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**AN EXPLORATORY STUDY OF SENIORS' EXPERIENCES OF  
PARTNERING/NON-PARTNERING WITH IN-HOME CARE  
PROVIDERS IN THE PROMOTION OF THEIR HEALTH**

Meghan Elan Fluit

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AN EXPLORATORY STUDY OF SENIORS' EXPERIENCES OF  
PARTNERING/NON-PARTNERING WITH IN-HOME CARE PROVIDERS IN THE  
PROMOTION OF THEIR HEALTH

(Spine Title: Seniors' experiences of partnering with in-home care providers)

(Thesis Format: Monograph)

by

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in  
Health and Rehabilitation Science

2  
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## Abstract and Keywords

While research suggests that partnering with care providers enhances seniors' independence and health, little is known about how seniors actually experience partnering/non-partnering with in-home care providers. Phenomenology was used to explore eight seniors' experiences of partnering/non-partnering with in-home care providers in the promotion of their health. Interpretive analysis of audiotapes of in-depth interviews revealed three themes which together captured seniors' holistic experience of partnering/non-partnering: (1) the psycho-social-cultural contextual attributes of partnering/non-partnering; (2) the process of enacting partnering/non-partnering; and (3) the subjective experience of partnering/non-partnering. Findings revealed partnering to constitute relational health promotion, and non-partnering, the traditional expert approach of care. Insights into social and practice norms and attitudes as impediments to partnering, and desire for involvement, interdependence and relationship-building as facilitators of partnering, may enhance health promotion practice. These insights suggest the merit of evolving health promotion agendas beyond behavioural approaches to embrace partnering, thus relational health promotion, to optimize health as a resource for everyday living.

**Keywords:** partnering, provider-client relationship, relational health promotion, health promotion, expert approach to care.

### Co-Authorship

Meghan Fluit completed the following work under the supervision of Dr. Carol McWilliam, Dr. Catherine Ward-Griffin, and Dr. Anita Kothari. Each member contributed to the work contained herein through their advisement on the conduct of the investigation, peer-review of the interpretive analysis of the findings, and the content, cogency and clarity of my writing.

Epigraph

You can only find nothing if you stare at a  
vacuum

You can only find nothing if you  
immerse yourself in nothing

You can only find nothing if you go  
nowhere

Go to real places

Talk to real people

Observe real things

You will find something

Indeed, you will find much, for  
much is there

You will find the world

-Halcolm

## Dedication

This thesis is dedicated to all those who have journeyed with me these past two years. To my family, friends and community – your words of encouragement and advice have been, and will continue to be invaluable.

To my parents, Harry and Nancy Okkema, for inspiring me to ask continually ask questions, seek answers (even ‘long’ answers), and teaching me that in every aspect of life, the journey is far more important than the destination. You have profoundly shaped who I am today, and for this I am eternally thankful.

Ultimately, this thesis is dedicated to my husband, Mike Fluit. You have stood by me these past two years through my many doubts, tears, moments of exhilaration, exasperation, and all the moments in between. I can’t begin to thank you enough for your unwavering support, your unlimited willingness to listen to my many ramblings, and for sharing your wisdom and knowledge with me. Thank you for believing in me, for championing me throughout this journey, and above all, for loving me so completely throughout the whole process. Without you, this thesis would not have become a reality.

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A special acknowledgement is extended to the eight individuals who willingly let me into their homes and provided me with the rich experiences, stories and insights that provided me with a deeper understanding of the phenomenon of partnering/non-partnering. I would also like to thank Anita Cole and the case managers at the SW-CCAC for their incredible willingness and speed in gathering the participants for this study in the middle of the summer.

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## CHAPTER ONE: INTRODUCTION

In 2006, over 13% of Canadians were aged 65 and older, and the proportion of these individuals is expected to increase from 13% to 22% by 2026 (Statistics Canada, 2006). This increase makes seniors the fastest growing segment of the population in Canada as they will account for over half of the growth of the overall population in the next two decades (Government of Canada, 2002).

Over 80% of individuals over 65 suffer from chronic conditions (National Advisory Council on Aging, 2006), for which many require in-home services. More than 33% of individuals aged 65 and over suffer from three or more chronic conditions (Statistics Canada, 2007). Approximately 95% of older people with chronic conditions may require in-home care (Jacobzone, 2000). Moreover, these individuals often have overextended or fragile resources for everyday living, including more limited emotional resources (Johri, Beland, & Bergman, 2003), reflected, for example, in a high prevalence of depression (Illife et al., 2003).

If health is understood as a resource for everyday living, and health promotion is understood as “the process of enabling people to increase control over, and improve, their health” (World Health Organization, 1986, p.1), one can appreciate that health beyond the absence of disease is a concern for these individuals and that health promotion is a relevant inclusion in the provision of their in-home care (McWilliam, Stewart, Belle Brown, Desai, & Coderre, 1996). In general, health promotion efforts for this group have become a high priority (Minkler & Estes, 1991).

## Background and Significance

Health and health promotion have been defined in many ways. The concept of health as a disease-free state permeated both medicine and nursing for the first half of the 20<sup>th</sup> century (Jones & Meleis, 1993). Health, governed by an ethic of cure, focused heavily on the treatment and cure of physical disease (Hartrick, 2002). This view of health implied that those with chronic illnesses could not be categorized as 'healthy'. This definition of health was expanded upon by the World Health Organization (1946) who re-defined health as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity" (p.1). This definition overcame the notion that individuals might only achieve health by being disease-free, yet still framed health as an ideal state rather than a realistic goal (Pender, 1987).

The Ottawa Charter, released in 1986, addresses this shortcoming, defining health as "a resource for everyday life, not the objective of living" (p.1), and health promotion as the "process of enabling people to increase control over, and improve, their health" (World Health Organization, 1986, p.1). The Epp Report (1986) also echoes the Ottawa Charter, outlining the effect of multiple factors that lie outside of the health care sector on health outcomes. From this more recent perspective, health is a resource for living and encompasses choice, the ability to realize aspirations, and to exercise control in one's life (Hartrick, 2002; World Health Organization, 1986). Resources are commonly categorized into either personal or social resources (Jones & Meleis, 1993). Personal resources include self-esteem (Antonovsky, 1979), adaptability (Jones, 1991) and hardiness (Kobasa, 1979). Social resources include social support, social networks and economic resources (Pearlin, 1989). These resources may enable individuals to manage internal or

external stressors and to develop skills to effect change, or take control over their own health, or life (Jones & Meleis, 1993). Hence, individuals may pursue health and indeed, be healthy, despite chronic illness.

Despite this knowledge that health and health promotion go beyond disease-treatment models and lifestyle behaviour change efforts, health promotion efforts targeting chronically ill seniors continue to be focused on precisely these aspects (Easom, 2003; MacDonald, 2002; Pender, Murdaugh, & Parsons, 2002; Rabiner, 2005, Lowenberg, 1995). The majority of literature on health promotion is dominated by a focus on lifestyle change through compliance with screening tests and behavioural modifications (MacDonald, 2002), largely aimed at promoting health as the absence of disease or as a state of complete physical, mental and social well-being. These perspectives severely limit health promotion interventions for chronically ill seniors, who can no longer achieve a disease free state.

Viewing health as a resource for everyday living, and health promotion as a process of enabling people to increase control over, and improve, their own health (World Health Organization, 1986), goes beyond the absence of disease (Hartrick, 2002). Therefore health promotion efforts become especially relevant when considering chronically ill seniors. This perspective invites consideration of a different approach to health promotion for this group of people.

#### Relational Health Promotion

A specific approach to health promotion that holds much promise for chronically ill seniors is relational health promotion. Labonte (1989) states that health professionals need to relate to, and abide by a philosophy of health promotion rather than a specific

process or method. A philosophy of health promotion serves as the foundation that shapes and influences health professionals' decision-making and actions. While a concept analysis is not provided, Hartrick and colleagues (2002) emphasize that the core of health promotion is a "way-of-being" with others that is inherently relational. This relational way of being transforms the practitioner-client relationship. No longer is the provider viewed as the expert and the client viewed to be compliant, but together they form an egalitarian, participatory form of alliance (Hartrick, 2002) that enables individuals to acquire increased control over and therefore, to improve their health as a resource for everyday living. This element of relational health promotion has been described (McWilliam et al., 1997, McWilliam et al., 2003) as an empowering partnering process. Relational health promotion views the relationship between provider and client in and of itself as health-promoting (Hartrick, 2002). Therefore, no longer is a relationship a means to some end, it is the medium through which health promotion occurs.

Empowerment has been conceptualized as a relational process, a way of being with others – contributing an equitable balance of knowledge, status and authority in the care relationship (Clarke, 1989). Empowerment can result in greater energy, well-being, and effectiveness in the realization of health potential (C. Brown & Schultz, 1991), as well as promote links between individuals and resources. Therefore, health can be experienced by individuals with chronic or acute illnesses or individuals who are terminally ill (Jones & Meleis, 1993).

Nevertheless, research has revealed that the empowerment of seniors with chronic medical conditions is often particularly challenged in their relationships with health professionals, who undermine seniors' confidence, interest and enthusiasm for

involvement in their own health promotion (McWilliam, Brown, Carmichael, & Lehman, 1994). Health care professionals tend to adopt a paternalistic approach toward clients, focusing their attention primarily on the clients' chronic illness and seldom asking clients about their views or inviting them to be partners in their care (Jarrett & Payne, 2002; McWilliam et al., 1994; Stewart et al., 2002). This paternalistic, or expert-driven (Brickman et al., 1982), approach has been shown to create passivity and dependence in clients, while the health professional maintains control (McWilliam et al., 1994; McWilliam et al., 2001) thereby undermining seniors' own resource for everyday living through these relationships. Such relationships effectively undermine seniors' health through undermining their own health promotion.

Partnership approaches between seniors and health care providers have been found to effectively empower seniors (D. Brown, McWilliam, & Ward-Griffin, 2005; McWilliam et al., 1999). Such partnership approaches have been conceptualized as ones in which the health care provider moves from being an expert care provider to being a partner with the client in order to improve the client's capabilities (Gallant, Beaulieu, & Carnevale, 2002) or create an equitable or fair balance of the client's contribution of knowledge, status and authority with that of the provider in a care partnership (McWilliam et al., 1997). This partnership approach has been found to increase senior's feelings of independence and involvement in managing their own life and care (D. Brown et al., 2005). When individual rights for autonomy and control of one's own life and health are recognized, strengths can be developed in any stage of illness (Jones & Meleis, 1993). Therefore, the partnering relationship (Benson & Latter, 1998) developed between clients and their health care provider has been identified as a significant health promoting

process for seniors with chronic conditions (McWilliam et al., 1996; McWilliam et al., 1997; McWilliam et al., 1999).

#### Statement of the Thesis Problem

Currently, the majority of research in the area of health promotion for senior populations is dedicated to the experiences and efforts of health professionals in their attempts to implement health promotion efforts with seniors. Many of the research studies involving senior clients have focused primarily on primary health education and disease prevention (Huang, Wu, Jeng, & Lin, 2004; Kerkstra, Castelein, & Philipsen, 1991; Nuñez, Armbruster, Phillips, & Gale, 2003). Seniors' partnering/non-partnering experience with their health care providers has not been investigated. Previous investigations, while important, have neglected the clients' experiences of the process of partnering/non-partnering. Thus, if and how seniors view their involvement in partnering is not known and little theory and evidence exists to inform the relational process of health promotion. Further research is needed to understand how clients experience this process. Greater understanding of seniors' experiences of partnering/non-partnering with in-home health care providers is needed to inform the provider-client partnering relationship, and ultimately, their process of relational health promotion.

#### Statement of Thesis Purpose

The purpose of this study is to describe, in-depth, the lived experience of seniors' partnering/non-partnering with in-home health care providers in the promotion of their health, and further, to uncover the meaning this experience has for seniors in the home care setting. As partnering focuses on the relationship between client and health care provider, it is important to illuminate and provide insight into clients' experience of



partnering/non-partnering. This may be of particular importance for senior clients with chronic conditions, as these individuals over more prolonged time in such relationships are apt to be most advantaged or disadvantaged by their experience in this regard. This understanding will achieve two main objectives: (1) to equip both health professionals and clients with a more thorough understanding of the theory of relational health promotion for people with chronic conditions and (2) to afford insights into how to go about health-promoting partnering approaches with older clients. Therefore, the overall aim is to advance understanding of the theory and practice of relational health promotion. The research question for this study was: What are senior clients' experiences of partnering/non-partnering with in-home care providers in the promotion of their health?

## CHAPTER TWO: LITERATURE REVIEW

This chapter presents a critical review of published research studies of (1) in-home health education and disease prevention strategies for chronically ill seniors; (2) relational approaches to health promotion; and (3) seniors' relational involvement in their in-home care. The aim of this review is to describe the current focus of health promotion geared towards chronically ill seniors, and identify the gaps in the current literature surrounding relational approaches to in-home care that examine chronically ill seniors' involvement and experience of involvement in their care.

A search of the literature was conducted using the key terms: "in-home", "health promotion", "provider-client relationships", "nurse-client relationships", "provider patient relationships", and "nurse-patient relationships" within CINAHL, Medline-Ovid, PubMed, and ProQuest Nursing Journals databases. From the list obtained, duplicate references and non-empirical articles were eliminated. Research investigations included in this section were those studies examining one-on-one in-home health promotion strategies involving chronically ill seniors and health care professionals, studies examining the formation and health-promoting aspects of provider-client relationships, as well as studies addressing seniors' relational involvement and perceptions of partnering in their care, all of which were identified as relevant. A secondary review of the citations contained within the studies uncovered investigations that were not discovered in the initial search. This further review identified a total of 21 relevant studies that examined relational health promotion between providers and clients, and between providers and chronically ill senior clients.

### Studies on In-Home Health Education and Disease Prevention Strategies

The majority of the research on in-home health promotion strategies for seniors focused on health education and disease prevention. Studies specifically addressed the experiences and efforts of health professionals (Huang, Wu, Jeng, & Lin, 2004; Kelley & Abraham, 2004; Kerkstra, Castelein, & Philipsen, 1991; Markle-Reid et al., 2006; Stuck et al., 2000), rather than the seniors' partnering/non-partnering efforts. However, these studies inform the practice of health promotion with chronically ill seniors.

A meta-analysis of fifteen studies of home visiting examined the effectiveness of home visits that offer health promotion and preventative care to older people (Elkan et al., 2001). The interventions of the selected studies involved the pursuit of a wide range of preventive outcomes. Thus, these interventions focused on providing social support, health education, problem identification, goal setting, service coordination, companionship, and referrals. The results of the quantitative meta-analysis suggested that health promotion through in-home visiting has the potential to significantly decrease mortality, admission to institutional care, and hospital visits. However, the focus of this meta-analysis was on the achievement of outcomes, not on how the home visits contributed to the positive outcomes experienced by study participants.

Li (2004) conducted an evaluation study using a pre-and post-test design to examine the effects of health promotion through home visiting on 89 lower income seniors. The intervention consisted of daily to bi-weekly personal visits by trained home workers, and phone-counselling provided by graduate nursing students to participants over an 8-month period. The first phase consisted of personal visits and included information about how to live a healthy life, illness prevention, nutrition, exercise and

medication. During the second phase, individualized regimens were created for each participant, based on their needs, and included a mix of six services: medical, nursing, home-making, caring, and financial assistance. Pre and post assessments included a demographic profile, health status (both physical and psychosocial), functional health status, and perceived health promotion needs in each of the six aforementioned areas. Study results indicated that the health promotion services achieved significant gains in nutritional health status ( $p < 0.05$ ) and performance of instrumental activities of daily living ( $p < 0.01$ ). An overall decrease in perceived needs for health promotion services was also reported.

In a three-year stratified randomized trial conducted in Switzerland, Stuck and colleagues (2000) explored the effect of in-home preventive visits with multi-dimensional geriatric assessments on the health of 791 seniors aged 75 and over, specifically examining the effect on instrumental activities of daily living (IADL). The intervention consisted of annual multidimensional assessments and quarterly follow-up in-home visits by three public health nurses, who, in collaboration with geriatricians, evaluated problems, gave recommendations, facilitated seniors' adherence to the recommendations, and provided health education. After three years, participants in the intervention group who were identified as low risk at baseline were less dependent in instrumental activities of daily living (IADL) compared to controls ( $p=0.04$ ). Participants who were at high baseline risk in the intervention group experienced no favourable intervention effects on ADL and an unfavourable increase in nursing home admissions ( $p=0.02$ ). The study results suggested that the intervention employed can improve seniors' ability to conduct IADL among elderly people at low risk, but not among those at high risk for functional

impairment. While this study found positive results of the intervention, health care professionals did not include nor partner with seniors in the process of promoting their health. Instead, these providers utilized a disease prevention approach as opposed to a process-oriented or relational health promotion approach.

Markle-Reid and colleagues (2006) tested a health promotion intervention to engage home care clients in their care. In a two-armed, single-blind, randomized control trial, frail older adults aged 75 or older who were eligible for service through a home care program in Ontario, Canada were randomly allocated to usual home care services (control) or a proactive nursing health promotion intervention (experimental group). The goals of the health promotion intervention focused on both disease prevention and health enhancement. Strategies to achieve these goals included: conducting an initial and ongoing health assessment, identifying and managing risk factors for functional decline, providing health education regarding healthy lifestyles, and managing chronic illnesses using a participatory approach. The results indicated that the intervention improved mental health functioning ( $p=0.009$ ), reduced depression ( $p=0.009$ ), and enhanced perceptions of social support ( $p=0.009$ ). While this study elicited positive results, once again the intervention represented a disease prevention focus, rather than relational health promotion.

Overall, while the preceding in-home health promotion studies targeting seniors revealed promising results, the studies were limited to a focus on disease prevention and healthy lifestyles education rather than a process-oriented health promotion approach to enable individuals to increase control over their own health (World Health Organization, 1986). Typically, the approaches described were rooted in the expert model of helping

(Brickman, et al., 1982) rather than engaging the client in a relational health promotion process. Therefore, the previous research, while important, focused on health outcomes, as opposed to on health as a resource for everyday living mobilized through the process of health promotion. Whether and how seniors receiving care in the home partner with health care providers in the promotion of their health has not been addressed in this research. If the theory and practice of relational health promotion is to be advanced, further investigation is required to explore these important questions.

#### Studies on Relational Approaches to Health Promotion

The search uncovered five studies that focused on relational approaches to care, although only one was directly aimed at health promotion. Roberts and colleagues (1995) conducted an experimental study on students (n=98) who sought treatment for upper respiratory symptoms at a university health centre to determine differences in their perceptions of two types of decision-making interactions between nurses and these students. Participants were assigned to either an actively negotiated (n=53) or a non-negotiated (n=45) approach to decision-making with a nurse. The active negotiation model consisted of three phases in which nurses' behaviours were directed at facilitating information-sharing and decision-making with the participants. In this approach, the nurses elicited participants' requests, attributes and expectations, described the interactional process, focused on consensus-building, and engaged in information-sharing, questioning and discussing, and negotiated decisions. Successful negotiations ended with a treatment plan mutually satisfactory to the nurse and the participant. The non-negotiated approach involved an interaction initiated and structured by the nurse only. In this approach, the nurse directed and limited patient answers through direct

questioning and assessment. The participants were not actively included in deciding and planning the treatment. Results indicated that participants in the negotiated approach had significantly greater perceived control and power in the relationship than those in the non-negotiated approach ( $p < 0.001$ ). These study findings suggested that when individuals are treated as active partners in their health care, their feelings of control and power increase. As this is in keeping with the definition of health promotion as “the process of enabling individuals to increase control over, and improve, their health” (World Health Organization 1986, p.1), this study suggests that partnering in decision-making may be an important component of the experience of relational health promotion.

In a qualitative study, Kirkpatrick and colleagues (2007) focused on the partnerships and relationships between in-home health care providers and clients, exploring vulnerable women’s perceptions of the value of 20 intensive home visits throughout pregnancy and the first year of their newborn child’s life. Health visitors, who received eight weeks of training, involved the women ( $n=20$ ) in partnerships aiming specifically to build a relationship based on trust, empathy and respect. The researchers conducted 20 in-depth interviews with women who had completed the home visiting program to explore which aspects of the program and provider qualities parents found to be the most helpful and whether the participants perceived the intervention had any impact. Thematic findings revealed that the women valued the health visitors’ ability to encourage them to have confidence in their own ideas and feelings, and described enhanced feelings of control over their situation. Some women mentioned that their confidence increased as a result of the visits; they became enabled to make difficult decisions about parenting and felt stronger and more in control of their life and

relationships. While the approach was not particularly focused on health promotion, this study described process outcomes reflecting health promotion, highlighting the value of establishing a trusting relationship between health care provider and client, quite possibly another component of relational health promotion.

McGilton, O'Brien-Pallas, Darlington, Evans, Wynn and Pringle (2003) examined the effects of a relationship-enhancing program of care (REPC) on resident and care provider outcomes. The researchers employed a quasi-experimental, repeated measures design, with intervention and comparison groups gathered from two long-term care units in the nursing home section of a large university-affiliated geriatric center in Canada. Resident outcomes consisted of measures of their perceptions of the care providers' empathic and reliable care and the closeness of the provider-resident relationship. The results indicated that the REPC had statistically significant effects on residents' perceptions of care providers' relational care ( $p=0.14$ ), care providers' relational behaviours ( $p=0.046$ ) and continuity of care ( $p<0.001$ ). This study is important in that it demonstrates that focus on relationships between health care providers and clients can improve perceptions of continuity of care and relationships. However, further research is still needed to investigate seniors' experiences of these relationships and any link between these relationships and their health.

A study conducted by Ward-Griffin and Bramwell (1990) utilized a descriptive correlational design to explore the relationship and congruence between nurses' and elderly clients' ( $n=40$ ) perceptions of the clients' self care-agency. Self-care agency was defined as actions and decisions that contribute to and maintain an individual's optimal capacity for functioning and well-being. The researchers identified this congruence as



vital to mutual goal-setting as a means of achieving self-care in the elderly. Forty elderly clients and forty registered nurses were selected from two community health agencies. Participants completed a questionnaire consisting of: (1) a demographic sheet; (2) the appraisal of Self-Care Agency Scale, and (3) the Perceived Health Status. Participants also were interviewed during individual home visits. Clients and nurses perceived the clients' health status differently, indicating a need for clients and nurses to validate their perceptions. The researchers surmised based on this study that if the client and nurse were to hold the same perception, working toward a common goal would become a greater possibility, as the client and provider would not be working at cross-purposes. The researchers proposed that nurses' validation of clients' perceptions reinforces that the client is an active participant in his/her health care, and facilitates the client's participation in decision-making. Thus, these findings also support the notion of relational health promotion. However, further research is needed to uncover clients' experiences of partnering in health promotion.

In an interpretive qualitative study, McWilliam and colleagues (1997) explored the lived experiences of 13 older adults who participated in a health promotion intervention that utilized the adult education theory of perspective transformation. The intervention required seniors to participate in reflective dialogue guided by a professional with the aims of: (1) enabling older adults to participate as partners in their care; (2) fostering a self-help philosophy; (3) enhancing active decision-making; and (4) improving morale, self esteem, self-care agency, interpersonal dependency, locus of authority and desire for information. Five health-promoting strategies emerged from the

data: building trust and meaning, connecting, caring, mutual knowing, and mutual creating. This study illuminated the nature of relational health promotion.

In another component of this investigation (McWilliam et al., 1999), a large randomized controlled trial tested the efficacy of this relational health promotion approach designed as a 10 hour long nurse-facilitated critical reflection intervention. The strategy engaged 149 frail chronically ill seniors randomized to the intervention of partnering with their in-home care providers, and compared them to 149 frail chronically ill seniors receiving the usual approach to in-home care. The researchers reported significantly greater independence ( $p=0.008$ ), perceived ability to manage their own health ( $p=0.014$ ), and less desire for information immediately post-intervention ( $p=0.021$ ). At the one year follow-up, the pattern persisted, and significant differences were found in independence ( $p=0.007$ ), and desire for information ( $p=0.035$ ). Thus, results suggested that the facilitated critical reflection process, an equitable partnering relational approach to health promotion, can enhance the health of chronically ill seniors. However, seniors' experiences of partnering approaches in the context of health care of this nature is not well understood, and therefore requires further investigation.

#### Seniors' Relational Involvement and Perceptions of Partnering in Care

Two studies shed more direct light on seniors' involvement in and perceptions of partnering in their care. Bastiaens et al., (2007) conducted a qualitative study using in-depth interviews to elicit the views of people aged 70 and over ( $n=406$ ), on involvement in their primary health care in 11 different European countries. Involvement was defined as enabling people to take an active role in deciding about and planning their care. The semi-structured interview format included questions on clients' views on their

involvement: what it means, the advantages, barriers and facilitators. Data analysis at national (primary) and international (secondary) levels revealed that participants did want to be involved in their care. This finding is extremely relevant in the area of relational health promotion as it reaffirms the understanding that seniors want to partner with their health care provider as opposed to the health care provider dictating the care plan or vice versa. However, these researchers defined involvement as related to the caring relationship, person-centered approach and information exchange with no mention of participation in partnering. Thus, how seniors perceive the partnering process is an unaddressed question.

A qualitative interpretive study by Gantert and colleagues (2008) begins to address this gap. Through in-depth interviews, researchers explored 15 senior clients' perceptions of relationship-building with in-home providers, with a focus on the facilitators of and barriers to this experience. The findings suggested that seniors perceived their relationship-building with providers as a dynamic process comprised of six components: (1) resigning to relate; (2) connecting through the larger life context; (3) seeking mutual knowing; (4) balancing knowledge, status and authority; (5) creating shared patterning; and ultimately (6) building and maintaining bonds. Seniors identified that facilitators and barriers were encountered at each component at both the individual and contextual level. Two facilitators and barriers were identified as being vital to the relationship-building process as a whole: having/not having time to build the relationship and having/not having continuity of relationship. Overall, provider-client relationship-building was identified by senior clients as a dynamic, non-linear process, with movement between and among all components (Gantert, McWilliam, Ward-Griffin,

Allen, 2007). This study emphasizes the importance of health care providers' understanding of seniors' experiences and perspectives, as this understanding could enable providers to offer care consistent with clients' needs, willingness and ability to enter into a care relationship. These findings demonstrate seniors' desire and willingness to enter into and build relationships with their in-home care providers, affording greater depth of understanding of senior's experiences of relationship-building with their in-home care providers. While findings suggest that seniors' perceptions of relationship-building encompass some elements of partnering, how seniors experience partnering/non-partnering per se was not investigated. Further investigation is warranted to enhance knowledge in the area of partnering, in particular, to inform the theory and practice of relational health promotion.

In summary, the research to date suggests the potential of partnering relationships for enhancing health promotion with seniors. However, little is known about how seniors actually experience partnering/non-partnering and therefore, further research surrounding senior's lived experience of this phenomenon is warranted. An increased understanding of seniors' experience of partnering/non-partnering may inform the theory and practice of relational health promotion and provide insight into how to go about forming effective partnering relationships with senior clients.

## CHAPTER THREE: METHODOLOGY AND METHODS

Heideggarian phenomenology was chosen as the methodology for this study. This chapter presents the philosophical foundations of this research methodology and its appropriateness as the design for this research study. The methods for participant recruitment and sampling, data collection and analysis strategies, as well as issues relating to rigor and ethical considerations, are also elaborated.

### Heideggarian Phenomenology

Interpretive phenomenology was used to study the lived experience of senior clients in order to gain a deeper understanding of their everyday experiences of partnering/non-partnering with in-home care providers in the promotion of their health (Patton, 1990; Van Manen, 1997). The researcher explored the meanings, motives, intentions, emotions and feelings of the participants (Patton, 2002) to gain an in-depth understanding of their experience of partnering/non-partnering.

Interpretive phenomenology originated from Martin Heidegger (1889-1976), who built on Husserl's foundation of descriptive phenomenology. Heidegger focused on the nature and relations of being (ontology), rather than Husserl's focus on the nature and grounds of knowledge (epistemology) (Cohen & Omery, 1994). Thus, interpretive phenomenology goes beyond a mere description of events (Lopez & Willis, 2004), and aims to uncover the hidden phenomenon of interest with an increased emphasis on the meaning of everyday experience (Cohen & Omery, 1994). Therefore, the focus of a hermeneutic study is on what humans experience rather than what they intuitively know (Solomon, 1987).

A central principle of interpretive phenomenology is that an individual's reality is readily influenced by the world in which he/she lives (Lopez & Willis, 2004), which Heidegger referred to as an individual's *lifeworld*. The lifeworld includes the meaningful set of relationships, practices, languages and traditions that an individual possesses due to the culture into which he/she has been born. Thus, this world encompasses the background understanding of an individual (Leonard, 1989). Therefore, the interpretive researcher must be attentive to what the individual's narrative implies about his/her daily experiences and life world (Lopez & Willis, 2004). In this study, the lifeworld of participants will encompass their experiences of partnering/non-partnering during the provision of in-home care.

To understand an individual's experience, the researcher must enter the person's world, and explore how that individual brings meaning and value to his/her life at that moment in time (Koch, 1995). When studying a concept such as partnering, the interpretive researcher must accept and value the descriptions given by participants as their realities and their understandings of the phenomenon of interest (Koch, 1999), taking into account how they are situated in the world. Therefore, for the purposes of this study, the researcher will not only question participants about their experiences of partnering/non-partnering, but also will encourage participants to describe their interactions and relationships with their in-home care providers, their bodily experiences of partnering/non-partnering and their experiences of time in relation to partnering/non-partnering in order to place the lived experience in the context of daily in-home care practices and socialization (Lopez & Willis, 2004).

Interpretive phenomenology maintains that understanding through interpretation cannot be accomplished unless interpretation is grounded in a consideration of time (Mackey, 2005). Heidegger's philosophical conceptualization of time as temporal differs from the western conceptualization of time as linear. Temporality refers to awareness of time through the experience of being-in-time, which Heidegger maintained is the ground for our awareness of our existence (Heidegger, 1962). Specifically, the way an individual exists in the present is affected by their past experience and future possibilities. It has been noted that individuals suffering from illness experience a significant disruption to their experience of time (Boughton, 1997; Madjar, 1991), and this disruption causes the experience to stand out (Fitzgerald, 1995). As a researcher exploring chronically ill seniors' experiences of partnering/non-partnering, it is important to be alert to those moments that stand out in the individuals' descriptions, as this will situate their experiences in time and may enhance understanding of their experiences (Mackey, 2005).

In interpretive research, the meanings that the researcher arrives at are a blend of the meanings expressed by both the researcher and the participants within the study (Lopez & Willis, 2004). Heidegger labelled this 'co-constitutionality' (Koch, 1995). Both the researcher and participants bring different backgrounds, assumptions, ideas, meanings and experiences to the interpretation and therefore the interpretation is bound by the individual and combined horizons that each participant holds (Geanellos, 1998). As an interpretive researcher, it is important to understand that there is no one true meaning generated by the study, yet the findings ideally reflect the realities of the study participants (Annells, 1996).

### Declaration of Self in Front of the Text

Because the meanings that the researcher arrives at include those of the researcher herself, it is important that the researcher explore her own subjective reality to understand the personal meaning of the phenomenon brought to the investigation (Munhall, 1994). The following declaration of self addresses this aim.

My interest in the topic of relational health promotion was partly due to my undergraduate focus on the theory and practice of health promotion, and partly due to my interest and curiosity surrounding how seniors' experience health promotion in the form of partnering, a topic to which I was exposed in the course of my graduate education. My beliefs and preconceptions of seniors' experiences with partnering are limited, as I have not had the opportunity to engage in health promotion with this group. Also, as partnering is a relatively new concept to me, I have not had much time to develop preconceptions regarding this phenomenon. Through critical reflection on my thoughts and beliefs, and experiences with my own grandparents, I realize that I do believe that all seniors are able to partner with health care providers regardless of their situation in life. This is an inherent bias of my own, as it fails to consider those individuals who may not have the resources or strength to invest into this relational experience.

I openly acknowledged these thoughts and feelings in order to consciously attend to how they might have entered into my interpretation of the experiences of seniors in the study as this work unfolded. In doing this, as I prepared to interview the participants and enter into the analysis of the text, I attempted to set aside my beliefs that all seniors should be able to partner with their providers, and to be open to meanings that emerged throughout the interview and analytical process. However, one's knowledge and



experiences are never truly absent from the interpretation and analysis of data. I therefore acknowledge that the findings of this study represent a blend of the meanings articulated by the participant and myself within the focus of the study, a principle entitled co-constitutionality (Koch, 1995, Lopez & Willis, 2004).

### Methods

The following section presents the methods, including the sampling strategy, the sample characteristics, how the data were collected and analyzed, and how ethical issues and the creation of authenticity were addressed.

#### *Sample Frame, Sampling and Recruitment Strategies*

Seniors with chronic illness comprised the sampling frame because of the inherent challenges these individuals face in the promotion of their health, as health professionals tend to primarily focus on their illness (Benner, Janson-Bjerklie, Ferketich, & Becker, 1994), rather than on their health as a resource for everyday living. Chronic illness was defined according to the U.S National Centre for Health Statistics (1995) as any illness of 3 or more month's duration. As the prevalence of chronic disease is particularly high for seniors, it was believed to be particularly relevant to focus the study on the experiences of this age group. Individuals selected to participate needed to be cognitively intact (as indicated by their client records), to have received or be receiving "chronic" in-home care (defined as a minimum of three months of continuous service), be receiving a diversity of services from providers of any category, and be English speaking, so that they were able to participate in the interview process. To ensure experience with partnering/non-partnering, individuals selected were those in receipt of three in-home visits per week, affording sustained contact with the same provider. Participants had to be able and

willing to participate in a one to two hour in-depth interview, to discuss the topic of their relationships with in-home care providers, and to articulate thoughts and feelings surrounding the research question. These requirements were addressed in seeking informed consent. This purposeful sampling strategy promoted appropriateness of the sample (Morse, 2000).

Case managers from the local Community Care Access Centre were asked to serve as key informants identifying senior clients who met the inclusion criteria and indicated an interest and a willingness to talk to a researcher regarding their care relationships with their in-home providers. In keeping with the privacy legislation, a list of the names of thirteen clients who met these criteria and agreed to be contacted by the researcher was provided to the researcher by in-home case managers.

From the list received, purposeful sampling strategies were utilized for deliberate selection of potentially information-rich cases for in-depth study. According to Patton (2002), the logic and power of purposeful sampling derive from the deliberate selection of a breadth of cases appropriate for in-depth study of the research topic. Therefore, the researcher intentionally selected eight seniors (Morse, 2000) who were sampled with the aim of maximizing variation (Patton, 2002) of the type of in-home care received, age, sex and chronic conditions. This strategy was followed in order to achieve diverse perspectives and experiences from clients, and to ensure that the breadth and depth of findings conveyed by the data might be optimized (Patton, 2002). Sampling ceased when theme saturation (Patton) was achieved, that is, when no new patterns emerged and almost all the variations were accounted for and understood, and the data provided

adequate information on seniors' experiences of partnering/non-partnering with their in-home health care providers (Morse, 2000).

Ultimately, the sample was comprised of six female clients and two male clients, ranging in age from 70 to 92 ( $\bar{x}$  = 83.4), with a variety of chronic conditions, including multiple sclerosis, parkinson's disease, chronic asthma, cellulites, diabetes, and chronic pain. As all were receiving only personal support worker care, variation in the category of care received was not achieved.

### *Ethical Considerations*

Ethics approval was obtained from the Human Research Ethics Committee of the University of Western Ontario (Appendix A). Potential participants whose names were released to the researcher by the key informants for the study were initially contacted by telephone by the researcher. A brief description of the study purpose and the researcher's role in the study were given. If the potential participant indicated an interest, ability and willingness to become involved, a time and place convenient to the participant was arranged. During the arranged interview, all participants received a letter of information (Appendix B), along with a consent form (Appendix C) to be signed to indicate a willingness to participate in the study.

Study participants were informed that all information they provided would be treated as strictly confidential and used anonymously only for the purpose of this research study. Participants were also made aware that they had the right to terminate the interview and withdraw from the study at any time without fear of repercussions. All transcripts were identified only by a study code number, and all records of the interviews

were kept in a locked filing cabinet. Computer files were stored in a password protected database.

#### *Data Collection Methods*

Data were collected through in-depth interviews approximately one to two hours in length ( $\bar{x}$  = 53.5 min) to elicit individual experiences and information-rich data. A semi-structured interview guide (Appendix D) with open-ended questions facilitated the gathering of data on the participants' thoughts, feelings and experiences related to partnering or non-partnering with their in-home providers, including their motives, expectations, beliefs, values, and interactions in the process of partnering/non-partnering for their health promotion. All interviews were audiotaped and transcribed verbatim. The researcher also took detailed field notes after each interview to document and record observations not captured in the tape recording, such as nonverbal cues or gestures, the context of the interview, the interview environment, and the thoughts and feelings of the researcher (Patton, 1990).

#### *Data Analysis Methods*

Data analysis was conducted using a phenomenological approach, which "seeks to grasp and elucidate the meaning, structure, and essence of the lived experience of a phenomenon for a person or group of people" (Patton, 2002, p. 482). Inductive data analysis was employed, specifically the immersion and crystallization approach (Crabtree & Miller, 1999). Analysis occurred after each interview, and several times thereafter as more data were collected. The researcher simultaneously listened to the audiotaped interviews and read the corresponding transcript, thereby immersing herself in the data until themes and patterns emerged (Lincoln & Guba, 1985). As patterns and themes

emerged, the transcribed data were deconstructed and coded to identify categories and sub-categories within the text. These identified categories and sub-categories were then examined to further identify patterns and themes. Lastly, the themes and sub-themes that emerged from the data were crystallized into an integrated, holistic interpretive analysis that made sense of the participants' experiences.

#### Qualitative Rigor

Due to the personal, individualistic subjective nature of interpretive research, objectivity is unattainable. Instead, several techniques that promote authenticity and applicability of findings were utilized (Anjen, 2000). Authenticity was established through the use of member-checking (clarifying with the participants whether the interpretation had made sense of their experiences) during the interview process in order to clarify the researcher's understanding of each participant's experiences and to ascertain whether the participant's experience had been understood. Interviewing techniques such as probing were used to promote a 'thick description' (Lincoln & Guba, 1985) of seniors' experiences of partnering/non-partnering with in-home health care providers, with the aim of enabling readers to better determine the applicability of the findings to their circumstances. Cogency was promoted through review of the preliminary and final analyses by the researcher's advisory committee, who advised on whether the interpretation made sense and resonated with their familiarity with the phenomenon under investigation (Kuzel & Like, 1991).

### Dissemination

To disseminate the research findings of this thesis, the researcher plans to present study findings at public conferences, which may include those of the Canadian Association on Gerontology, the American Society on Aging, WHO, and the International Conference on Health Promotion. A poster of the study findings was presented at the Faculty of Health Sciences Research Day in London, Ontario on February 6, 2009, and an oral presentation of the study findings was delivered at the STTI Iota Omicron Chapter Annual Research Day in London, Ontario on May 1, 2009. A manuscript of the study will be submitted for journal publication, with options being the North American Health Promotion Journals, the Canadian Journal on Aging, and the International Journal of Health Promotion.

## CHAPTER FOUR: SENIORS' EXPERIENCE OF PARTNERING/NON-PARTNERING

This chapter presents the themes and sub-themes that emerged from the analysis of the interview data. Three themes captured seniors' holistic experience of the partnering/non-partnering process, as follows: (1) the psycho-social-cultural contextual attributes of partnering/non-partnering; (2) the process of enacting partnering/non-partnering; and (3) the subjective experience of partnering/non-partnering. These themes, each containing sub-themes, are described, discussed and illustrated in the following sections. In the final section of this chapter, the holistic interpretation of partnering/non-partnering is presented, illuminating the dynamic and evolving process of partnering/non-partnering experienced by the senior participants.

### Psycho-social-cultural Context to Partnering/Non-Partnering

The seniors participating in the study described a psycho-social-cultural context to partnering/non-partnering with their in-home care providers. Several of their experiences revealed factors comprising a psycho-social-cultural context that appeared to impede or facilitate partnering in their relationships with care providers. This context, unique to each individual's life situation and history, informed and shaped their perspectives on life, and ultimately their perspectives on partnering/non-partnering. The following sub-sections convey the nature of factors that appeared to be impediments

#### *Seniors' Expectations of Providers*

Senior participants described an expectation that their providers be the experts in the care relationship, and enact an expert role in lieu of partnering. Seniors who viewed their provider as an expert did not appear to be consciously aware of the significant

contributions they could make to the care partnership/process. One participant conveyed that she did not understand how she could contribute her skills to the care partnership, or even what type of skills she possessed. This participant viewed herself as the recipient of care and looked to her provider for answers, setting the stage for providers' enactment of an expert approach (Brickman et al., 1982):

You ask what they [health care provider] want you to do, and you try to do what they say because that's what you're having them for. They know more about what you should be doing than you do, so...I think you should try to do what they tell you to do, no use having them if you ignore them.

Another said:

What am I supposed to do with them [personal support workers]? ..... These questions [about involvement in care] don't apply to me maybe.

A third participant revealed her view of her provider as an expert, valuing this professionalism as an important part of her experience. When asked about the best aspects of the relationship with her provider, the participant answered:

Her [provider's] attitude toward work, she's very professional, she writes a chart and she's observant when she's talking. And if I fell or something, she would report it.

Providers' actions also shaped seniors' expectations, dampening their inclination to participate. A participant shared how her provider did not listen to her concerns regarding stability with bathing:

In the beginning.....I was concerned about my bathing because I knew I could get into the tub for a shower but I wasn't at all sure I could get out of it, so I mentioned to the one nurse that I was a little concerned about that, and she more or less ignored that.

In these instances, there was no partnering between seniors and providers in the promotion of health. This socio-cultural phenomenon has been noted by others who have found that seniors are more inclined to view providers as experts (McCormack, 2001;



McWilliam, Brown, Carmichael, & Lehman, 1994), and that health care providers are more inclined to act as experts by emphasizing their authority and expertise (McCormack, 2001; McWilliam et al., 2001; Penney & Wellard, 2007).

### *Personal Philosophy of Life*

Seniors in the study also described personal philosophies of life or ways of being that appeared to enter into their inclination to participate or voice their opinion in care relationships. One client explained:

Well I don't pick at things...you don't fret the small stuff...I've learned that over the years, it isn't worth it, you hurt yourself more than you hurt anybody else really, and so I don't. If it's something that annoys me, I let it go. Let it go. It isn't worthwhile making bad feelings.

Not fretting about the small stuff' inhibited the client's ability to voice her opinion in the care relationship as she was more content to let her concerns go unarticulated than to create what she perceived would be conflict and bother in the care relationship.

Another client explained her way of being that also entered into her experience of partnering/non-partnering:

What you see is what you get. I never get mad, never raise my voice. I'm an even-keeled person. I stay at one level...so I let the girls do what they want pretty much.

A third participant also expressed a similar mentality:

I accept whatever comes. You learn that when you get older. You don't make too many judgments.

Thus, these seniors' aforementioned philosophies of life entered into their partnering/non-partnering experience, as the enactment of these philosophies were reflected in passivity and acceptance, and their contribution/non-contribution of knowledge, status, and authority to care partnering.

### *Gratefulness*

Feelings of extreme gratitude were also part of the psycho-social-cultural context of partnering/non-partnering. Seniors expressed immense thankfulness for the fact that anyone would be willing to help them. For example, one senior stated:

I am just so gosh darned grateful for *anything they do*...it's wonderful, that's all I can say. *I am so grateful*. Anybody that comes in and, without any comments whatsoever [about] "That's an old woman." I think that's wonderful.

Another participant shared how her provider's attitude was very aggressive, yet because she was so grateful to have someone help her, she did not say anything:

I tried not to let it [her PSW's attitude] bother me...she was just very tense and .....her attitude was very aggressive...bossy if you want to call it...but, as I said, I was so thankful that someone was coming... it took me months before I finally said something.

Participants' feelings of extreme gratitude or thankfulness meant feeling unjustified in expressing dissatisfaction with an aggressive care provider. Participants felt extremely fortunate to be receiving *any* service or help at all, and hesitated to jeopardize this in any way by suggesting ways to enhance or change the care that they were receiving. Similar research has found that clients often comply with their provider in order to please them (Waterworth & Luker, 1990). Thus, partnering in care was thereby impeded by feelings of extreme gratitude.

### *Social Morés*

Clients also described social morés they had learned as children that appeared to impede partnering. Such morés included the appropriate ways to behave to and interact with others, in this instance, with health care professionals. For example, one participant explained:

I'm 70 years old, but still the way you're brought up as a child is still going around in your mind...and you were not supposed to talk about yourself, not to draw attention to yourself, and coming from a working class background you were taught to respect your elders and your betters, and if they were better, that meant you were less than. So I'm not used to talking about myself.

Another participant expressed a similar sentiment:

See, I'm of a generation, and there's people older than myself that live in this building, that we were brought up not to rock the boat, and your doctor was on a pedestal...Whatever they decided you went along with it, even if you weren't comfortable.

A third participant stated"

They [providers] don't seem to be interested in asking, or anything, and I'm not going to be spouting off, 'This is wrong, that is wrong.'

Clients who were raised to not speak about themselves or draw attention to themselves also appeared impeded in partnering with their home care providers. This set the stage for providers functioning as experts, as these clients did not want to, or could not bring themselves to share in the discussions relating to their health.

#### *Cultural Factors*

Seniors on occasion also experienced a misfit with the ethnicity of some health care providers, which similarly appeared to impede partnering. One client had difficulty participating in care and engaging in bathing activities with their provider:

I had one [PSW] before that was a different culture and it was a little difficult [participating in care with her]...I wasn't very happy about it, and she wasn't too happy about bathing and that thing because of her culture...I don't think she liked you taking all your clothes off, and that makes it rather embarrassing, and I was getting rather tense with her.....it was really me, not her, we just didn't fit with each other and that is a problem I guess if you have it.

This pattern is important to understand in an increasingly multicultural and ethnically diverse society.

### *Unfamiliarity with the Care Provider*

When seniors were visited by a new health care provider with whom they had never met and thus had no established relationship, they expressed a lack of connection and willingness to voice their opinion in regard to their care routine due to a lack of comfort or familiarity with the new provider:

When [regular care provider] was on holidays, I had a very young girl in...and you don't get any personal feelings with a person that just comes in once to do personal things for you. You don't feel as close to them...It's impersonal...I would never complain about her [new provider]. She did what she thought was right and that's all there was too it...as far as I was concerned, I knew [regular provider] was coming back.

Another client expressed an unwillingness to receive care from anyone else besides his regular provider, due to a lack of comfort and trust in the new provider's skills:

When she [regular care provider] takes holidays...and they ask if I want to have somebody else, I say, "No...I'm used to [regular care provider]". There was a fellow who came in and I didn't care for him...So that's why when she's [regular provider] not here, I get [my wife] to do it [bath].

This too, appeared to impede partnering. Thus, clients experienced various psycho-social-cultural contextual factors that entered into their experience of partnering/non-partnering in their care.

However, seniors' psycho-social-cultural context also appeared to contain elements that fostered their experience of partnering. The following sub-themes illuminate these elements of their psycho-social-cultural context.

### *Learning Interdependence*

The experience of learning interdependence was described by the seniors who participated in the study. Seniors conveyed their experience of becoming interdependent as a facilitator to partnering with their care providers. Seniors described this as a learning

experience, as they came to the realization that they could neither be completely independent, nor did they want to be fully dependent. Many of the participants in this study experienced a formation of an interdependent relationship with care-providers, which enabled them to participate in their care. As one participant explained:

See, I never ever wanted to be a nuisance to people. I was the eldest daughter that looked after the younger ones. I've always been... a caring person wanting to care for people, and it's harder for people who like to care for people to let people care for them. I've had to learn how to do that, and it's not such a bad thing.

The client acknowledged her discomfort with allowing someone to care for her, and learned how to accept help from another individual, becoming interdependent, rather than fully dependent. Another participant described how her family situation enabled her to learn how to share in relationships with others, interdependently:

See, she [her mother] had four living children by the time she was 20. And I had other brothers and sisters after that. If you come from a family like that you learn how to sit back and have patience, and you learn how to share, and use things together.

Current North American values emphasize the importance of self-reliance and independence (Hirvensalo, Rantanen, & Heikkinen, 2000) as gold standards in self-care. Thus, dependence is seen as a less-empowered status or state. Interdependence has been suggested in the literature as an alternative to independence and dependence (Nolan, Davies, Brown, Keady, & Nolan, 2004). Interdependence is defined as the action of being joined together with a common bond (*Merriam-Webster dictionary*, 2004). Adopting interdependence thus defined enables individuals to compensate for their limitations through the support provided by their interpersonal networks (Del Aguila, Cox, & Lee, 2006). Hence, learning interdependence was a facilitator of partnering for participants in this study.

### *Cultivating Care-Recipient/Provider Relationships*

The formation and development of a care relationship between seniors and their health care providers was also an important contextual factor that fostered partnering. Seniors who spent time in relationships with their health care providers described mutual understanding and comfort in working together. One senior described her care relationship with her personal support worker of many years:

She [personal support worker] understands, we've been together for some time now so you get to know each other...what you can do, what you can't do. That's nice.

Another participant shared what she experienced as the benefits of her relationship with her provider:

I think it [relationship] opens a door that if I needed to talk to anybody I could....You get a good friendship going, and then you feel more at ease with them week after week that if there was anything bothering me I wouldn't have any trouble to talk to [them] about anything.

Thus, seniors experienced a positive relationship between themselves and their care providers as a facilitator to being able to contribute and participate in the care. Research has emphasized the importance of cultivating a care relationship as it promotes self-esteem and a feeling of love and belonging, thereby facilitating or enhancing the client's ability to partner in their care (McWilliam et al., 1997).

### *Client's Need/Desire for Involvement*

Some seniors stressed how important it was for them to have their voice heard in the care partnership. One senior described her need to be involved in her care:

I think it's important that you need to do that [participate in care]. I don't think you can be passive. You can be thankful and appreciative, but I think you need to be...more involved.

Another client stated her ideal in regard to involvement in her care, "I think you should take an interest in your care. If you don't, who's going to?" These participants did not perceive the providers as the only experts, but rather saw the need for their own active engagement in the care relationship. These individuals made an effort to be involved in the care relationship, and were not hindered by their providers' expert knowledge, status, and authority. Such clients not only viewed their involvement as imperative, they also acknowledged that the relationship should consist of an equal contribution from both themselves and their health care providers. One client described her ideal role within her relationship as:

I think it's [the ideal relationship with her health care provider] about a 50-50 relationship.

In summary, seniors described psycho-social-cultural factors that entered into their experience of partnering/non-partnering. These factors appeared to constitute a relational context that inhibited or impeded partnering with their health care providers. In some, but not all instances, seniors were consciously aware of the psycho-social-cultural factors that constituted their way of being in relationships and acknowledged that they had to make a conscious effort to work through these factors to enable them to partner in care.

#### The Process of Enacting Partnering/Non-Partnering

Seniors engaged in the process of enacting a partnering relationship were consciously aware of and critically reflective about what they could and were contributing to the care partnership. Those enacting partnering contributed their knowledge, skills and decision-making to the care process. Those not enacting partnering

described little sharing of knowledge, skills and decision-making, instead describing their experience of the expert model of care.

*Sharing/Non-Sharing of Knowledge*

Seniors who enacted partnering with their health care providers shared their personal knowledge throughout their care. For example, one senior described how she shared her personal knowledge with her health care providers, as follows:

I [share] knowledge about myself, my body, my physical situation right now, and I know what I can and can't do, and then when they want to move my legs, I'll say, you'll have to move them because my legs won't move...So I think [I share] my knowledge of myself.

Another participant described her experience of sharing knowledge, and the realization that she could speak up and contribute to the care process without being reprimanded or punished:

It's realizing that I can say things and that I won't get slapped down. I'll be listened to and hopefully there'll be some changes made.

Conversely, other seniors described an enactment of non-partnering. As one senior explained:

I don't say too much [i.e. doesn't share her knowledge] because I figure they know more about my care than I do. That's what they're doing here. So I more or less take their advice and do what they say.

This participant deliberately did not contribute her knowledge to care, describing her provider as the expert in regard to knowledge about her care. Thus, she remained passive, taking a non-partnering approach. Another participant shared a similar experience:

I don't even mention it [her knowledge] to her [provider]...If she's going to come in...I appreciate [her] coming in to help...so I never say anything.

Thus, the senior participants in this study sometimes enacted partnering, but also did not partner, as they did not share their personal knowledge with their health care providers.



*Sharing/Non-Sharing of Skills*

Seniors also experienced a sharing/non-sharing of their care skills in the enactment of partnering/non-partnering with their health care providers. In the enactment of partnering, seniors and health care providers shared the responsibilities associated with one task, as opposed to having duties and responsibilities rest with either the provider or the senior. For example, one senior described the collaboration between herself and her providers when being bathed:

She'll [provider] get the brief that I'm wearing, then she'll go into the bathroom and get the hot water in a bowl that's in the bathroom, a washcloth and a towel that's for my body, and she'll pass me the facecloth...and I'll wash my face and my hands, and then I take off my nightgown...and I wash my own arms, and then she starts to wash the upper part of my body...then she'll roll me, and I can pull with the rails on the bed, and then she'll wash my back and dry me off.

Another participant described how he and his provider worked together during the bathing process:

She [provider] helps me get into the bathtub, and then I shampoo my hair.....then I give her the face cloth and soap when she does my back, and helps me get out.

A third participant described how she shared tasks with her daughters, and thus experienced partnering outside of the client-provider relationship:

I do as much as I can looking after myself. Once I'm up in the chair, then I'm able to prepare meals...I have the help of my two daughters, the eldest takes the laundry and they youngest does my shopping and takes me for appointments.

In contrast, seniors who experienced non-partnering with their health care providers did not take opportunities to collaborate on health care tasks. For example, one senior explained how he and his health care provider made decisions, "They [providers] tell me what's required, and I say go ahead". This participant deferred to his provider to perform the necessary tasks well. This action precluded the client's realization of the

contribution he could make to his own care. Another participant who was able to do things on her own, like dressing, opted for her health care provider to perform these tasks when she was present:

She [health care provider] does things for me when she comes that I can do, and do do when she's not here ... so its nice to have the help, for instance, in dressing and so on.

This participant apparently did not see the potential to complete these tasks together with the health care provider, but rather allowed the provider to do all the work. Similarly, another senior, when asked about his role in health care, did not see the opportunity to collaborate with the provider in the tasks related to his care. Instead, he viewed his role to be passive:

Passive...I mean there's nothing, nothing [I can contribute to care]. I can't do my back and my shoulders, he [Personal support worker] does it for me, and the leg [cellulitis] is pretty well all cleared up now, and when the...nurses came for that, they just looked after the leg, you know, applied whatever was required, and that was it. So I have no involvement in that at all other than to sit and take the care.

Therefore, seniors experienced sharing/non-sharing of tasks with their health care providers in the enactment of partnering/non-partnering, respectively

#### *Sharing/Non-Sharing of Authority and Power*

Seniors' also described the enactment of authority and power in their experiences of partnering/non-partnering. In the enactment of partnering, seniors and their providers shared authority and power in their care relationship. As one senior who required some assistance with her bath described:

All she bathes is my back, and she comes in to do that, and we leave the door open a little in case I need help..... We do that just for precautionary purposes. And you know, I don't wait until the last minute and say, "Okay I'm ready for my back to be scrubbed." I've got to give her [provider] a few minutes to finish doing what she's doing. So that's how we get along with that.

In this instance, the senior client and the provider established a mutually agreeable approach which respected both the client's need for privacy and the provider's need for time, thereby creating a balance of authority and power in the partnering relationship.

Another senior client described how she ventured into establishing a balance of authority and power in the care relationship:

You can be respectful and not be screeching at people [providers]. You can say you're not comfortable about this, or you think maybe we could try [something different] before we do this....And I'm finding that I'm getting good reaction to that. So wow, you know, it's a surprise, but then you get emboldened and then you can get along with it. So I feel very positive about the way things are going.

Seniors who did not experience partnering with their health care provider either did not contemplate sharing power and authority or experienced the power as primarily residing with the health care professional. As one client explained in regard to her bathing:

[There is] nothing to negotiate really [in regard to bathing]. She just comes in, says, "Your bath is ready." I go in, she bathes me, and then I get dressed.

This client did not contemplate sharing power and authority in the care relationship, and as such, did not see an opportunity to contribute to her care in this way. Another client described how her experience of being bathed by her health care provider was beyond her control, as the provider held the authority and decision-making abilities in the relationship:

Well... [it] depends on who the girl [PSW] is, I guess, because Tuesday...the woman bathed me all over. I'm not used to that...The regular girl [PSW], she doesn't touch my face, my hair or my private parts, but this lady that was here on Tuesday, she did everything. I guess I would prefer to do the private parts, but I'm not picky, I really am not picky...this other lady [new PSW] is probably used to doing that for the other patients...so she just automatically does it.

Therefore, seniors either experienced a balance of authority and power in partnering, or experienced non-partnering, with an imbalance of authority and power apparent in their interactions with their health care providers.

### The Subjective Experience of Partnering/Non-Partnering

Seniors conveyed stark contrasts between their subjective experience of partnering and that of non-partnering. Seniors who described the experience of partnering with their health care providers expressed satisfaction in their daily health and life, positive experiences of care, and the belief that they could continue to participate in decision-making and contribute their knowledge and skills to the relationship. One senior described the benefits she experienced from being involved in partnering in her care:

Well if you can get things, you know get things taken care of better [by participating], then you feel better because your daily life is going along a lot smoother. Then you feel really good about that especially if you helped to make it like that.

Another client described how sharing her knowledge with her personal support workers enhanced the care she received:

I think it [sharing her knowledge with providers] enhances the care. We both work at it together, and the only hard work is when it comes to doing the rolling [of herself in bed] ...and if I can help them with the rolling, then I do that

Seniors derived satisfaction from contributing to their care and helping to make it "better". Seniors also found that through participation and involvement in care that they experienced a change in themselves and their way of being. One client, who had been receiving in-home care for approximately 18 months, described how it was only in the last three months that she had begun to take an active role in her care. She explained how this had changed her experience of care in a positive way.

I know that I'm a different person to what I was when this started [18 months previously]. At the beginning, I wouldn't have said too much about myself and trying to get things changed. And now if I'm not pleased with something I'll talk about it. And it's been a good transition. I feel better about myself. I feel that I'm contributing and I'm not just...soaking everything in and not giving anything out. I think I'm giving out in a positive way.

This client described how, over time, she began to become more empowered and emboldened to contribute to her care and how this was a positive experience. Her experience revealed both self-efficacy, and self-esteem. Another client described how being actively involved in her daily activities relating to her health fulfilled her need to feel that she is living her own life:

Now lately I've been feeling pretty good, so I've been...they allow me to do the work, do whatever I feel comfortable doing...and that feels good because at least I get a little bit of it back, you know, they're not taking my life away completely.

Another participant described what it meant for her physician to acknowledge her personal understanding of her own body by entrusting her with her own care:

I was using the microwave, and I got a steam burn, and I got an infection in that. And I called the doctor, and I had been going to him for quite a while, and I said to him, "I just had a microwave steam burn yesterday, and today I'm looking and I can see red lines down my fingers from the burn". I said to him, "I've got [an] infection in it." And he said, "You sure have." And he sent the antibiotic right out, he didn't even want to see me, he trusted me, he knew that I knew my body [Interviewer asks, "How did that make you feel?"] Great! Because I mean he believed me. He let me have control of my own health.

Thus, seniors related the subjective experience of partnering positively, and conveyed that they were enabled to take control over their own health. Overall, clients who described the experience of partnering with their health care providers described feelings of self-efficacy, control over their own health, and empowerment.

Seniors also experienced an enactment of non-partnering, sometimes alongside an experience of partnering. One participant, who viewed independence as the key to her

health, experienced great distress at the realization that she could no longer do things on her own, and apparently had not contemplated the opportunity to partner with her health care providers as a viable option. She said:

Oh I can feel I'm not able to do what I used to do [tears up]. I was a very fast worker, and it bothers me...it bothers me to think you can't do what you used to do, and I got nobody else, you see, to help me.

Other clients who apparently wanted to engage in partnering met opposition from their providers. These individuals described feelings of tension, hopelessness, and ultimately, disempowerment. One participant described her experience of one personal support worker, who did not listen to her attempts to contribute to care and was not gentle with her:

I don't want to say that I was always glad to see the back of her, but in a way I was, and I didn't think there was any outlet [alternative source of care]. I didn't think that...we'd be able to find someone.....I would lie in bed and she [provider] would...ring the phone and I'd think to myself, "Oh what kind of a mood is she in?" So there'd be...tension.

Seniors also expressed frustration and hopelessness when their home care providers either did not listen to what they were telling them about their condition, or did nothing about the information provided by the client. For example, one senior explained a situation in which she shared knowledge about her condition with her personal support worker:

I have a lot of trouble with my bowels, and I keep telling her [provider], and then nothing happens [as a result of her sharing this knowledge]. So I figure, well, I guess that's my problem and I go along with it....Sometimes I feel, "What's the use of telling her?" So I don't. You get to the point where you don't bother anymore.

Thus, the experience of non-partnering revealed disempowerment, hopelessness, and distinct feelings of loss relating to seniors' ability to perform roles and activities that they were once able to do.

These experiences of the enactment of a partnering/non-partnering relationship were not static. Seniors expressed experiences of both partnering and non-partnering in their care with their health care providers. Thus, the holistic experience of partnering/non-partnering was a dynamic and fluid process revealing either or both facets of this experience at any given time.

#### The Holistic Experience of Partnering/Non-Partnering

For the seniors in this study, the holistic experience of partnering/non-partnering with their providers in the promotion of their health was a dynamic process comprised of three major themes or components: the psycho-social-cultural context of partnering/non-partnering, the process of enacting partnering/non-partnering with providers, as well as the subjective experience of partnering/non-partnering with providers in the promotion of their health. Seniors did not experience each of these components in isolation; rather, they experienced these features of partnering/non-partnering holistically.

Seniors experienced psycho-social-cultural contextual elements related to both partnering and non-partnering, sometimes describing a struggle between the two. Seniors whose context set the stage for partnering appeared to be consciously aware and critically reflective about psycho-social-cultural elements of partnering, and made a conscious effort to enact partnering. Nonetheless, seniors also seemed to be sensitive and responsive to their providers and respectful of social morés they believed to govern their relationships with providers. Hence, both partnering and non-partnering transpired in a

dynamic, non-linear way. Ultimately, seniors described their subjective experience of partnering as satisfying, revealing feelings of both self-efficacy and self esteem, while their subjective experience of non-partnering portrayed feelings of tension, hopelessness, and ultimately, disempowerment.



## CHAPTER FIVE: DISCUSSION

The findings of this study provide many insights into how seniors with chronic illness experience partnering/non-partnering with in-home health care providers in the promotion of their health. Three themes together captured seniors' holistic experience of partnering/non-partnering, as follows: (1) the psycho-social-cultural contextual attributes of partnering/non-partnering; (2) the process of enacting partnering/non-partnering; and (3) the subjective experience of partnering/non-partnering. As the research findings that emerged are a blend of both the participants' and the researcher's personal knowledge and experience, the interpretation is inherently individualistic and intersubjective (Koch, 1995; Lopez & Willis, 2004) precluding the generalizability of the research findings. However, as phenomenological research aims to uncover participants' lived experience of partnering/non-partnering with in-home care providers, these findings may contribute to our theoretical understanding of the topic area. They also may provide insights that future researchers and practitioners may consider and use to inform investigation and practice related to the experience of partnering/non-partnering. As well, these findings may have applicability in considering the partnering/non-partnering experience of other seniors receiving care for chronic diseases, particularly those in other home care contexts.

### Partnering and Relational Health Promotion

The insights and experiences uncovered in this study emphasize the meaning and value of partnering to some seniors receiving in-home care. As little theory and evidence exist to inform the relational process of health promotion in chronically ill seniors receiving in-home care, the findings of this study serve to advance the theoretical

understanding of the nature of relational health promotion. Relational health promotion views the relationship between practitioner and client, in and of itself, as health promoting (Hartrick, 2002). In this approach, the provider is not viewed to be the expert, nor is the client viewed to be compliant. Rather, together they form an egalitarian, participatory form of alliance (Hartrick) that enables individuals to acquire increased control over, and therefore, to improve their health as a resource for everyday living (World Health Organization, 1986). Therefore, the relationship is the medium through which health promotion occurs (Hartrick).

Currently, health promotion strategies for seniors focus predominantly on health education and disease prevention, namely, trying to increase physical activity and encourage healthy lifestyle changes in these individuals (Easom, 2003; A. Stewart et al., 2001). As is apparent in the findings of this study, which confirm previous research by McWilliam et al. (1997; 1999), the process of partnering may enhance health as a resource for everyday living, specifically by enhancing seniors' involvement in their daily health and life, self-esteem, and sense of control over their own health and life. The findings of this study illuminate the enactment of partnering between client and practitioner as characterizing relational health promotion. As such, findings illuminate this enactment of relational health promotion through partnering as an experience that places emphasis on the process of promoting health. This contrasts with the current health promotion literature that focuses on achieving health and health promotion outcomes through "fix-it" interventions aimed at behaviour change or healthy lifestyle factors (Easom, 2003; MacDonald, 2002; Pender, Murdaugh, & Parsons, 2002; Rabiner, 2005).

Seniors in this study who described actively partnering with their health care providers reported that in so doing, they experienced feelings of self-efficacy, control over their own health, and empowerment. This experience appeared to further their desire and ability to share their knowledge and skills with providers and to participate in decision-making regarding their care. Research in the field of home care suggests that seniors who play an active role in their care experience health (Fletcher, Breeze, & Walters, 1999; McWilliam, Brown, Carmichael, & Lehman, 1994; McWilliam et al., 1997) and achieve positive health care outcomes (McWilliam et al., 1999). As health promotion is defined as “the process of enabling people to increase control over, and improve, their health” (World Health Organization, 1986, p.1), the findings from this study emphasize the relevance and value of partnering as a component of relational health promotion.

This study also affords insights into seniors’ experiences of non-partnering with practitioners. Seniors who described the experience of non-partnering portrayed little participation or sharing of their knowledge, skills or decision-making abilities with their providers. These individuals described distinct feelings of loss relating to their ability to perform roles and activities that they were once able to do, feelings of hopelessness, and ultimately, disempowerment. Such an experience constitutes the antithesis of promoting health as a resource for everyday living (McWilliam et al., 1994). Thus, relational health promotion did not transpire in these instances. Non-partnering between seniors and their health care providers may constitute a service provision approach that actually undermines health as a resource.

### Contextual Factors Relevant to Relational Health Promotion

Senior participants within this study described various psycho-social-cultural factors that entered into their experience of partnering/non-partnering with health care providers. These factors may provide insights into, and have implications for the practice of relational health promotion.

In the context of in-home care for seniors with chronic medical conditions, health care providers were sometimes expected to enact, and sometimes experienced as enacting an expert or paternalistic approach to care. This expert approach has been previously documented in the literature (Markle-Reid et al., 2006; McCormack, 2001; McWilliam, Ward-Griffin, Sweetland, Sutherland, & O'Halloran, 2001; Penney & Wellard, 2007; A. Stewart et al., 2001). As experts, health care professionals tend to focus their attention primarily on the clients' problems, limitations, treatments, and illness, seldom asking clients about their views or inviting them to be partners in their care (Jarrett & Payne, 2002; McWilliam et al., 1994; M. Stewart et al., 2002). The findings from this study suggest that this expert approach to care may impede partnering with health care providers by inhibiting seniors' ability to develop or feel comfortable in assuming a partnering role. Thus, in contexts in which care approaches preclude partnering, relational health promotion may not transpire.

As well, seniors also described feelings of extreme gratefulness for services received, social morés regarding the appropriate ways to interact with health care professionals, and life philosophies such as 'not fretting the small stuff' or accepting whatever happens in life without judgment or input, that appeared to impede partnering. Seniors' sometimes described passivity and acceptance, as opposed to a mutual

contribution of knowledge, status and authority in the relationship. As partnering requires individuals to value co-operation (Courtney, 1995), and share responsibility, power and accountability (Gillies, 1998), the psycho-social-cultural context of the seniors in this study constituted an impediment to partnering. Overall, these findings are congruent with previous research that suggests that the enactment of partnering is influenced and, in certain cases, precluded, by the antecedent values, beliefs and assumptions that both the professional and client hold about people and relationships (Gallant, Beaulieu, & Carnevale, 2002).

While providers' experiences were not the focus of this study, current literature also addresses the barriers that health care professionals may face when entering into an enactment of partnering with clients. Health care providers often experience barriers to partnering in the form of social morés associated with their professional status and their organizational hierarchy. McPherson, Popp and Lindstrom (2006) suggest that it is difficult for professionals to enact patient-centred approaches in traditionally led, hierarchical organizations, such as health care organizations, where decisions most often flow from the top down. Thus, health care professionals may experience barriers to partnering due to the organizational context within which they work.

Health care professionals also may experience their own tendency to draw professional esteem from their expert status as a barrier to partnering. Health care professionals experience pressure from their organization and their culture to be knowers (Fisher, 2001). As such, they are educated and acculturated to hold their professional knowledge in high esteem, thus making partnering with clients more difficult, as partnering requires practitioners to acknowledge the knowledge and abilities of their

clients as equally valuable (Munro et al., 2000; M. Stewart, Banks, Crossman, & Poel, 1995). Given the conceptual link between partnering and relational health promotion, factors that impede professionals' partnering efforts may also inhibit the realization of relational health promotion. For partnering to be realized, the health care professional must believe in the capacity of the client, and be willing to relinquish the status and privilege associated with being a professional (Courtney, 1995; Courtney, Ballard, Fauver, Gariota, & Holland, 1996; Farley, 1993; Munro et al., 2000; M. Stewart et al., 1995).

Study findings also revealed several psycho-social-cultural contextual factors that appeared to foster partnering. One such factor was seniors' learning interdependence. Participants expressed that they had come to the realization that they could neither be completely independent, nor did they desire to be fully dependent on their care providers. Thus, seniors described the importance and value of learning interdependence. This finding is supported by current literature which suggests that interdependence is an emerging alternative to independence and dependence (Nolan, Davies, Brown, Keady, & Nolan, 2004). As interdependence is thought to enable individuals to compensate for their limitations through the support provided by their interpersonal networks (Del Aguila, Cox, & Lee, 2006), it can act as a facilitator to partnering. Accordingly, in certain situations, interdependence may be an important component of relational health promotion as it promotes the sharing of knowledge, skills, and decision-making abilities between the client and health care professional.

Another contextual factor that fostered the enactment of partnering experienced by seniors in this study was the cultivation of a care relationship between themselves and

their health care providers. Seniors who developed a positive care relationship with their health care providers, often developed over time in continuous care relationships, described mutual understanding and comfort in working together, which, in turn, fostered seniors' ability to share their knowledge, skills, and decision-making abilities with their providers. This is echoed in other research (Gantert, McWilliam, Ward-Griffin, & Allen, 2008; McWilliam et al., 1997) that emphasizes the potential of a care relationship to facilitate and enhance the client's ability to partner in their care (McWilliam et al., 1997). Thus, study findings reveal that partnering in a way that optimizes health as a resource for everyday living can be facilitated through the development of a care relationship. Findings also suggest that time spent in continuous care relationships fosters positive relationships.

The findings of this study also illuminate how seniors' needs or desires for participation in their care could constitute a facilitator to partnering. The seniors in the study who experienced partnering with their health care providers expressed a desire or a need to participate in their care. This expressed desire of the participants to be involved in their care contradicts previous research that suggests that individuals in poorer health or who are chronically ill prefer a provider-directed style of decision making (Biley, 1992; Levinson, Kao, Kuby, & Thisted, 2005; Waterworth & Luker, 1990). However, these findings are congruent with other research suggesting that people with chronic illness very much value being partners in their care (Bastiaens, Van Royen, Pavlic, Raposo, & Baker, 2007; Thorne, 2006). Findings suggest the potential importance of seniors' own needs and desires for participation in their care to relational health promotion.

### Implications for the Practice of Relational Health Promotion

The insights provided by this study serve to inform future directions in this field. Conscious attention to changing health care professionals' traditional approaches to practice may be required if these professionals are to facilitate the realization of relational health promotion. Health care professionals may optimize their health promotion efforts by adopting a participatory form of alliance with their clients (Hartrick, 2002). In keeping with relational health promotion theory, all health promoters, regardless of discipline, need to become collaborators with their target population to fully realize the health promoting potential found in the partnering relationship (Hartrick).

The importance of seniors' psycho-social-cultural context to the practice of relational health promotion is also underscored. Health care professionals wanting to practice relational health promotion need to work with clients to identify factors within their psycho-social-cultural context that may either impede or foster partnering. Together, health care professionals and seniors can explore the expectations of care, what health means to seniors, the obstacles they may encounter, and the strategies they have developed to achieve their optimal health (Tapp, 2000). This process has the potential to foster clients' identification of personal strengths (Feeley & Gottlieb, 2000), and facilitate self-reflective learning (Courtney et al., 1996). These strategies may help seniors overcome factors associated with their psycho-social-cultural context that may impede partnering and the optimization of health as a resource for everyday living.

Reflection and self-awareness have also been identified as key antecedent factors essential for transforming health care professionals into partners. Many health care professionals have been socialized into the patriarchal ideology of power associated with



the medical model of care (Gallant et al., 2002), which, study findings reveal, may preclude partnering. Thus, self-awareness and reflection-on-action (Schon, 1983) become necessary strategies for health care professionals wishing to engage in and refine their practice of partnering, hence relational health promotion.

Findings also suggest that health care practitioners and health promoters may enhance their efforts by focusing on fostering interdependence, building on seniors' existing strengths, relationships and community resources (Bowers, 2001), viewing clients as resourceful and knowledgeable about their own health, and validating clients' contributions to care provision. Such a direction is consistent with optimizing health as a resource for everyday living. By contrast, focusing on the achievement of complete independence tends to draw attention to older adults' deficits and compensation for loss of function (Baker, 2005). By fostering opportunities for seniors to have a more empowering interdependent partnering relationship, health care professionals may be better able to engage seniors in optimizing their health as a resource for everyday living, thereby enacting relational health promotion.

The uncovering of these strategies from the findings of this study suggest that behavioural health promotion interventions focused on healthy lifestyles education and disease prevention strategies alone may not be enough to achieve the aim of optimizing health as a resource for everyday living in chronically ill seniors. Health education and disease prevention approaches run the risk of conveying that individuals are wholly responsible for their unhealthy behaviours and for being sick (Donahue & McGuire, 1995; MacDonald, 2002) instead of recognizing and building on their strengths. Therefore, it seems important for health care professionals and health promoters to

recognize the utility of relational health promotion as an expansion of healthy lifestyles education and behaviour change programs. A combination of approaches with a focus on individuals' strengths and an expansion of their positive potential for health (Caelli, Downe, & Caelli, 2003) may help to optimize health and well-being in both chronically ill seniors, and individuals in general (Hodgson, Abbasi, & Clarkson, 1996; McWilliam, Diehl-Jones, Jutai, & Tadrissi, 2000; World Health Organization, 1998).

#### Implications for Future Research

The findings of this study suggest the relevance of seniors' experiences of partnering with their health care providers to relational health promotion. However, further investigation is needed. This study encapsulated the experience of eight chronically ill senior participants who were receiving in-home care from personal support workers only. As this study did not achieve variation in the practitioners engaged in the care experiences of study participants, all of whom received care from personal support workers only, the findings cannot be construed to reflect seniors' experiences of partnering/non-partnering with all other categories of home care providers. Future research could address this shortcoming by intentionally sampling senior clients in receipt of other services such as nursing, physiotherapy and occupational therapy. Additionally, future investigation needs to be conducted in other health care contexts to enhance the depth and breadth of insights into the experience of partnering/non-partnering. As well, investigations might explore the partnering/non-partnering experiences of people in other age groups, as well as health care providers' experiences of partnering/non-partnering.

Other areas for future research might include testing research interventions to promote seniors' mastery of, and self-efficacy for partnering with health care practitioners. Future research might also examine if and how partnering transpires between clients and family caregivers. Additional research may be warranted in the area of how the social determinants of health affect experiences of partnering, as people's experiences of health are interrelated and affected by other factors in their living world (Hartrick, 2002).

Overall, the findings of the study illuminate seniors' experiences of partnering/non-partnering with their in-home care providers. One of the strengths of this study was the utilization of a hermeneutic phenomenological approach to conducting and analyzing research (Lopez & Willis, 2004). This approach allowed the researcher to openly engage seniors throughout the interviews in a genuinely inquisitive manner, thereby gaining insights into seniors' true experiences of partnering/non-partnering with their in-home care providers. As phenomenology acknowledges the importance of the participants' life context (Lopez & Willis), the use of this methodology helped to uncover participants' psycho-social-cultural context, illuminating how this context entered into and organized the participants' experiences of partnering/non-partnering. Study findings were strengthened by the fact that sampling only ceased when theme saturation was achieved (Patton, 2002). As well, the analysis done by the researcher was validated by her advisory committee as peer reviewers, to ensure cogency of the interpretation.

## Conclusion

This study explored chronically ill seniors' experiences of partnering/non-partnering with in-home care providers in the promotion of their health. While findings of interpretive research are not generalizable, the understandings and insights uncovered may have applicability to other client and professional groups, in other health care contexts. Thus, these findings may serve to inform their practice and approach to relational health promotion, as well as the theory of relational health promotion. Overall, seniors' experiences of partnering/non-partnering afforded many insights into the psycho-social-cultural factors that enter into this experience, and portrayed the subjective enactment of partnering/non-partnering in the mobilization of health as a resource for everyday living, and hence, relational health promotion. The insights gained from this investigation suggest the merit of evolving health promotion agendas beyond behavioural and healthy lifestyles approaches to embrace partnering, and thus relational health promotion, to optimize health as a resource for everyday living.

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Appendices

APPENDIX A  
Ethics Review Form



## Office of Research Ethics

The University of Western Ontario  
 Room 00045 Dental Sciences Building, London, ON, Canada N6A 5C1  
 Telephone: (519) 661-3036 Fax: (519) 850-2466 Email: ethics@uwo.ca  
 Website: www.uwo.ca/research/ethics

### Use of Human Subjects - Ethics Approval Notice

**Principal Investigator:** Dr. C.L. McWilliam

**Review Number:** 15241E

**Review Level:** Expedited

**Review Date:** June 18, 2008

**Protocol Title:** An exploratory study of seniors' experience in partnering in the promotion of their health

**Department and Institution:** Nursing, University of Western Ontario

**Sponsor:**

**Ethics Approval Date:** July 7, 2008

**Expiry Date:** May 31, 2009

**Documents Reviewed and Approved:** UWO Protocol, Letter of Information and Consent.

#### Documents Received for Information:

This is to notify you that The University of Western Ontario Research Ethics Board for Health Sciences Research Involving Human Subjects (HSREB) which is organized and operates according to the Tri-Council Policy Statement: Ethical Conduct of Research Involving Humans and the Health Canada/ICH Good Clinical Practice Practices: Consolidated Guidelines: and the applicable laws and regulations of Ontario has reviewed and granted approval to the above referenced study on the approval date noted above. The membership of this REB also complies with the membership requirements for REB's as defined in Division 5 of the Food and Drug Regulations.

The ethics approval for this study shall remain valid until the expiry date noted above assuming timely and acceptable responses to the HSREB's periodic requests for surveillance and monitoring information. If you require an updated approval notice prior to that time you must request it using the UWO Updated Approval Request Form.

During the course of the research, no deviations from, or changes to, the protocol or consent form may be initiated without prior written approval from the HSREB except when necessary to eliminate immediate hazards to the subject or when the change(s) involve only logistical or administrative aspects of the study (e.g. change of monitor, telephone number). Expedited review of minor change(s) in ongoing studies will be considered. Subjects must receive a copy of the signed information/consent documentation.

Investigators must promptly also report to the HSREB:

- a) changes increasing the risk to the participant(s) and/or affecting significantly the conduct of the study;
- b) all adverse and unexpected experiences or events that are both serious and unexpected;
- c) new information that may adversely affect the safety of the subjects or the conduct of the study.

If these changes adverse events require a change to the information/consent documentation, and/or recruitment advertisement, the newly revised information consent documentation, and/or advertisement, must be submitted to this office for approval.

Members of the HSREB who are named as investigators in research studies, or declare a conflict of interest, do not participate in discussion related to, nor vote on, such studies when they are presented to the HSREB.

Chair of HSREB: Dr. Paul G. Harding

#### Ethics Officer to Contact for Further Information

Janice Sutherland       Elizabeth Wambolt       Grace Kelly       Denise Grafton

*This is an official document. Please retain the original in your files.*

cc ORE File

APPENDIX B

Letter of Information

**Seniors' experience of partnering or non-partnering with in-home health care providers in the promotion of their health – June 2008**

You have been invited to participate in a research study designed to explore seniors' experience of partnering or not partnering with their in-home care providers.

**What this Study is About:**

The relationship an individual receiving in-home care has with their health care providers has been shown to have a significant impact on their overall health. In this study, we are interested in exploring your involvement in care with in-home care providers in the promotion of your health, or your ability to manage well on a day to day basis. It is hoped that with your contribution, in-home health care providers will gain insight into how to partner with you in the promotion of your health in the way that works best for you.

**What being in this study means for you:**

If you agree to take part in this study, you will be one of approximately 10 people participating. The researcher will arrange a time with you to meet in your own home or at a location of your choice for your convenience. At this time, the researcher will ask you a series of questions about your involvement in care with your in-home care providers, and how you feel about the presence or lack of participation in your in-home health. The interview will last approximately 1-2 hours. Audio-taping of the interviews is required to ensure accuracy of data, therefore all interviews will be audio-taped and transcribed word for word. You may ask to have the tape recorder turned off at any time.

**Voluntary Participation and Confidentiality Issues:**

Participation in this study is voluntary. You may refuse to participate, refuse to answer any questions or withdraw from the study at any time with no effect on your future care. If you choose to withdraw from the study, any information you provided will be destroyed. All information gathered is strictly confidential. Your name or any identifying feature will not appear on the audiotape or any other records or publications related to this study. All information about this study will be locked in a private office. All tapes and records will be destroyed after the study follow-up time is complete.

**Risks of the Study**

There is a possibility that you may get tired or experience emotional distress during the interview. If you do get tired, the researcher will provide you with a break, or stop the interview and come back to finish the interview at another time convenient to you. You will also be made aware of supportive resources available to you in the event that you experience emotional distress due to the interview.

**Benefits of the Study**

You may gain a deeper understanding of your involvement in your care with your in-home care providers. The combined findings from the experiences of all seniors who take part in this study may help health care providers and policy makers to improve how they work with seniors to achieve and improve their health.

This letter is yours to keep. If you agree to take part in this study, you will be asked to sign a consent form. You will receive a copy of the consent form after it has been signed.

If you have any questions about the conduct of this study or your rights as a research participant, you may contact Research Ethics at the University of Western Ontario at (519) 661-3036.

If you would like further information about this study, please feel free to contact:  
Dr. Carol McWilliam (Principal Investigator) at

Sincerely,

Meghan Fluit, BHSc, M.Sc (candidate)



APPENDIX C

Consent Form

**Seniors' experience of partnering or non-partnering with in-home health care providers in the promotion of their health**

I have read the letter of information, and I have had the nature of this study explained to me. I have been given the opportunity to ask questions.

All of my questions have been answered to my satisfaction.

I agree to participate in the study.

_____	_____	_____
Date	Participant's Name (please print)	Participant's Signature

_____	_____	_____
Date	Person Obtaining Consent (please print)	Signature of Person Obtaining Consent

APPENDIX D

Semi-structured Interview Guide

### Semi-structured Interview Guide

*I would like to talk to you about your experiences of involvement in your in-home health care. In particular, I would like you to tell me how you feel about your participation in the care process with your health care provider. There are no right or wrong answers, and I assure you that all the information will be kept confidential. Please feel free to discuss any experiences or thoughts that come to mind.*

1. Tell me a little bit about your experiences of in-home care
  - What is it like?
  - What do you and your in-home providers do?
  - What are your thoughts about this?
  - How do you feel about this?
2. How do you and your in-home providers relate to one another throughout care provision?
  - What is that like?
  - What do you talk about?
  - What are your thoughts about this?
  - How do you feel about this?
  - What do they say/do that makes you like them?
  - What do you say/do to promote them liking you?
  - Can you tell me about conversations that relate to your care?
3. What is your involvement in your care?
  - What, if anything, do you do?
  - What knowledge do you bring to your care? What do you know about your care that they would benefit from?
  - What, if any, skills do you bring to your care?
  - How, if at all, are you involved in decision-making? How do you make decisions about your care or what you do together?
4. How do you feel about your involvement in your care?
  - How do you feel about participating in your care?
  - How do you feel about the knowledge you bring/do not bring to your care?
  - How do you feel about the skills you use/do not use in your care?
  - How do you feel about your involvement in decision-making about your care?
  - Describe your satisfaction with your involvement
  - Has any of your involvement been different in the past and present
  - How would you like your involvement to look in the future?
5. What if anything, makes it harder for you to be involved in your care?
  - Who, what makes it harder? Who initiates the partnering effort? Who starts the partnering effort?
  - Who, or what, makes it easier?
  - When, where and how is it made harder/easier?

6. What would your ideal role be with your care provider?
  - Why would you desire \_\_\_? Or not desire \_\_\_\_\_?
  - Explain
7. What would your ideal relationship with your care providers be like?
8. What does health mean to you? If health means how you manage on a daily basis, where /how would you rate your health?
9. What is your role in getting there?