Home Health Care Nurse Interactions With Homebound Geriatric Patients With Depression and Disability

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ABSTRACT

Building therapeutic nurse–patient relationships is pivotal to the provision of optimum nurse care management for geriatric home health care (HHC) patients. However, little is known about which strategies most effectively treat older adult HHC patients with concomitant depression and disability. This qualitative descriptive study was conducted in two parts to explore the issue further. The first part involved interviews regarding HHC nurse perceptions of geriatric depression and disability care management. The second part, which is the focus of the current analysis, describes HHC nurses’ use of care management and therapeutic strategies during home visits. Observation of nurse–patient interactions involved 25 nurse home visits to HHC patients 60 and older who had depression and disability. Drawing on clinical knowledge and interpersonal skills, nurses built relationships and fostered trust. However, despite their abilities to make these connections, multiple missed opportunities occurred for nurses to engage in more productive interactions. Four training components to support improvement of nurse–patient therapeutic relationships are described and recommended.

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Major depressive disorder (MDD) and milder forms of depression are disproportionately higher (14% and 11%, respectively) in the population of older adults receiving home health care (HHC) services than in the larger older adult population (Brown, McAvay, Raue, Moses, & Bruce, 2003; Bruce, 2002). The high prevalence of illness and/or disability among HHC older adult patients increases their vulnerability to depression and related untoward outcomes, including poor quality of life with greater mortality and disability (Brown et al., 2003; Bruce, 2002); unnecessary hospitalizations (Sheeran, Byers, & Bruce, 2010); and higher health care use and costs (Byers et al., 2008; Friedman, Delavan, Sheeran, & Bruce, 2009; Middleton, Hing, & Xu, 2007). Thus, for these patients, the need for depression recognition and care management (DCM) is as great as the need for care management of any other medical condition. However, HHC patients seldom receive treatment for depression partly because Medicare HHC reim-

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bursment emphasizes assessment and treatment of physical health. Furthermore, a growing shortage exists of HHC nurses with mental health skills. Both situations reduce the likelihood that patients’ depression will be recognized and addressed in the HHC context. Consequently, responsibility for DCM often falls on the generalist HHC nurse (Cabin, 2010). In a report of study findings based on HHC nurse perceptions of DCM within the context of caring for geriatric patients with disabilities (Liebel & Powers, 2014), the authors of the current article argued that generalist HHC nurses have a unique opportunity to play a pivotal role in improving patients’ depression outcomes by capitalizing on the therapeutic potential inherent in relationships formed with patients over several HHC visits. In the current article, the authors present findings from the second part of their study that, in follow up to focus group and individual interviews with HHC nurses, involved the observation of nurses’ interactions with patients in their homes.

Study aims were as follows:

• Describe HHC nurses’ perceptions of depression and disability care management (Liebel & Powers, 2014).
• Observationally identify nurses’ use of care management and therapeutic strategies to evaluate and address depression in home visits to patients with chronic illness and disabilities.
• Assess HHC nurse skillsets that, when supported and used, may have valuable potential to improve patient depression and disability outcomes.

The focus of the current analysis of home visit observation data is on the nurse–patient relationship as a potential mechanism through which generalist HHC nurses may integrate valuable care management for depression concurrent with chronic illness and disability patient care.

Relatively little is known about which therapeutic strategies can most effectively treat older HHC patients with depressive symptoms and concomitant disability (Forsman, Schierenbeck, & Wahlbeck, 2011). Nevertheless, a core value of the nursing profession is the notion that a positive and effective nurse–patient relationship is essential to optimize treatment.

THEORETICAL UNDERPINNINGS

The conceptual basis for the current research was guided by the chronic care model (CCM) (Wagner, Austin, & Von Korff, 1996; Wagner et al., 2001), a comprehensive framework for understanding the contexts of chronic care management. A key component of the CCM model is patient-centered, timely, coordinated, and evidence-based productive interactions supported by therapeutic provider communications and collaborative goal-setting with the patient. The authors used Peplau’s (1991, 1997) interpersonal relationship theory to conceptualize therapeutic relationships resulting in productive interactions that promote self-care management in the HHC context.

Peplau (1991, 1997) was one of the earliest proponents of using the nurse–patient relationship to help patients work toward self-empowering and health-promoting behaviors. Her conceptual framing of the nature and phases of a therapeutic interpersonal relationship focused on factors affecting communication within it and the dynamics of the interactive communication process. The goal of nurse–patient communication is to identify treatment goals, mobilize health care resources, and help patients attain an optimal level of functioning. The dynamic interactive communication process engages nurses and patients as both senders and receivers of messages. The interpersonal relationship challenges the manner in which patients communicate problems and needs to (a) accurately decode and comprehend these messages within the context of a conversation and (b) sustain continuity by picking up threads of conversation that patients offer within the temporal boundaries of a single encounter and/or succession of interpersonal interactions.

Peplau’s (1991, 1997) theory, framed within the notion of productive interactions in the CCM, informed the current analyses to determine how HHC nurses promote communication that facilitates self-care management through (a) mutual goal setting and (b) providing opportunities that help patients realistically assess their situation, needs, and capabilities for improving physical and emotional functioning. Specifically, the authors evaluated nurses’ use of therapeutic relationship skills within the HHC visit that enabled them to connect with patients to gain their trust and set the stage for productive interactions that would promote self-management of both disability and depression.

METHOD

The current qualitative descriptive study (Sandelowski, 2000, 2010) was conducted from October 2011 to December 2012. The research protocol was approved by the researchers’ institutional review board and the director of the participating HHC agency. Informed consent was obtained from all participants (i.e., nurses and patients).

Participants

Purposeful criterion-based sampling was used to obtain a sample of 16 RNs who had experience of ≥1 year working
with geriatric patients and who were full-time employees providing agency-based HHC services for adults 60 and older with chronic illness, disability, and depression. Of these RNs, 10 were prepared at the associate-degree level, and six were baccalaureate prepared. Nurses’ previous experience in geriatric community health nursing varied; the range of experience included 1 year (n = 3), 2 to 5 years (n = 2), 6 to 10 years (n = 4), 11 to 15 years (n = 2), and more than 20 years (n = 5).

The sample also included five HHC geriatric patients who consented to participate by allowing the researcher (D.V.L.) to be present in their homes as an observer during nurse visits. Sampling criteria for patients included community-dwelling adults 60 and older who (a) were receiving HHC services; (b) needed assistance with one or more activities of daily living (ADLs) and two or more instrumental activities of daily living (IADLs), as determined using the most recent version of the Outcome and Assessment Information Set (OASIS-C; Shaugnessey & Hittle, 2002); and (c) were experiencing current depression (i.e., mean score of 4 on the Patient Health Questionnaire [PHQ-2] depression scale) (Kroenke, Spitzer, & Williams, 2003). Patients were excluded if they (a) had reoccurring major depressive episodes (MDEs), according to the Mini-International Neuropsychiatric Interview-Major Depressive Episode Module 6.0 (Sheehan et al., 1998); (b) were diagnosed with cognitive impairment, according to the PCP Diagnosis/Cognitive Function on the OASIS-C (Shaugnessey & Hittle, 2002); or (c) were receiving hospice care. Participating patients (i.e., three women and two men, ages 60 to 89) all reported having four or more chronic illnesses, including depression, and needed ADL/IADL assistance (Shaugnessey & Hittle, 2002).

Procedure

The study was designed in two parts; the first author (D.V.L.) conducted the data collection for both parts. In Part I, nurses participated in two 60- to 90-minute focus groups and individual, follow-up, semistructured interviews. The interview guide used to conduct these audiorecorded and transcribed conversations contained questions related to nurse attitudes and perceptions about (a) depression and disability; (b) nurse activities associated with patient self-care management; and (c) nurses’ opinions about policies, procedures, and institutional resources related to delivery system design, decision support, and the clinical information system used to communicate with other HHC team members. (See Liebel & Powers [2014] for an expanded description of the interview guide and a report of Part I findings.)

In Part II, 25 patient home visits (lasting 30 to 120 minutes) with one or another of four nurse volunteers were completed. Nurses were prepared at the associate-degree (n = 1) and baccalaureate level (n = 3), with previous experience in geriatric community health nursing ranging from 2 to 20 years. The researcher (D.V.L.) engaged in what has been described by Spradley (1980) as moderate participation (i.e., primarily observing nurse–patient interactions and responding, conversationally in a socially appropriate manner). A structured observation guide was used to record descriptions of case management activities (all of which were examples of health/illness-related nursing care) and nurse actions related to disability and depression management, communication (verbal and nonverbal), and therapeutic interaction. Visits were audiorecorded and transcribed verbatim. Handwritten field notes were recorded after each visit and later converted to computer files.

Data Analysis

An iterative analytic process of review and discussion of interview/home visit transcripts concurrent with data collection facilitated evaluation of the database. Conventional qualitative content analysis methods (Hsieh & Shannon, 2005) were used to code and categorize the observation data. Data sources were initially reduced to reflect details of the visit context, communication strategies used, and therapeutic interactions across patients and visits. As analysis progressed, the authors refined codes to reflect a more theoretical approach, guided by Peplau’s perspectives on therapeutic nurse interaction and communication and mapped to the productive interaction component of the CCM (Wagner et al., 1996, 2001). An iterative data reduction yielded two levels of nurse–patient relationship (i.e., connection and therapeutic interaction) necessary for productive interactions to occur and one category of ineffective communication (i.e., disconnection) that diminishes the relationship and reduces the likelihood of productive interactions. Relationship connections included patient-centered nurse communications that conveyed, both verbally and nonverbally, nurses’ interest and concerns for patients that occurred within or proximal to discreet home care visits. Therapeutic interactions occurred coincidently and consequently to relationship connections. These interactions included setting mutual goals, establishing continuity across sessions, acknowledging patients’ physical and emotional experience, and helping patients explore and come to terms with their current situations. Relationship disconnections included nonverbal and verbal communications that inhibited pa-
tients’ trust and honest communication with nurses. These communications were not patient centered and included one-way communications, demeaning and confusing communications, or nurses declining to engage in meaningful conversations with patients.

An effort has been made to integrate information from field observations into the presentation of findings in a manner designed to protect the anonymity of participants. Because of the small size of qualitative samples, researchers must try to find ways to report pertinent details and relevant demographics while also avoiding the violation of this important principle (Morse, 2008).

Validation and Reliability

Measures integrated into the methodological design of the current study to maximize rigor and enhance validity/credibility (Creswell, 2006) included (a) the triangulation of multiple sources of data to corroborate findings (e.g., focus groups, individual interviews, participant observation); (b) the collection of rich data; (c) peer debriefing and plausibility checking; (d) prolonged engagement in the field, including an orientation to the agency and computerized documentation system used by nurses in their care activities; and (e) the demonstration of dependability by maintaining an audit trail of research materials and processes governing the execution of the research.

FINDINGS

Establishing Connections Between Patient and Nurse

Productive interactions that promote self-management are preceded by HHC nurses establishing a proximal and emotional connection with patients, which includes helping patients feel safe and ensuring they perceive nurses as interested in them and their needs, as well as capable of responding to them in a caring and respectful manner. HHC nurses are skilled in establishing connections with patients and their families in the patient home setting.

Connecting and Reconnecting With Each Visit

Establishing a connection that facilitates productive interactions with patients and their families was a primary first step at each home care visit. Upon entering patient homes, HHC nurses had to navigate a multitude of environmental and social factors that ultimately affected the way they communicated and interacted with their patients at each discreet visit. These factors included (a) understanding how to address patients’ mental and physical statuses, (b) assessing chaotic and unsafe environments, and (c) gauging how to respond to family and/or caregiver input. HHC nurses were observed to readily understand the home context and respect patients’ physical and emotional space. Upon entering patient homes, HHC nurses used social conversations, mutual disclosure, and banter to “break the ice” and establish (and then renew) their connection with patients and caregivers. These types of interactions enabled nurses to negotiate effectively with patients about their roles in the patients’ homes, establish professional boundaries, and define the working relationship with patients and families for the visits.

Connecting and reconnecting are important processes in HHC and were visible on every home visit observed. Having contact with the same nurse seemed to facilitate continuity in the relationship and a sense of comfort and ease between nurses and patients. However, little evidence existed otherwise that the nurses established continuity from one visit to another in their verbal communications. Overall, HHC nurses missed opportunities to sustain a conversation with patients about their important self-care management work that continued between and across visits. Consequently, for productive interactions to occur, HHC nurses and patients had to some extent “restart” their relationship with each visit.

Using the HHC Visit to Establish Connections With Patients

HHC nurses used various methods (e.g., listening, silence, making observations, asking questions) to establish connections with patients that would facilitate communication and set the stage for meeting the goals of home care visits. For the most part these communication strategies were based on nurses’ stated desire to establish intimacy, warmth, acceptance, affection, and empathy with patients. The key objective was creating an environment in which patients felt safe to express themselves and felt emotionally supported. To create this environment, nurses expressed affection and concern, used knowledge of patients’ lifestyles to foster a sense of familiarity, encouraged patients to talk, and listened carefully to patient responses. Many used touch to reassure and convey comfort to patients. Nurses also connected with patients by encouraging them, observing patient gains in health, and praising patient efforts in self-care.

Patients also expressed a desire to get to know their nurses as individuals, and HHC nurses used self-disclosure to foster that connection. For example, patients volunteered information, showed interest in nurses’ personal life, and asked nurses to share food as a gesture of their cultural norms. Subsequently, these patients were somewhat
more likely to share information with nurses about hidden fears and perceptions regarding their health conditions, especially depression. In turn, HHC nurses might share personal stories about their own similar health issues, such as personal experiences with depression and use of antidepressant agents. In response, patients seemed more willing to discuss their treatment options (e.g., whether or not to try antidepressant therapy).

HHC nurses also connected with patients through their role as helper and health care expert, using a number of various strategies that reinforced their helper role and asking questions to ensure that they were addressing the goals and concerns that patients had for the current visit. They used directive guidance and teaching, as appropriate, to help patients learn how to manage their care. Nurses also advocated for patients’ needs with others involved in their care.

The helper and health care expert roles were the basis for the most common interactions observed during the study. Patients expressed an expectancy for nurses to problem solve and perform activities deemed part of the professional HHC nurse role, such as clinical nursing tasks (e.g., taking patients’ blood pressure, checking patients’ blood glucose level) and physical assessment (e.g., listening to lung sounds, responding to acute issues) during visits. Patients reinforced appreciation for nurse services that were focused on the performance of skilled nursing tasks. When nurses went beyond the physical manifestations of the illness to connect with patients (e.g., asking about a patient’s family), nurse–patient relationships were strengthened. This approach provided an opportunity for nurses to focus more on patients’ agendas and life contexts that enhanced relationship building. However, despite the physical and emotional connections made, little data exist demonstrating productive interactions likely to produce self-care management for disability and depression.

Communications Promoting Productive Interactions: Therapeutic Interactions

Productive interactions included setting a focused agenda with patients, practicing active listening and providing feedback, exploring issues in depth to obtain a greater understanding of patients, and partnering with patients in decision making. Agenda setting included obtaining patients’ attention and sustaining their engagement through the entirety of the visits, setting realistic expectations for the current visits and across visits, and linking present visits to previous visits. Active listening was evident when HHC nurses were observed attending to what patients were saying, followed by nurses asking questions, giving feedback, and listening once more. When HHC nurses explored issues with patients, they asked probing questions that would elicit patient self-reflection; they also asked patients about their emotional reactions to the current conversation and/or patients’ health situation. Productive interactions were facilitated by acknowledging patients’ sadness and depression, encouraging self-expression, and positively evaluating patients for their persistence in moving toward their personal health goals.

Communications Disconnecting Nurse and Patient

Unfortunately, nurses also communicated in ways that caused patients to withdraw and disconnect interpersonally. For example, failure to engage patients in mutual conversational give-and-take occurred when nurses engaged in one-way communication where they would give advice, be directive, or lecture the patient. Similarly, nurses would sometimes act in an authoritarian manner, trying to convince patients to do something they did not want to do, telling patients how they felt instead of letting patients report their own feelings, or telling patients that if they persisted in certain behaviors, there would be consequences. Nurses were observed mildly scolding patients who failed to self-manage their care and taking charge of the conversation by telling patients what they needed to do to preserve or improve their health status. They also communicated ambiguously, at times, by sending mixed messages, providing false reassurances, or citing platitudes. On occasion, nurses demeaned, argued with, or criticized patients. Moreover, verbal and nonverbal communications could be invalidating to patients when nurses acted frustrated or used jokes and solicitude to try to lighten the mood. For example, when a HHC nurse noted that a patient’s expression was downcast and sad, the nurse tried to cheer the patient up by saying, “Oh come now…. You have a great family…stay positive.” This type of verbal invalidation was likely to occur when nurses seemed uncomfortable with patients’ intense emotions or believed that they were helping patients feel better by providing comfort.

Overall, nurses’ communication was primarily directive during home visits and focused on providing guidance about patients’ health care or performing technical tasks, such as taking vital signs or checking blood glucose levels. Patients who perceived this type of directive guidance by nurses as being pushy, indifferent, or lacking in concern responded with resistance, anger, and, in one case, detachment. They seemed to retreat inward and away from social conversation, perhaps trying to limit or avoid any chance
of shared perceptions with nurses regarding care management. In addition, some nurses seemed to have their own care plan agenda and avoided any interaction with patients that deviated from such an agenda. Although it was not unusual for some patients to verbalize disagreement when their autonomy seemed threatened, others seemed happy to take a less active role in self-care management. In these cases, most care management decisions were made by nurses and guided by standardized protocols (e.g., the OASIS-C).

Missed Opportunities for Making Connections

Opportunities also existed to engage in productive interactions that were directly thwarted by nurses missing or ignoring the openings provided by patients. HHC nurses missed these opportunities by selectively responding to patients, ignoring their statements, or changing the subject to avoid difficult conversations. The following are examples of missed opportunities:

- A patient says, “I’m feeling sad today,” while the nurse comments on a blood pressure reading.
- A patient says, “I just want to die,” and the nurse nods head without verbal response and asks if the patient has had a recurrence of a bothersome physical symptom.
- A patient says, “I’m lonely,” while the nurse fills a Mediset with pills and, subsequently, asks if the patient has had a medication delivery that day.
- A patient brings up emotional concerns as the nurse leaves the room to telephone for an appointment for care; the nurse does not pause or return to explore the patient’s strong expressions of depression, isolation, and fears about the future.

Missed opportunities could be as benign as not asking how patients are feeling about their health situations or not encouraging them to try to do more for themselves. Sometimes interruptions and distractions (e.g., ringing telephones, doorbells, pets, other individuals) led nurses to wait for an opening in the turmoil to shift the focus to activities (e.g., recertifying Medicare eligibility, checking of OASIS items in the computer).

DISCUSSION

Nurses in the current study used existing communication strategies and interpersonal skills to establish connections with patients and promote productive therapeutic interactions. Key objectives in meeting HHC visit goals were providing emotional support and creating an environment in which patients felt safe to express themselves. Sustaining therapeutic relationships over multiple visits builds the capacity for engagement in interactions that are foundational to patient progress in resolving depression and disability. However, opportunities to engage in productive interaction were sometimes missed or thwarted, thus challenging the sustainability of therapeutic relationships. In addition, little evidence of interpersonal nurse–patient interactions likely to foster patient self-care management skills existed. This finding is not surprising, given that other researchers have found that although HHC nurses are skilled providers of patient care management, they are less skilled facilitators of patient self-care management (Bruce, Van Critters, & Bartels, 2005). Nonetheless, the authors believe that nurses’ existing communication skills can be expanded through training that will help them sustain therapeutic relationships with patients and engage in productive reciprocal interactions prerequisite to patient progress in self-care management of depression and disability.

The HHC Context and Barriers to Therapeutic Relationships

System barriers and lack of depression training are threats to increasing HHC nurse proficiency in promoting self-care management for patients with the coincident conditions of disability and depression. First among these threats is the historic emphasis of Medicare HHC benefit on short-term intermittent physical health, which requires the need for skilled health professionals. Predetermined eligibility criteria foster expectations for acute care delivery by nurses rather than relationship building. CMS/agency regulations also affect the amount and frequency of HHC visits, so nurses are pressured to work within a set time
structure. Spending too much time on distractions in the home or listening to patients’ disclosure of non-medical information may be at the expense of other HHC patients in need of nurses’ care and attention. It was challenging for HHC nurses in the current study to find a realistic balance between time spent on relationship building and ensuring home visits were as efficient as possible.

In addition, many HHC agencies nationally do not provide depression training or consistent standards for DCM to guide nurse assessment and treatment of depression (Bruce et al., 2011; Pickett, Raue, & Bruce, 2012). CMS mandates that HHC nurses assess and treat disability outcomes (i.e., OASIS-C assessment) but only suggest nurse assessment for depression (CMS, 2014; L & M Policy Research, 2011). Some nurses in the current study stated that questioning their role and lack of training in DCM prompted their use of avoidance strategies or humor when they lacked confidence in directly communicating with patients about depressive symptoms (Liebel & Powers, 2014).

Finally, a lack of emphasis on the use of nurse–patient therapeutic relationships to promote goal-directed self-care management existed in the current study. HHC nurses can help patient goal setting and goal activation; however, it is not required by CMS and is often not part of patients’ care plans (Kroenke et al., 2009; Scott, Setter-Kline, & Britton, 2004).

Disability and Depression Self-Care Management and the Nurse–Patient Relationship

Overall, extant literature supports the preeminence of the therapeutic nurse–patient relationship as one of the most practical and powerful mechanisms to help patients engage and maintain self-care management (Liebel, Powers, Friedman, & Watson, 2012). The current study’s findings provide new insights into the nature of HHC nurse–patient relationships and suggest the importance of integrated care for the interrelated health conditions of disability and depression. Integrating DCM into HHC nursing care of homebound patients can create a useful synergy that will beneficially impact both patient depression and disability.

Educating HHC Nurses to Support Patient Self-Care Management

Although communication is increasingly understood to be the key to effective patient-centered care in all health care settings, training that nurses receive in promoting and enhancing effective nurse–patient communication is lacking in quantity and quality (Smith & Pressman, 2010). Productive patient-centered interactions supported by therapeutic provider communications and collaborative goal setting are primary components of the CCM (Wagner et al., 1996, 2001). The CCM provides a structure within which the principles of self-care management may be better understood and practiced. Evidence exists that patient-centered self-care management support delivered through the CCM can improve health outcomes (Coleman, Austin, Brach, & Wagner, 2009). In addition, emerging evidence from quality improvement studies shows that CCM can be effectively adapted, used, and taught to HHC nurses (Suter et al., 2008). Further testing of interventions involving CCM nurse training in HHC settings should include education about core components of the model to help nurses gain expertise in relationship building, teaching, medication management, and care coordination.

In addition, incorporating Peplau’s (1991, 1997) interpersonal relationship theory into HHC nurse training programs would help expand participants’ understanding of communication within the context of HHC nurse home visits (McNaughton, 2000). Making this process more transparent would enable the use of strategies to facilitate connections and reconnections and monitor HHC patients’ responses to nursing interventions and goal attainment. However, more research is needed to determine which aspects of the nurse therapeutic relationship may be modifiable and whether these aspects could be modified by training to better target depression (Dinç & Gastmans, 2013; Tejero, 2012).

The authors of the current article suggest that model training programs use the adapted model of CCM developed in the current study to conceptualize program infrastructure (Figure). This adapted model contains the essential elements of CCM identified by Wagner (2001) and illustrates where opportunities may exist for patients to engage in purposeful interactions. The heart of the authors’ adapted version of CCM integrates the novel components of therapeutic interaction (e.g., trust) with patient assessment to connect and communicate with patients and facilitate productive dyadic interactions (e.g., goal setting, setting an agenda). These interactions are a vital part of optimal nurse care management, leading to improved patient disability and depression self-care management. HHC nurses can learn to use their existing communication skills and relationship connections with patients as a foundation that, with additional training, could be leveraged to decrease disconnections and support development of therapeutic relationships. Nurse–patient disconnections hinder progress in patient self-care management by requir-
Nurse Interactions with Homebound Geriatric Patients with Depression and Disability

Based on extant literature and these study findings, the authors recommend that training curricula developed for HHC nurses include the following four components:

- **Setting an agenda to meet the goals of the HHC visit.** This agenda needs to integrate accurate identification and documentation of patient status (i.e., OASIS assessment) and identification of factors that may hinder disease management and overall medical management (e.g., depression). Acknowledgement of all factors affecting patients’ conditions is critical to building a therapeutic relationship and planning care.

- **Sustaining continuity across visits.** Because HHC nurses visit patients in the home over multiple visits, they have a unique opportunity to provide coaching for patients to develop skills and the confidence to fully participate in disability and depression care management. Therefore, nurses need education and training in therapeutic strategies, including motivational interviewing skills and skills related to investigating and negotiating change strategies and assessing readiness to change (Cramm & Nieboer, 2012).

- **Staying engaged despite barriers.** Prior research has found that when barriers to self-care management are identified, strategies can be instituted to sustain active goal setting, which, in turn, helps minimize the effects of patient, home, or system barriers on patients’ self-care management (Bayliss, Steiner, Fenald, Crane, & Main, 2003). Therefore, nurses need training in developing skills to deal with the simultaneous management of patients facing multiple stressors, complex health problems, and extended periods of physical impairment.

- **Recognizing nurse fears and/or ambivalence translating into avoidant disconnections.** Similar to previous studies, nurses in the current study often exerted power over patients when nurses’ vulnerability was threatened (Yamada et al., 2011). Avoidant disconnections from patients occurred when nurse–patient relationships were disrupted by nurses’ own fears (e.g., discussing depression/suicide) and ambivalence regarding patients’ physical/mental status, personality, or environment. In these cases, almost no attempt was made by nurses to establish an ongoing rapport. Therefore, nurses need training in how to (a) best acknowledge their own limitations, fears, and biases and (b) find alternative ways to respond to patients from a wellness perspective and promote equitable, balanced exchanges in which they use communication strategies that affirm patient participation.

Additional research is needed to examine the best training programs for health providers, as well as methods for...
engaging and activating self-care activities, creating and sustaining behavior change, and promoting improvement in self-care management in HHC patients who are balancing multiple problems. Reflection on what this may entail suggests a need for multipronged approaches to help HHC nurses fully engage patients in self-care management and provide more comprehensive care to these vulnerable older adults with complex needs.

CONCLUSION

Despite evolving evidence that HHC patients with disability and depression need integrated care that uses coordinated care management strategies (McGregor, Lin, & Katon, 2011), these approaches have not been fully implemented by nurses in Medicare HHC settings (Ell, 2006). This finding is concerning because these vulnerable, homebound patients have disproportionately higher rates of depression and disability and are therefore more susceptible to higher morbidity, mortality, and health care utilization (Brown et al., 2003; Bruce et al., 2005; Raue, Meyers, Rowe, Heo, & Bruce, 2007). Based on prior research and these study findings, emerging evidence exists that HHC agencies need to design and test interventions that include formal training of nurses to effectively use therapeutic communication as part of their care delivery repertoire (Fleischer, Berg, Zimmerman, Wüste, & Behrens, 2009). HHC is well positioned to adapt the above-described practices into its current infrastructure.

REFERENCES


