal-Sivoux, Nabet, Maret and Hamel (2010) point out, systematic reviews are not immune from ethical problems. For instance, the original studies might lack ethical information and considerations, and even be unethical. Most of the articles used for this thesis work reported receiving ethical approval by a committee and participant consent. Literature reviews might also be influenced by conflicts of interests, which is very important to consider, since often care guidelines are drawn based on systematic literature reviews. However, only a few studies explicitly reported no conflicts of interest or their funding source. In this case, the best course of action would have been to contact the authors of the original papers to clarify the missing information and, at the same time, receive direct permission to include their data in a review study. However, this would have required excessive time. In addition, although theoretically, patients might have given consent for a certain type of study, the literature review might have a different purpose. This would lead to the possibility that patient's data is used for a type of study he or she has not given consent to. This thesis aims at analysing the relationship between nurses and elderly home-care clients, so we can assume the purpose is the same as those of the original articles.

Other ethical considerations are related to the writing process, rather than to the sources used for the systematic review (Wager and Wiffen 2011). First of all, it should be clear who has been working on the study. In this case there was only one author, with of course the feedback and help of teachers and opponent. Secondly, duplicates should be avoided: repeated publication of the same outcomes might skew results of reviews towards them. A preliminary research on Theseus.fi showed that there are no available theses on this topic. Moreover, the one duplicate article that was found during data search was excluded from the final set of works used for this thesis. A third concern is plagiarism, which in this thesis was avoided by reformulating text of source documents and by attributing thoughts and conclusions to their authors by means of referencing. Lastly, reviews should be accurate and the data extraction process clear. For this reason, the procedure was described in Paragraph 4.1.

Vergenes et al. (2010) report that a protocol for evaluating ethical quality of clinical trials has been proposed by Weingarten, Paul, and Leibovici (2004), but such a protocol has not yet been adapted to literature review. On the other hand, even if a similar instrument existed, it would be difficult to use it, for instance because of lack of information about ethical issues in the original papers (which might not necessarily mean that the study was conducted unethi-

cally). Moreover, it is not possible to compare ethical values of different articles based on research performed at different times, in different countries, with different patients. Therefore, the question of ethics in review works, like this thesis, remains still partially open.

9 Limitations and recommendation

The University of Southern California (2016) defines limitations in a systematic review as those features that affected the interpretation of findings. These can be the result of faults in the initial design or the consequence of methods used. While the initial question has been answered, this thesis still presents some limitations.

Firstly, the thesis was the result of the work of a single author. Therefore, it was not possible to compare ideas, brainstorm, and discuss opinions the same way that two or more authors could. A single author might fail to notice bias or prejudice in his or her own way of thinking, which could result in incomplete discussion and result analysis. Moreover, article search could have been more complete and effective as the result of the effort of more people. Not only articles that have been excluded might have been considered under a different light, but more studies could have been analysed, for instance by using less keywords and retrieving more results.

Secondly, only articles in English were chosen to make it possible for the readers to go back to the original sources if needed. However, this is at the same time a limitation because other languages had to be excluded, leading to possible loss of data and skewing of results. Similarly, articles that could not be read in their entirety had to be left out. A partial solution to this problem was to try to access the articles connecting through the University of Helsinki, which has subscriptions to different journals than Laurea. Even so, many articles remained unavailable.

The novelty aspect of this thesis work is that literature has so far described home-care from either the client's or the nurse's point of view. However, the parts involved in the relationship are connected, and describing them singularly can not portray the whole situation. For the first time, aspects related to both patients and nurses are analysed together, thus giving the opportunity to notice elements that had been overlooked in the past. However, while this thesis represents a step forward in the analysis of therapeutic relationship in home-care, there are aspects that still need to be researched. For future studies, it would be interesting to analyse the relationship both in short and long-term care. The articles used as sources somehow imply that the relationship had been going on long enough for nurses to know their clients, but nothing was mentioned about the initial phases of the therapeutic relationship or about short-term home-care. Another interesting possibility would be to compare home-care and elderly home settings, as it would be interesting to know whether the peculiarity of therapeutic relationship in home-care comes from the home setting or derives from it being a long-term connection.

References

Academy Canada. 2016. Programs: Home support worker & Personal care attendant. Accessed 30th August 2016. https://www.academycanada.com/home-support-worker/

American Nurses Association. 2016. What Nurses Do. Accessed 30th August 2016. http://www.nursingworld.org/EspeciallyForYou/What-is-Nursing/Tools-You-Need/RNsAPNs.html

Brown, D., McWilliam, C., Ward-Griffin, C. 2006. Client-centred empowering partnering in nursing. J Adv Nurs. 53 (2), 160-8.

Cheng, W.L., Lai, C.K. 2010. Satisfaction Scale for Community Nursing: development and validation. J Adv Nurs. 66 (10), 2331-40

Cohen D., Crabtree, B. 2008. Qualitative Research Guideline Project. Accessed 21st August 2016. http://www.qualres.org/index.html

Corbett, S., Williams, F. 2014. Striking a professional balance: interactions between nurses and their older rural patients. Br J Community Nurs. 19 (4),162-7.

Doherty, M., Thompson, H. 2014. Enhancing person-centred care through the development of a therapeutic relationship. Br J Community Nurs. 19 (10), 502, 504-7.

Duffy, J.R. 2014. Quality Caring in Nursing and Health Systems: Implications for Clinicians, Educators, and Leaders. 2nd Edition. New York: Springer Publishing Company.

Equator Network Online Wizard. ND. Have you remembered everything? Accessed 10th July 2016. http://www.peneloperesearch.com/equator-wizard

Finnish Nurses Association. ND. I can I know I care. Accessed 30th August 2016. http://nurses-fi-bin.directo.fi/@Bin/6a60c152e64c38502d743bd31b837705/1472559697/application/pdf/201545/SHL_ESITE_ENG_auk.pdf

Griffith, R., Tengnah, C. 2013. Maintaining professional boundaries: keep your distance. Br J Community Nurs. 18 (1), 43-6.

Hautsalo, K., Rantanen, A., Astedt-Kurki, P. 2013. Family functioning, health and social support assessed by aged home care clients and their family members.
J Clin Nurs. 22 (19-20), 2953-63.

Helsingin kaupunki. 2015. Kotihoitoa Itä-Helsingissä. Accessed 30th August 2016. http://www.hel.fi/static/sote/julkaisut/esitteet/Kotihoitoa_Ita_Helsingissa_15.pdf

Helsingin kaupunki. 2016. Kotihoito. Accessed 27th April 2016. http://www.hel.fi/www/Helsinki/fi/sosiaali-ja-terveyspalvelut/ikaantyneiden-palvelut/kotihoito

Holmberg, M., Valmari, G., Lundgren, S.M. 2012. Patients' experiences of homecare nursing: balancing the duality between obtaining care and to maintain dignity and self-determination. Scand J Caring Sci. 26 (4), 705-12.

Laurea Finna. ND. Article search ABC. Accessed 30th May 2016. https://laurea.finna.fi/Content/artikkelihaun_ohje

Liveng, A. 2011. The vulnerable elderly's need for recognizing relationships – a challenge to Danish home-based care. J Soc Work Pract. 25 (3), 271-83.

Lucas, S. 2013. The missing link: district nurses as social connection for older people with type 2 diabetes mellitus. Br J Community Nurs. 18 (8), 388, 390-7.

McGarry, J. 2009. Defining roles, relationships, boundaries and participation between elderly people and nurses within the home: an ethnographic study. Health Soc Care Community. 17 (1), 83-91.

MedicineNet.com. 2016. Definition of Patient. Accessed 30th August 2016. http://www.medicinenet.com/script/main/art.asp?articlekey=39154

Michaelsen, J.J. 2012. Emotional distance to so-called difficult patients. Scand J Caring Sci. 26 (1), 90-7.

Millard, L., Hallett, C., Luker, K. 2006. Nurse-patient interaction and decision-making in care: patient involvement in community nursing. J Adv Nurs. 55 (2), 142-50.

MOT Oxford Dictionary of English. 2016. Accessed 08th August 2016. https://mot-kielikone-fi.nelli.laurea.fi/mot/laurea/netmot.exe

O'Brien, B.C., Harris, I.B., Beckman, T.J., Reed, D.A., Cook, D.A. 2014. Standards for reporting qualitative research: a synthesis of recommendations. Acad Med. 89 (9), 1245-51.

Onwegbuzie, A.J., Jiao, Q.G., Bostik, S.L. 2004. Library Anxiety: Theory, Research and Applications. Oxford: The Scarecrow Press, Inc.

Peplau, H. 1991. Interpersonal Relations in Nursing: A Conceptual Frame of Reference forPsychodynamic Nursing. New York: Springer Publishing Company.

Riley, D., Gagnier, J., Kienle, G., Moher, D., Plotnikoff, G., Shamseer, L., Barber, M. 2013. CARE CHECKLIST of information to include when writing a case report. Accessed 20th July 2016. http://www.care-statement.org/care-checklist.html

Ritchie, J., Lewis J. (eds.) 2003. Qualitative Research Practice: A Guide for Social Science Students and Researchers. London: Sage Publications.

Roberts, A., Philip, L., Currie, M., Mort, A. 2015. Striking a balance between in-person care and the use of eHealth to support the older rural population with chronic pain. Int J Qual Stud Health Well-being. 2, 10, 27536

Schoot, T. Proot, I., Legius, M., ter Meulen, R., de Witte, L. 2006. Client-Centered Home Care: Balancing Between Competing Responsibilities. Clin Nurs Res. 15 (4), 231-54.

The University of Edinburgh. 2013. Systematic reviews and meta-analyses: a step-by-step guide. Accessed 30th May 2016. http://www.ccace.ed.ac.uk/research/software-resources/systematic-reviews-and-meta-analyses

Theseus.fi. ND. Ammattikorkeakoulujen opinnäytetyöt ja julkaisut verkossa. Accessed 26th April 2016.

University of Southern California. 2016. Organizing Your Social Sciences Research Paper: Limitations of the Study. Accessed 25th August 2016. http://libguides.usc.edu/c.php?g=235034&p=1561758

Vergnes, J.N., Marchal-Sixou, C., Nabet, C., Maret, D., Hamel O. 2010. Ethics in systematic reviews. J Med Ethics. 36 (12), 771-4.

von Elm, E., Altman, D.G., Egger, M., Pocock, S.J., Gotzsche, P.C., Vandenbroucke, JP. 2007. The Strengthening the Reporting of Observational Studies in Epidemiology (STROBE) Statement: guidelines for reporting observational studies. Ann Intern Med. 147 (8), 573-577.

Wager, E., Wiffen, P.J. 2011. Ethical issues in preparing and publishing systematic reviews. J Evid Based Med. 4 (2), 130-4.

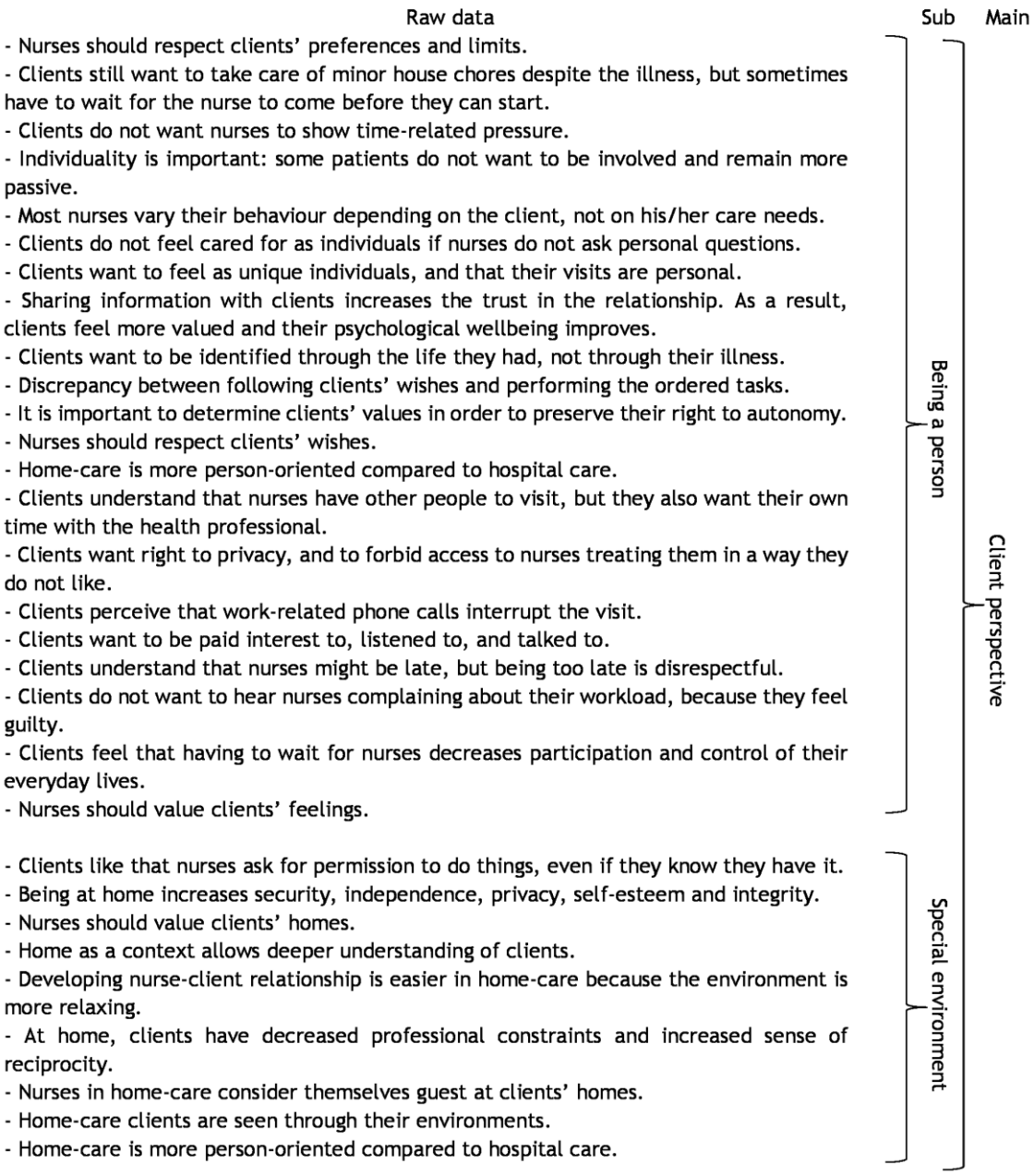
Witsø, A.E., Eide, A.H., Vik, K. 2011. Professional carers' perspectives on participation for older adults living in place. Disabil Rehabil. 33 (7), 557-68.

World Health Organization. 2016. Definition of an older or elderly person. Accessed 30th August 2016. http://www.who.int/healthinfo/survey/ageingdefnolder/en/

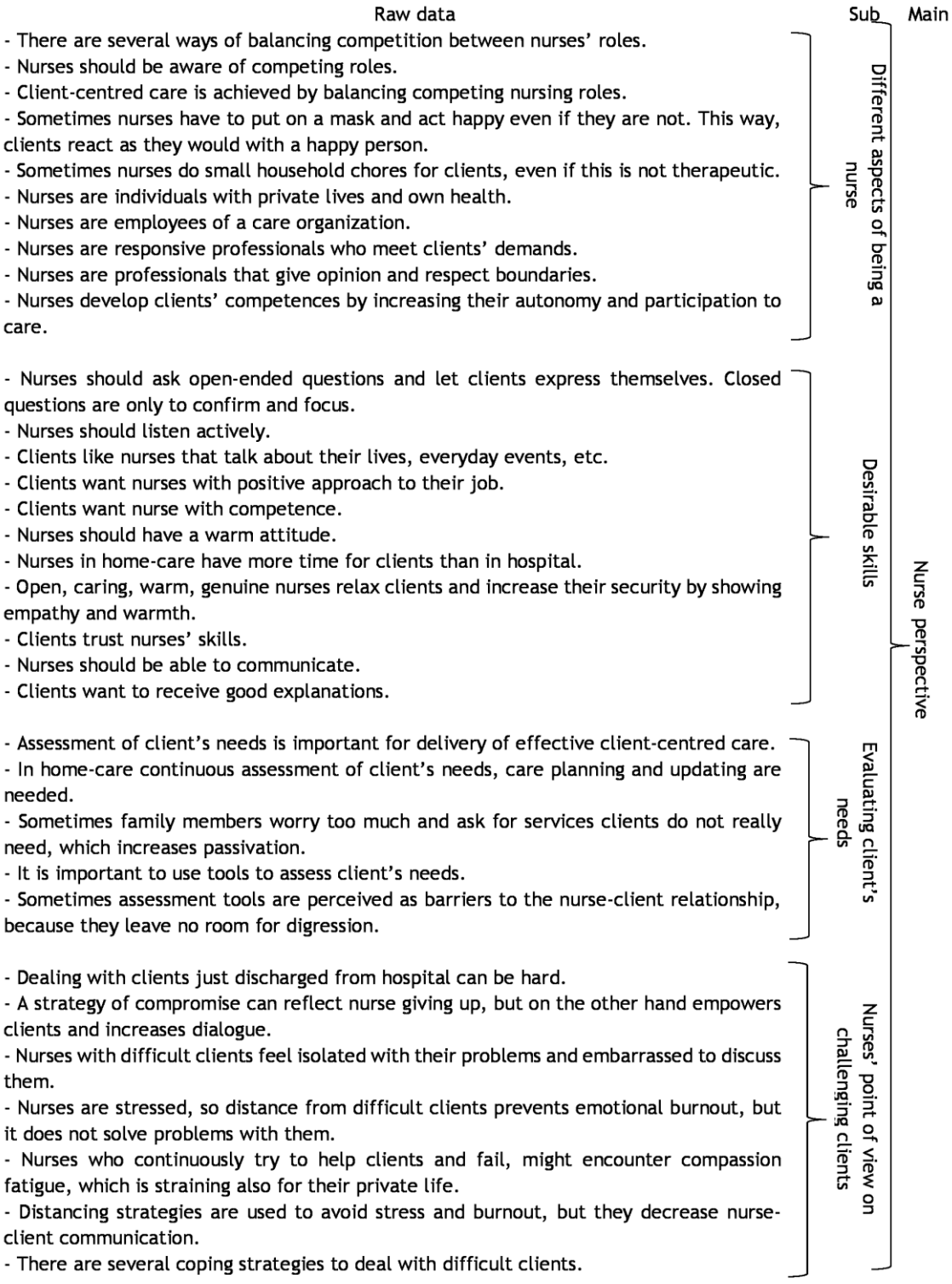
Figures

Tables

Appendix 1: Complete data analysis process.



Raw data	Sub	Main
- Clients want to be respected as human beings, despite the need for help. - Clients want to live has they always had, despite the weakness and illness. - Pain affects communication levels. - Clients want to be identified through the life they lived, not through their illness. - Illness is part of clients' lives, they are used to it. - For clients it is important to balance self-determination and dignity with the need for care.	Role of disease	Client perspective
- Clients like to share community news, public happenings, common topics, information about family activities and relatives. - Isolation of elderly clients is due to migration, illness, and decreased access to transport. - Nurses' visits connect clients to the outside world. - Nurse is a central social connection for clients. - Decreased health is the cause of decreased social connections. - Nurses' visits provide social contact and clients consider them as important as good care. - Clients still want to attend social activities and/or to follow events outside their house, for instance on television. - Sometimes nurses do not understand how important social role they play. - Client-nurse connection is fragile and clients are afraid of being discharged, even when self-sufficient, because of nurses' social role.	Social networks	
- Nurses should value clients' right to decision-making. - In home-care there is the implicit assumption that clients are part of the caring process. - Clients want to take part in nursing task, to instruct new nurses - Nurses might think that some interventions increase client's involvement, but clients perceive them as passivating. - Nurses try to involve clients in care, but often they take a passive role. - Individuality is important: some clients do not want to be involved and are more passive. - Involving clients in care and giving them positive feedback increases clients' self-esteem. - Empowerment does not mean that patients should take care of themselves without the help of nurses. - In client empowerment, nurses should not give up all of their power. - Clients want to regain or keep up function, but this is something that takes time and effort. - A strategy of compromise can reflect nurse giving up, but on the other hand empowers clients and increases dialogue. - Empowerment of client is essential for client-centred approach. - Home-care empowers client. - Clients want to participate in care-planning.	Empowerment of client	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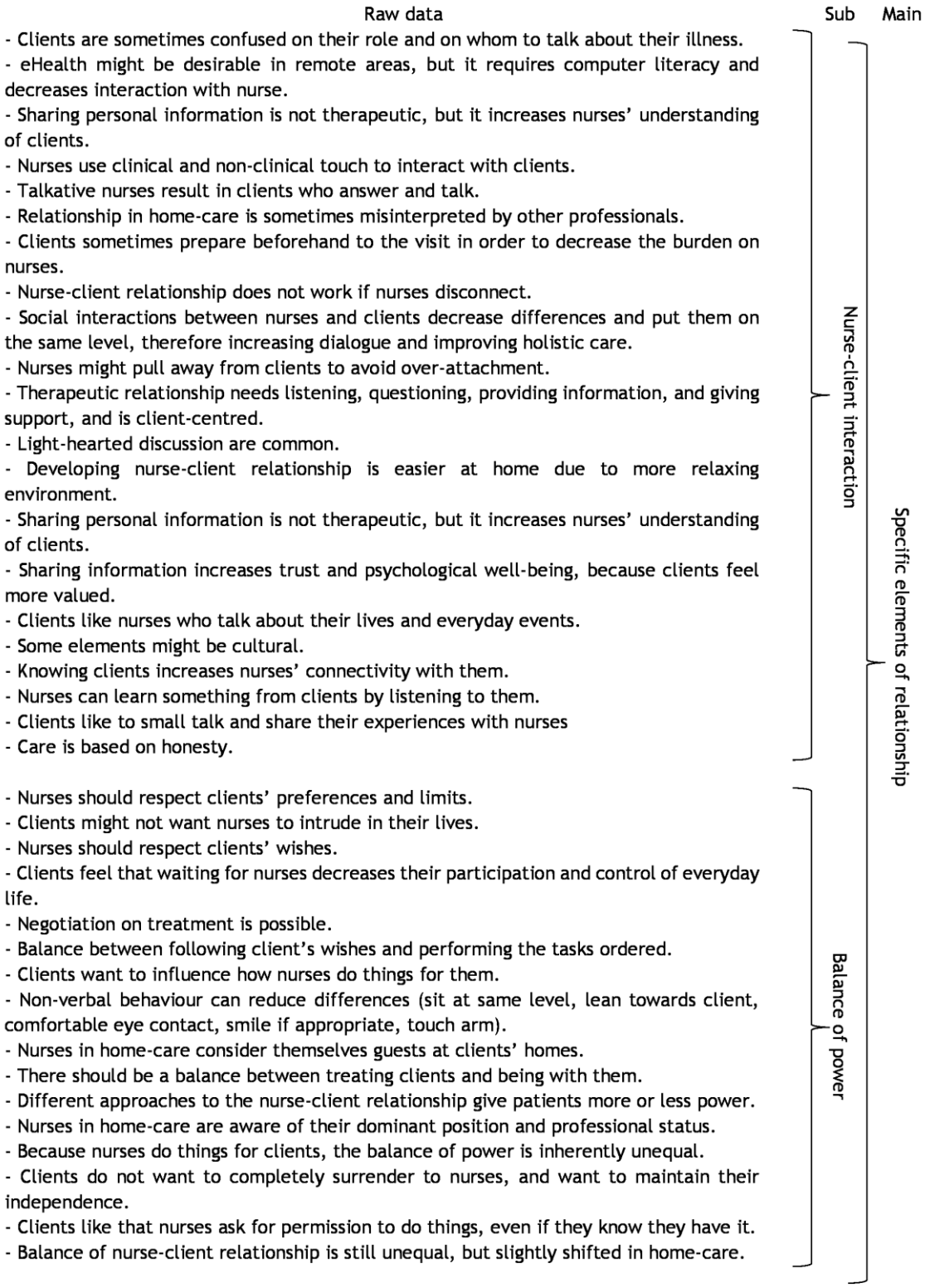
Main
- There are several ways of balancing competition between nurses' roles.
- Nurses should be aware of competing roles.
- Client-centred care is achieved by balancing competing nursing roles.
- Sometimes nurses have to put on a mask and act happy even if they are not. This way, clients react as they would with a happy person.
- Sometimes nurses do small household chores for clients, even if this is not therapeutic.
- Nurses are individuals with private lives and own health.
- Nurses are employees of a care organization.
- Nurses are responsive professionals who meet clients' demands.
- Nurses are professionals that give opinion and respect boundaries.
- Nurses develop clients' competences by increasing their autonomy and participation to care.
Different aspects of being a nurse
- Nurses should ask open-ended questions and let clients express themselves. Closed questions are only to confirm and focus.
- Nurses should listen actively.
- Clients like nurses that talk about their lives, everyday events, etc.
- Clients want nurses with positive approach to their job.
- Clients want nurse with competence.
- Nurses should have a warm attitude.
- Nurses in home-care have more time for clients than in hospital.
- Open, caring, warm, genuine nurses relax clients and increase their security by showing empathy and warmth.
- Clients trust nurses' skills.
- Nurses should be able to communicate.
- Clients want to receive good explanations.
Desirable skills
- Assessment of client's needs is important for delivery of effective client-centred care.
- In home-care continuous assessment of client's needs, care planning and updating are needed.
- Sometimes family members worry too much and ask for services clients do not really need, which increases passivation.
- It is important to use tools to assess client's needs.
- Sometimes assessment tools are perceived as barriers to the nurse-client relationship, because they leave no room for digression.
Evaluating client's needs
- Dealing with clients just discharged from hospital can be hard.
- A strategy of compromise can reflect nurse giving up, but on the other hand empowers clients and increases dialogue.
- Nurses with difficult clients feel isolated with their problems and embarrassed to discuss them.
- Nurses are stressed, so distance from difficult clients prevents emotional burnout, but it does not solve problems with them.
- Nurses who continuously try to help clients and fail, might encounter compassion fatigue, which is straining also for their private life.
- Distancing strategies are used to avoid stress and burnout, but they decrease nurse-client communication.
- There are several coping strategies to deal with difficult clients.
Nurses' point of view on challenging clients
Nurse perspective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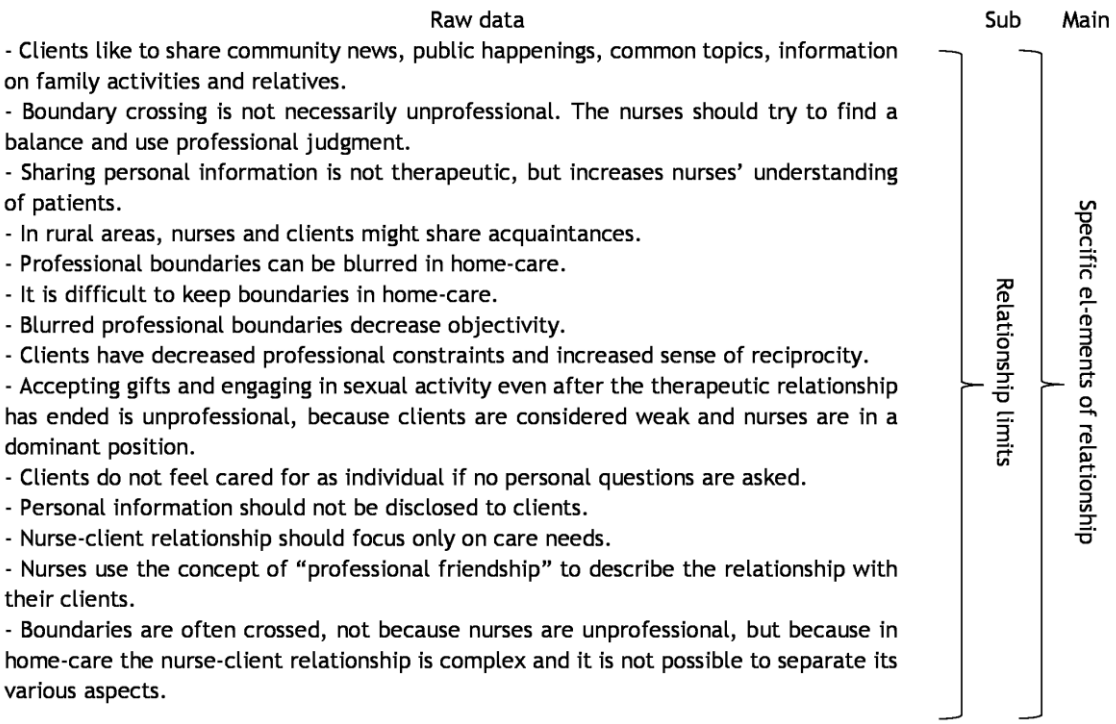
Main
- Clients are sometimes confused on their role and on whom to talk about their illness.
- eHealth might be desirable in remote areas, but it requires computer literacy and decreases interaction with nurse.
- Sharing personal information is not therapeutic, but it increases nurses' understanding of clients.
- Nurses use clinical and non-clinical touch to interact with clients.
- Talkative nurses result in clients who answer and talk.
- Relationship in home-care is sometimes misinterpreted by other professionals.
- Clients sometimes prepare beforehand to the visit in order to decrease the burden on nurses.
- Nurse-client relationship does not work if nurses disconnect.
- Social interactions between nurses and clients decrease differences and put them on the same level, therefore increasing dialogue and improving holistic care.
- Nurses might pull away from clients to avoid over-attachment.
- Therapeutic relationship needs listening, questioning, providing information, and giving support, and is client-centred.
- Light-hearted discussion are common.
- Developing nurse-client relationship is easier at home due to more relaxing environment.
- Sharing personal information is not therapeutic, but it increases nurses' understanding of clients.
- Sharing information increases trust and psychological well-being, because clients feel more valued.
- Clients like nurses who talk about their lives and everyday events.
- Some elements might be cultural.
- Knowing clients increases nurses' connectivity with them.
- Nurses can learn something from clients by listening to them.
- Clients like to small talk and share their experiences with nurses
- Care is based on honesty.
- Nurses should respect clients' preferences and limits.
- Clients might not want nurses to intrude in their lives.
- Nurses should respect clients' wishes.
- Clients feel that waiting for nurses decreases their participation and control of everyday life.
- Negotiation on treatment is possible.
- Balance between following client's wishes and performing the tasks ordered.
- Clients want to influence how nurses do things for them.
- Non-verbal behaviour can reduce differences (sit at same level, lean towards client, comfortable eye contact, smile if appropriate, touch arm).
- Nurses in home-care consider themselves guests at clients' homes.
- There should be a balance between treating clients and being with them.
- Different approaches to the nurse-client relationship give patients more or less power.
- Nurses in home-care are aware of their dominant position and professional status.
- Because nurses do things for clients, the balance of power is inherently unequal.
- Clients do not want to completely surrender to nurses, and want to maintain their independence.
- Clients like that nurses ask for permission to do things, even if they know they have it.
- Balance of nurse-client relationship is still unequal, but slightly shifted in home-care.
Nurse-client interaction
Balance of power
Specific elements of relationship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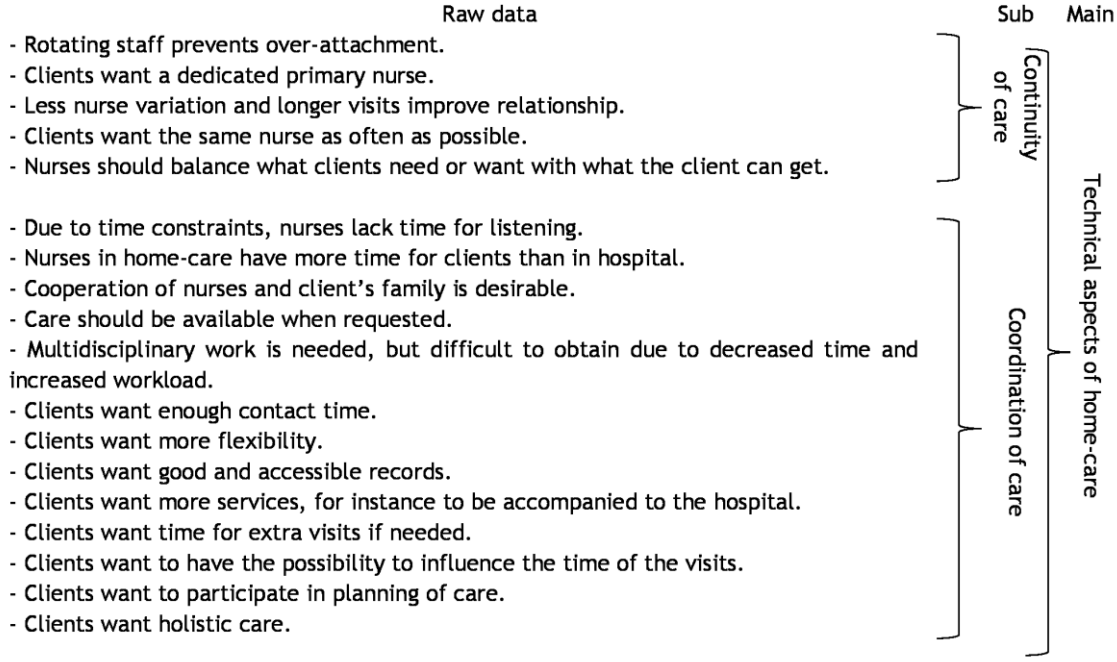
Main
- Clients like to share community news, public happenings, common topics, information on family activities and relatives.
- Boundary crossing is not necessarily unprofessional. The nurses should try to find a balance and use professional judgment.
- Sharing personal information is not therapeutic, but increases nurses' understanding of patients.
- In rural areas, nurses and clients might share acquaintances.
- Professional boundaries can be blurred in home-care.
- It is difficult to keep boundaries in home-care.
- Blurred professional boundaries decrease objectivity.
- Clients have decreased professional constraints and increased sense of reciprocity.
- Accepting gifts and engaging in sexual activity even after the therapeutic relationship has ended is unprofessional, because clients are considered weak and nurses are in a dominant position.
- Clients do not feel cared for as individual if no personal questions are asked.
- Personal information should not be disclosed to clients.
- Nurse-client relationship should focus only on care needs.
- Nurses use the concept of "professional friendship" to describe the relationship with their clients.
- Boundaries are often crossed, not because nurses are unprofessional, but because in home-care the nurse-client relationship is complex and it is not possible to separate its various aspects.
Relationship limits
Specific el-ements of relationship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Main
- Rotating staff prevents over-attachment.
- Clients want a dedicated primary nurse.
- Less nurse variation and longer visits improve relationship.
- Clients want the same nurse as often as possible.
- Nurses should balance what clients need or want with what the client can get.
- Due to time constraints, nurses lack time for listening.
- Nurses in home-care have more time for clients than in hospital.
- Cooperation of nurses and client's family is desirable.
- Care should be available when requested.
- Multidisciplinary work is needed, but difficult to obtain due to decreased time and increased workload.
- Clients want enough contact time.
- Clients want more flexibility.
- Clients want good and accessible records.
- Clients want more services, for instance to be accompanied to the hospital.
- Clients want time for extra visits if needed.
- Clients want to have the possibility to influence the time of the visits.
- Clients want to participate in planning of care.
- Clients want holistic care.
Continuity of care
Coordination of care
Technical aspects of home-care