Registered Nurses' and nurse assistants' responses to older persons' expressions of emotional needs in home care

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Title page

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Impact statement

This study contributes to knowledge regarding nurse assistants' and registered nurses' responses to older persons' expressions of negative emotions during home care visits. The results showed that nursing staff responses most often provided space for further disclosure and invited older persons to talk about emotional needs and their experiences.

The impact of emotional communication needs to be emphasized in order to support a more person-centered communication and care for older persons.

Abstract

Aim: This study aims to explore nurse assistants' and registered nurses' responses to older persons' expressions of emotional needs during home care visits.

Background: Communication is a central aspect of care. Older persons might express different emotions and needs during home care visits and such expressions can be challenging to respond to. Little is known about communication in home care or nursing staff responses to older persons' expressed emotional needs.

Design: Descriptive, cross-sectional design on nursing staff responses to older persons' negative emotions in home care.

Methods: Collected data consisted of audio recordings of home care visits between older persons and nursing staff. Data was collected between August 2014 – November 2015. The

nursing staff responses to older persons' negative emotions in the communication were analyzed with the Verona Coding Definitions of Emotional Sequences (VR-CoDES).

Results: The nursing staff most often give non-explicit responses, providing space for further disclosure of older persons' expressed negative emotions. Such responses were more frequent if the nursing staff had elicited the older persons' expressions of a negative emotion than if such expressions were elicited by the older persons themselves. Most frequent types of responses were backchannel, active invitation or information advice.

Conclusion: The nursing staff responses were mainly non-explicit responses providing space for older persons to tell more about their experiences. Such responses can be discussed in terms of person-centered communication and is important for the comfort of emotional concerns.

Summary statement

Why is this research or review needed?

- There is a gap of knowledge on how nursing staff communicate with older persons regarding emotions in home care.

- This study highlights how nursing staff respond to older persons' negative emotions in this setting.

- Knowledge is needed about how to communicate in a more person-centered way when caring for older persons in their homes.

What are the key findings?

- Nursing staff responses were mainly non-explicit and provided space for further disclosure of older persons' expressed negative emotions, hence letting older persons narrate their needs and concerns.

- Less common were responses that reduced space for further disclosure of emotional expressions.

- Responses providing spaces for disclosure were more common when the older persons' emotional expressions had been elicited by the nursing staff rather than by the older persons.

How should the findings be used to influence policy/practice/research/education?

- The challenge to respond in a good way highlights a need for education and support for nursing staff.

- The findings underpin a need for further research on interventions to improve communication and handle communication challenges.

- Knowledge on how nursing staff respond to emotional expressions can influence the practice of home care in terms of the importance of communication regarding older persons' emotional needs.

INTRODUCTION

A central aspect of care is communication (Caris-Verhallen *et al*. 1999, Uitterhoeve *et al*. 2008, Sundler *et al*. 2016). The nursing staff's communicative competence is hence critical. Such competence might, however, be challenged in encounters with older persons expressing emotional and existential issues, which can be difficult to detect and respond to (Sundler *et al*. 2016). How nursing staff respond is an important aspect of communication in caring encounters (Uitterhoeve *et al*. 2008) to make older persons feel heard and respected. Handling negative emotions in caring encounters is known to be difficult (Sheldon *et al*. 2006). In previous communication research using Verona coding definitions of emotional sequences (VR-CoDES), the focus has been on physician and nurse consultations with patients in hospital or primary healthcare (Heyn *et al*. 2012, Finset *et al*. 2013, Butalid *et al*. 2014). Previously, few studies have focused on communication of older persons' emotional needs in home care (Hafskjold *et al*. 2016, Sundler *et al*. 2016, Sundler *et al*. 2017). Still more knowledge is needed on how to respond to these needs and how to enable a more person-centered communication based on older persons' needs and concerns.

BACKGROUND

Home care for older people involves care performed by nursing staff with different levels of education and training (Bing-Jonsson *et al*. 2016). In Sweden, where this study was carried out, home care services are performed either by nurse assistants (NAs) or by registered nurses (RNs). The home care performed by NAs mainly includes social care and, for example, help with daily living, personal care and medication, while home health care performed by RNs includes elements such as tests, medical information and administration (Sundler *et al*. 2017). Social needs and health complaints posed by the older persons are common but not always systematically assessed by health professionals, who may focus on practical aspects of care (Karlsson *et al*. 2010, Sundler *et al*. 2016). This may be seen as a lack of comprehensive care

when the older person's health and well-being is not given as much attention in terms of the compensation for decreased physical and cognitive abilities (Karlsson *et al*. 2010). Receiving home care is valued and considered as important by older persons. This is partly related to being cared for but also to having someone to talk to, especially for those who live alone (Nicholson *et al*. 2013).

Home care services are often organizationally driven and experienced by older persons as being based on routines, where individual needs and resources may not be included (Turjamaa *et al*. 2014). Nursing staff can be restricted by working conditions, routines and time boundaries, where they are trying to strike a balance between the older person's needs and the decisions and procedures required by the organization (Breitholtz *et al*. 2013). Older persons' need to talk or receive emotional support becomes difficult to satisfy when the time needed for caring is restricted. The imbalance between older people's needs and the support provided may be an ethical challenge for the nursing staff, who may experience that they cannot provide quality care for the older people (Choe *et al*. 2015).

Communication in caring encounters

Communication is essential for the nurse–patient interaction, for a relationship to develop and information to be exchanged (Caris-Verhallen *et al*. 1997). Even so, it is not easy for the nursing staff to detect and respond to patients' worries or concerns in communication. Older persons' concerns may not be clearly expressed during home care visits (Hafskjold *et al*. 2016, Sundler *et al*. 2017). Research points to expressions of negative emotions such as worries or concerns as being more commonly implicit rather than explicit (Eide *et al*. 2011, Sundler *et al*. 2017). Furthermore, to acknowledge and respond to expressions of negative emotions requires both practice and time to learn how to handle such expressions (Sheldon *et al*. 2006). In successful communication, the ability to be sensitive and to listen to patients is essential (Rogers 1989/1995). When nurses show empathy and sympathy in their

communication, patients can feel that their experiences are acknowledged (McCabe 2004).

Furthermore, sensitive listening is central when preserving an older person's dignity

(Anderberg *et al*. 2007). However, sometimes patients experience that nurses have their own

assumptions about their concerns and needs, instead of using a more personal approach and

talking to them as individuals (McCabe 2004). An individualized care needs to be attentive to

a person's wishes, needs, habits and life story (Anderberg *et al*. 2007), which put demands on

the nursing staff's communicative competency and how to respond to older persons'

expressed needs.

Person-centered approach in communication

Person-centeredness includes both an individual and a holistic approach, where the person

behind the disease comes into focus (Leplege *et al*. 2007). Person-centeredness comprises an

awareness and understanding towards another person's needs and concerns (O'Hagan *et al*.

2014) and can bring comfort to emotional distress (Jones & Guerrero 2001). Communication

and relationships are of importance in person-centered care. These include aspects such as

listening to and understanding a patient's story (Ross *et al*. 2014). To understand is about

understanding with the person rather than understanding about the person (Rogers

1989/1995). Person-centered care needs to consider life-oriented aspects, where the patient's

perspective has to come to the foreground (Zoffmann *et al*. 2008). The person's view and

narrative are thus important aspects in person-centered care (Ekman *et al*. 2011).

To sum up, nursing staff encounter communicative challenges as well as emotional

expressions of older persons' worries and concerns when performing home care services. As

previously described, the understanding and encountering of such needs is part of person-

centered care. Furthermore, older persons' ability to regulate their emotions is connected to

healthy ageing (Suri & Gross 2012), but sometimes negative emotions can be hard to manage

and become an obstacle in everyday life (Pejner et al. 2012). When not being able to handle

their emotions, older persons turn to the nurses for support (Pejner *et al.* 2015). However, handling and responding to negative emotions might create communicative challenges for the nursing staff (Sundler *et al.* 2016), who can experience a lack of time or knowledge on how to talk about emotions. This might create helplessness or avoidance regarding emotional talk (Pejner *et al.* 2012). Today, little is known about how nursing staff respond to expressions of emotional needs or what responses that might be preferred. Therefore, more knowledge is needed about how nursing staff respond to older persons' expressions of emotional needs.

THE STUDY

Aim

This study aims to explore NAs' and RNs' responses to older persons' expressions of emotional needs during home care visits by seeking to answer the following questions: a) To what extent do NAs and RNs respond explicitly or non-explicitly to expressions of negative emotions? b) To what extent do NAs and RNs provide or reduce space for further disclosure of negative emotions? c) Does the elicitation of emotional expressions influence NAs' and RNs' responses? And d) What type of responses are most frequently used?

Design

This is a descriptive, cross-sectional study on nursing staff responses to emotional expressions in communication with older persons in home care. The emotional expressions, i.e. cues and concerns, have been reported in a previous paper (Sundler *et al.* 2017), as parts of the international research program COMHOME (Hafskjold *et al.* 2015).

Sample and setting

A convenience sample of audio-recorded home care visits between NAs, RNs and older persons were collected from eight home care institutions. Twelve home care institutions from a county in mid-Sweden were approached for participation. Eight of these institutions agreed to participate in the study. Inclusion criteria for the nursing staff were that they were Swedish

speaking and employed in home care. Inclusion criteria for the older persons were that they were 65 years or older, Swedish speaking and without speech impairment. Older persons with cognitive deterioration were excluded. A total of 31 nursing staff and 81 older persons participated in the study. The nursing staff consisted of 20 NAs and 11 RNs, aged 22 to 62 and the older persons were aged 65-102.

Data collection

Data from audio-recorded home care visits were gathered between August 2014 – November 2015. First, the heads of department at the care institutions were contacted and informed about the study. After their approval, oral and written information about the study were presented to the nursing staff during workplace meetings. The nursing staff were asked to participate in the study and informed that their participation was voluntary. Those willing to participate gave their written consent and were asked to recruit older persons that met the inclusion criteria for the study. They were instructed to give the older persons both oral and written information. After receiving their written consent, the older persons were included in the study. Thereafter the data collection began with the nursing staff recording their ordinary home care visits to participating older persons. No information about the number of persons who refused to participate was collected. However, information about reasons for decline to participate, for the nursing staff, were for example heavy workload and/or feeling stressed and on behalf of the older persons, some did not like the idea of participating.

During data collection, the nursing staff were told not to ask or do anything out of the ordinary and instructed to wear the recording equipment, preferably on their upper arm, while starting the recording when entering the older person's home and to stop it when leaving. Thus, older persons could be recorded either once or several times by one or more of the nursing staff. The nursing staff were asked to make between five to ten audio recordings each, with the goal to collect approximately 200 audio recordings. These numbers were decided in

the COMHOME study to make analyzes and comparisons between the countries of Sweden, Norway and the Netherlands (Hafskjold *et al*. 2015). Excluded were recordings that were incomplete, i.e. when the recording device did not work properly. This finally resulted in data from 188 audio-recorded home care visits.

Ethical considerations

Ethical approval from the regional ethics committee was obtained (Dnr 2014/018). The participants were given oral and written information about the research, their participation and rights as participants as well as how the data would be handled, stored and presented/published. All participants had to be able to give their written, informed consent to participate. The data were coded and the participants guaranteed confidentiality. Quotes used to illustrate responses are presented in this article in a way to maintain confidentiality.

Data analysis

Data were coded with the VR-CoDES, which were developed by the Verona Network as a system to code expressions of patients' emotional distress in medical consultations (Zimmermann *et al*. 2011) and health providers' responses to these expressions (Del Piccolo *et al*. 2009). The manual 'Coding of health provider talk related to cues and concerns' (Del Piccolo *et al*. 2009) was used for the coding and it was accessed at the website for the European Association for Communication in Healthcare [EACH] (www.each.eu). In addition, the Noldus software Observer XT (Grieco *et al*. 2011) was used for the coding.

The coding of responses is dependent on the coding of expressions of emotional distress, i.e. cues and concerns (Del Piccolo *et al*. 2011). Therefore, the coding started with the locating and coding of cues and concerns. Thereafter, the immediate responses to these expressions were coded. Next, these responses were coded either as explicit or non-explicit to the expressed negative emotion and whether the response reduced or provided space for further disclosure (Figure 1). Subsequently the responses were divided into categories to further

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define the response further. For definitions of different codes (Table 1). During the process of coding the elicitation of the negative emotions is coded, either as patient-elicited [PE] or health provider-elicited [HPE]. The coding system is descriptive and does not intend to define whether responses given are good or bad (Del Piccolo *et al*. 2011). The codes were then analyzed descriptively and are presented as frequency, mean, range and percentage.

Validity and reliability

The VR-CoDES have been used and found reliable in studies on communication from different caring contexts (Del Piccolo *et al*. 2011, Wright *et al*. 2012, Sundler *et al*. 2017). Initially the recordings were co-coded by two of the authors to establish an understanding of the VR-CoDES and how to code and to establish internal agreement. Cohen's kappa was used to calculate inter-rater reliability on the coding of the emotional expressions. In total, 27 recordings were co-coded. The co-coding was conducted until satisfactory kappa was reached, $\kappa = 0.64$ ($p < 0.01$). The kappa calculation included 15 of the co-coded audio recordings. Thereafter the continued coding was performed by the first author, with continued discussions and consultations with the co-coder.

RESULTS

Sample description

The sample consisted of audio recordings of home care visits performed by 20 NAs (8 male) and 11 RNs (3 male). The mean age of the NAs was 41 years (range: 22–62 years) with a mean working-life experience of 18 years (range: <1–36 years). The mean age of RNs was 49 years (range: 39–62 years) with a mean working-life experience of 23 years (range: 7–41 years). The mean duration of the NAs' visits was 17 minutes while the RNs' mean duration was 9 minutes. Additionally, 44 older persons (15 male) receiving home care participated in the visits with NAs and 37 older persons (8 male) receiving home care in the visits with RNs. The mean age of the older persons was 86 years in both groups, with the age ranged from 65

to 102 years in visits with NAs and 65-95 years in visits with RNs. The majority of the older persons lived alone (89%).

Frequency of explicit or non-explicit responses

A total of 316 nursing staff responses to older persons' emotional needs were coded. The responses were mainly non-explicit responses (92.1%). Of the NAs' total responses (n = 195), 90.8% were non-explicit and 9.2% explicit and of the RNs' total responses (n = 121), 94.2% were non-explicit and 5.8% explicit (Tables 2 & 3).

A non-explicit example of a response is from an encounter between an old woman (94 years) and an RN. The old woman is tired of living a life where she is not able to take care of herself and is dependent on the care from others:

Older person: 'I think this could come to an end.'

RN: 'Mmm, is that how you feel?' (NPAi)

In the example the response is related to, but not explicitly, to the emotion or the content of the older person's expression. Another example of an explicit response is from an encounter where an older woman (85 years) is worried about her medication and how tired she has become:

Older person: 'I am tired, tired, tired!'

RN: 'Tired, tired – do you sleep at night?'(EPCEx)

This response acknowledges the older person's expression by explicitly referring to its content, in this example by repeating the same word in the response.

Frequency of responses providing or reducing space for further disclosure

The nursing staff more often gave responses that provided space for further disclosure (75%) rather than reduced space (25%). Of the NAs' total responses (n=195), 72.8% provided space and 27.2% reduced space and of the RNs' total responses (n= 121), 78.5% provided space and 21.5% reduced space (Tables 2 & 3).

Responses providing space could, for example, be responses back-channeling, acknowledging or actively inviting the older person to continue with questions or with encouragement. An example of a response providing space is from a visit with an older man (78 years) and an NA. After a long silence the NA asks the old man why he was shaking his head:

Older person: 'You have to shake your head at life.'

NA: 'Do you have to?'(NPAi)

In the example, the nurse assistant responded with an active invitation to the older person to talk more about his emotional need and so gain more information about his experience.

The less frequently used response was to reduce space. Reducing space can consist of responses that, for example, are shutting down or switching the conversation by referring to something or someone else other than what is introduced by the older person. An example of reducing space is an NA's response to an older man (95 years) who is pondering about his life coming to an end:

Older person: '… soon it will be over with the old man'.

NA: 'No, I don´t think so.' (NRIa)

In this response there is no space provided for further disclosure, neither does it confirm the older man's emotional need to ponder about his life coming to an end.

Type of response related to elicitations of emotional expressions

Responses providing space for further disclosure were more often given by the nursing staff (69.2%) when they had elicited the older persons' emotional expressions and less often when emotional expressions were elicited by the older persons themselves (30.8%).

Responses providing space for further disclosure were given by the NAs in 81.6% of their responses to expressions elicited by them, compared with 63% of their responses when the emotional expressions were elicited by the older persons (Table 4).

Responses providing space for further disclosure were given by the RNs in 82.5% of their responses to expressions elicited by them, compared with 62.5% of their responses when the emotional expressions were elicited by the older persons (Table 5).

Most frequent types of responses to older persons' utterances of negative emotions

The most frequent type of response was non-explicit, providing space back-channeling [NPBc] (*n* = 98), which is responses that provide space for further disclosure, but through a minimum use of words such as 'Mmm', 'Ok' or 'Yes'. An example of an NPBc response is from an NA in an encounter with an older woman (91 years) who is angry at the healthcare services for trying to poison old people with pills; the NA switches the topic towards something else other than her medication:

> Older person: 'You know, I think you are the only one who does not look at the clock and says, "well now I have to leave".'
>
> NA: 'Yeah…' (NPBc)

In the example, the response encourages the older woman to continue and gives her space for further talk on the topic.

The second most frequent type of response was responses of non-explicit, providing space active invitation [NPAi] (*n* = 58) to further information or disclosure. This is an example from a visit when an older woman (92 years) is describing her experiences of feeling frail at nights:

> Older person: 'Do you know that… that I was as close to death as I could be yesterday, I mean, the night before yesterday?'
>
> RN: 'No, what happened then?' (NPAi)

In the example above the RN encouraged the older woman to tell more by asking her to further elaborate her experience. When using active invitation nursing staff encourage the older person to tell more or use questions that are related, but not explicit, to the older person's utterance, to gain more information about their negative emotion.

The third most frequent response was the non-explicit, reducing space information advice [NRIa] ($n = 48$). This response aims to inform, reassure or give advice that is non-explicit to the cue or concern. An example of an information advice is from an encounter between an RN and an older woman (89 years) who is talking about feeling frail and being in pain:

Older person: 'I am so sad, I am so sad, I have… I can't do anything…'

RN: 'Of course you can, you were at that lecture yesterday!' (NRIa)

The response is providing the older person with information, telling her that she can do something, but is not aiming to explore why the older person is feeling sad or what she means by what she has said.

The first two of the most frequent responses provide space for further disclosure of older persons' worries and concerns, while responses reducing space were the third most frequently used type of responses. For the frequency of all types of responses (Table 6).

DISCUSSION

This study provides insight into NAs' and RNs' responses to older persons' expressions of negative emotions in home care. Even though most of the nursing staff responses were non-explicit, they were commonly related to the older person's expressed emotional need, similar to findings reported on responses to fibromyalgia patients' expressions of negative emotions during hospital care (Eide *et al.* 2011). The findings further indicate that even if older persons' worries and concerns most often are vague the nursing staff responded to these in the communication. Nursing staff often become someone for the older person to talk to (Nicholson *et al.* 2013, Choe *et al.* 2015) and provide them with emotional comfort (Choe *et al.* 2015). This emphasizes the importance of nursing staff responses to emotional concerns during home care visits. Knowledge is needed on how to perform care and communication in a person-centered way and the present study seems to be one of the first studies to explore nursing staff responses to older persons' worries and concerns during home care visits, as coded by the VR-CoDES.

To respond to an older person's negative emotion is a challenge. Earlier studies have described how nursing staff encounter older person's needs and wishes in an organizational-driven (Breitholtz *et al*. 2013, Choe *et al*. 2015) and task-oriented home care (Sundler *et al*. 2017), which may have an impact on communication. To facilitate a holistic care, time for older persons' emotional concerns has to be acknowledged and considered as essential when practicing home care. Earlier studies have found that older persons in home care express worries, concerns or other emotional needs often implicitly (Sundler *et al*. 2016, Sundler *et al*. 2017). This can make them difficult to detect or respond to and hence there is an increased risk of misinterpretations or incorrect conclusions of the older persons' needs. In the current study, despite the common presence of implicit emotions, the nursing staff were able to detect and respond to the older persons' emotional needs. Although, further research is needed to gain knowledge about the accuracy of the response or the older persons' satisfaction with the response.

In the current study, the nursing staff provided rather than reduced space for the older

persons' concerns. This is consistent with how nurse responses have provided space in

previous studies using VR-CoDES in different health care contexts (Heyn *et al*. 2012, Finset

et al. 2013). In our previous study (Sundler *et al*. 2017), expressions of negative emotions

occurred in approximately half of the visits. These types of expressions are not uncommon in

home care and are of relevance to the older persons' well-being. Nursing staff who give space

for further disclosure provide the older person a chance to talk, to ponder and to feel that their

concerns are acknowledged and important. To give the older person space to talk more also

provides the nursing staff with information about the person's own experience and their

perspective is highlighted. To focus on the person's view, to listen to and try to understand

their perspective is further related to a person-centered approach (Zoffmann *et al*. 2008,

Ekman *et al*. 2011, Ross *et al*. 2014). Time and space for listening and responding to

emotional needs therefore must be taken into account when planning for and practicing home care.

The nursing staff especially provided space if the negative emotion was elicited by the nursing staff themselves rather than by the older person. An explanation for this finding may be that the nursing staff are actively asking the older persons questions about their health, about family and social events as a way to communicate, exchange information and to be social. Whereas the older persons give utterances of emotional needs in return. Even so, it is important to follow up negative emotions elicited by older persons to acknowledge and respond to emotional needs seen as essential by the older persons themselves. Therefore, attention to older persons' own elicited concerns is needed. This may however be a challenge for providers as well as in communication education.

Based on the present findings it is not possible to draw conclusions about what type of responses are preferable. In person-centered care, it has been pointed out as important to listen to the person and his or her experience, needs and wishes (Ekman *et al*. 2011, Ross *et al*. 2014). Responses providing space by, for example, back-channel or active invitation to the older person to tell more can thus be part of person-centered care and may support communication that focuses on the needs of the person being cared for. In addition, listening to an older person's experience can preserve the person's dignity (Anderberg *et al*. 2007). This can be related to empathic communication, where nursing staff need to confirm the older person's feelings (Eide *et al*. 2011) and this involves being attentive and responding to emotional expressions.

Limitations

Audio recordings can be an effective way to collect data but are limited to paraverbal and verbal communication (Boon & Stewart 1998). This does not provide information about body language or other visual indicators. However, audio-recordings have shown to be equal to

video-recordings to analyze affective qualities in nursing staff communication (Williams *et al.* 2013). The findings are further dependent on the accuracy of the analysis and coding processes. The coding process has been validated with co-coding and discussions to achieve inter-rater reliability and to strengthen the accuracy in coding the communication. Furthermore, the audio recordings were gathered in a specific Swedish context, which may restrict its transferability to other contexts or countries. On the other hand, this study is based on a large sample of audio recordings containing a variety of examples of nursing staff communication with older persons. However, difficulties and challenges related to nursing staff's responses to negative emotions and needs are not limited to a specific Swedish context.

CONCLUSION

The nursing staff often provided space for the older persons to talk about their concerns, especially when the older persons' emotional expressions were elicited by the nursing staff. Even though the nurse responses were mainly expressed non-explicitly, they were still related to the worries and concerns previously expressed by the older persons. These kind of responses, where nurses are attentive to the expressed emotions and respond in a way that allow the older persons to narrate their experiences are important for care tailored to older persons' emotional needs and for providing comfort. These kinds of nursing staff responses would in future research need to be further explored in the light of theories about patient and person-centered communication.

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