

# Research & Reviews: Journal of Nursing & Health Sciences

## Home Care in France: A Study of Interactions between Independent Nurses, Patients and Their Family

Florence Douguet\*

University of South Brittany, Lorient, France

### Research Article

Received date: 28/01/2016

Accepted date: 10/03/2016

Published date: 17/03/2016

#### \*For Correspondence

Florence Douguet, University of South Brittany, Lorient, France, Tel: 0297876507

E-mail: florence.douguet@univ-ubs.fr

**Keywords:** Care, Health care, Home, Nurse, Patient, Family.

#### ABSTRACT

Within the context of the rise in ambulatory health care, there is a significant increase in the presence of independent French nurses in the patients' homes. Based on the analysis of the contents of a corpus of semi-directive interviews, this article deals with the relationships that these professionals maintain with their patients and their relatives throughout the duration of the health care provided. Oscillating between tension and cooperation, these relationships highlight the privileged role these nurses play in the lives of this fragile population.

### INTRODUCTION

In France, home care nursing has significantly progressed during the last three decades in response to the needs generated by the increase in the number of dependent elderly people. This form of health care is provided on medical prescription either in the context of services or establishments who employ nursing staff, or by independent nurses who are paid directly by their client patients. In 2011, over 60 % of people aged 80 + thus benefited from the intervention of a nurse in their home for medico-technical acts and / or *nursing care* <sup>[1]</sup>. In 2013, 42 % of the client patients of independent nurses were aged 70 and over <sup>[2]</sup>.

The increase of this demand for home care nursing is accompanied by a change in the follow-up of patients due, amongst other things, to the pressure exerted by the Public Authorities to develop mobile health care for the chronically ill. In the home the independent nurses thus find themselves having to deal with the patients and their relatives increasingly implicated in the organization, indeed the implementation of the appropriate care (participation in the treatment of long term illnesses or pathologies relating to ageing, for example, diabetes).

This article addresses the very nature of the relationships between the professionals and the patients and the manner in which they try to articulate their respective competencies in terms of health care. How do the private nurses feel about the contribution of non-professionals? How do they rate them? How do the aforementioned actors consider the work carried out by the nurses?

### MATERIALS AND METHODS

The elements outlined in this article are taken from extensive sociological research dedicated to the different dimensions of the profession of independent nursing supported by the French Ministry of Health, carried out in collaboration with colleagues of The University of Western Brittany (Brest) <sup>[3]</sup>. The data collection, which was spread out over several years (1999-2004), combined qualitative and quantitative research techniques. This data was subsequently (2006-2014) completed by the work of students from the University of Southern Brittany (Lorient). The studies were carried out under our supervision and were based on subjects relating to the topic hereby addressed (the organization of home care for elderly people suffering from chronic pathologies, the role of the independent nurses in the use of hospitalization in the home, etc.).

In the course of the first phase of our research, a questionnaire was circulated on a national scale and completed by 985 independent nurses. The body of the questionnaire was subject to computerized statistical study in order to extract a series of framework data about the profession. During this same period, under the supervision of A Vilbrod, sociology students from the University of Brest carried out exploratory interviews with 120 independent nurses in Brittany. In parallel, we accompanied the nurses during several rounds of health care visits in the homes of their patients.

In the course of the second phase of the study (**Table 1**), 50 in-depth interviews were carried out with professionals working in different regions of France (mainly in Franche-Comté, Nord-Pas-de-Calais, the Centre, Aquitaine, Ile-de-France / Paris area and Brittany) and in varied contexts (alone or in group practices, in the countryside or in urban zones, etc.). In order to achieve this work as a duo, we referred to a common interview guide which included a series of open questions relating to the interactions with the patients.

**Table 1.** Gender and age composition of nurses - In-depth interviews (N=50).

	Under 30	30-39	40-49	50-59	60 and over	Total
<b>Women</b>	0	7	23	10	3	43
<b>Men</b>	0	1	4	2	0	7
<b>Total</b>	0	8	27	12	3	50

The results presented here are principally based on the analysis of the thematic content of all the in-depth interviews recorded and transcribed (**Table 2**).

**Table 2.** Items - In-depth interviews.

Characteristics and expectations of the client patients
Particularities of the nurse - patient relationships in the home
Contents of the activities used with the patients
The physical rapport with the suffering
Relationships established with the different members of the entourage

## RESULTS

In the home, the patient and their entourage find themselves involved in the health care work to a certain extent. How do the independent nurses perceive these situations which tend to occur more and more frequently? The professionals we interviewed observe that the doctors – the GPs and in particular the surgeons – regularly encourage the patients and their entourage (most often, the spouse and / or children) to get involved in the health care work: *« There is a real sense that the families are encouraged to carry out the health care work themselves, indeed it's more than evident! »*. These injunctions are linked to the decline of medium term hospital stays, which in practice comes down to home returns which the independent nurses consider to be “premature”. In these conditions, the entourage is invited to take over from the hospital staff, in order to “oversee” the convalescence and the follow-up care of the patient. According to the independent nurses, the nature of the care tasks left in the hands of these non-professionals may prove to be particularly delicate and difficult to implement. The aforementioned nurses refer to situations in which the doctors ask the patients or their relatives to handle medical injections themselves (*« anticoagulants », « insulin », etc.*) or to proceed with changing post operational dressings *« with packing in the back »* for example. *« They [doctors] tell them outright, whether it's the husband, the wife or the patient themselves to carry out the injections [...] and I even heard "sort yourself out, call a neighbor" »* deploras one of our interviewees. In this context, the patient is perceived as being more active as opposed to in a hospital where they would be more passive: *« He [patient in hospital] is hidden under the covers and says amen »*.

Yet, the nurses encountered tend to consider that the care provided, whether it's complex or purely technical (such as bathing and dressing), fall within the category of almost exclusively professional competencies. It is true that throughout the course of the interviews, the nurses rarely spontaneously evoked *the uninitiated provision of care by the family* <sup>[4]</sup>. When the existence of such care is recognized, the latter is generally discredited due to its profane nature: in reference to the daughter of one her patients, a nurse tells us: *« She always knows what is best for her mother, but in reality she's completely on the wrong track. That said, she is so devoted to her mother, too much so. She needs to take a step back, but again, she is devoted to the extent that sometimes she would do something stupid, in her desire to do things well. »*.

The actions taken on by the entourage can indeed generate suspicion and reticence, in particular because they are carried out in a very *emotional* context <sup>[5]</sup>. In a way, those close to the patient can be too close to be able to provide sufficient quality of care. In these situations, independent nurses may call in the appropriate medical authority to restore, in a manner of speaking, a professional logic in terms of the provision of the health care. One nurse interviewed insisted on this point: *« We must trust the care providers who are there. After seeing a person over and over again, we no longer realize what state they are in, they have needs so sometimes we are obliged to go to the doctor to get him/her to write a prescription for such and such an item. »*.

In such care circumstances, what roles do the nurses attribute to the non-professionals? In the minds of the independent nurses we interviewed, the role of the entourage in the provision of care is focused on two major functions. First and foremost, this role is based on the function of *« sentry »*: keeping an eye on the general state of the patient and raising the alert are activities

judged to be appropriate for the entourage. Secondly, the nurses recognize – and even assign- the function of « medical aide» to the entourage. In certain contexts, the members of the entourage are led to support the professionals in their tasks <sup>[6]</sup>. On occasion the entourages – especially the women – cooperate with the nurse carrying out *nursing* actions: « *There is one person, whose daughter helps us, who is there practically every morning and helps us with the bathing, but this person is really 100% dependent with muscle contractures, deformed limbs*». At this point, it is important to stress the fact that the independent nurse works solo with the patient and that they cannot count on assistance from a colleague as per in an establishment hence this working together with certain members of the entourage. Whilst these members of the entourage are not considered as care workers in the true sense of the term, they are not considered to be totally useless in the provision of care either. To some extent, we could call them « care helpers » in the literal sense of the expression (the tasks of the entourage effectively being minor and regularly referred to by the professionals met as « *help* » or « *helping hand from the family* »).

On another side, it is the professional practice of nurses which may be belittled by the patient and their entourage. Independent nurses indicate being extremely uncomfortable in the presence of non - professionals whilst providing care and feel it is an intrusion into their work. In a domestic environment dominated by uninitiated actors, the nurses may sometimes feel « *that they are under surveillance by the families who are treading on my [their] toes at work* », one of them went as far as saying that « *the patients are the ones in charge of us* ».

Those who do not feel up to supporting these situations in the long-term will disengage from the patient who « poses a problem »; this latter party is subsequently sent to another nursing practice or another colleague within the same practice. In this respect, sentiments differ considerably from one professional to another, which moreover can facilitate this type of transfer: « *I know someone like that, she stays with her mother during the care work, she is in the bedroom without speaking or doing anything, she wants to watch, and so that bothers some people but not me, not in the slightest ... When there is a subject of interest to her, the contact is easy, but it doesn't always work like that with the others* ».

Such adjustments are characteristic of the profession of independent nursing. Indeed, whilst the patients have the possibility of choosing the independent nurse who will provide the care prescribed by their doctor, the nurses themselves have a degree of autonomy in choosing their patients, especially when there is little competition: « *When there is a problem with the families, when it's not working out for either party, we don't have to continue. They can look for another practice.* ».

Furthermore, nursing can be endangered by the gap between professional and profane practices. In this respect, bathing constitutes a particularly sensitive activity. The practices of corporal hygiene carried out by the nurses are principally characterized by the domination of the *medical model* <sup>[7]</sup>. As a result, certain patients don't fully understand the point of this care act, one which moreover they haven't always requested and which may have been prescribed by the doctor without their approval. In these conditions, some nurses may have the impression that they are imposing these acts of hygiene, in particular with regard to the more elderly patients for whom showering or bathing are not part of their generation's rules or practices of hygiene: « *There is a grandmother who used to say to me "The only time I washed was when I went to bathe in the river after harvesting"* ». One such patient went as far as equating this practice with a « corporal violation ». Situations like this also cause the care workers to suffer, even more so, considering the fact that these nurses do not benefit from the approval of their acts by a work community. Whilst, in the hospital their counterparts are regularly reassured by their peers with regard to the validity of their tasks; the independent nurses often remain uncertain about this matter. One of the nurses interviewed told us about an incident during which her professional competencies were questioned: « *It's the daughter [of the elderly patient] who caused a scene! We weren't supposed to put her in the bath, at 92 years old, it just isn't done so I said "well alright then, we're used to it, bearing in mind how many we put in the bath". It's hard, because it isn't what you would call a fault. So, telephoning the entire sector to complain about it ...* ».

In these situations, the nurses will engage in *negotiations* with the person and/ or their entourage in a bid to overcome their resistance about certain care acts <sup>[8]</sup>. The most commonly adopted strategy is to take the time initially to build trust with the patient and then to introduce them little by little to these new acts: « *It is imperative to do things gently* » one nurse told us; « *You start with the feet, then you move up to the knees, and then after that, all the rest* » another specified. The introduction of medico-technical practices in the private universe can generate comparable difficulties. In these circumstances, we can observe that the negotiation can give way to as many forms of imposition. Thus, for example, it is not unusual that the patient and their relatives are hostile to the idea of equipping themselves with a patient lifting unit or a medical bed, the image of which is associated with the hospital, illness and extensive reliance. In turn, the nurse may wish to have access to this equipment in order to be able to carry out the care work more readily and efficiently. That is, in what they consider to be optimal conditions of security and comfort both for the patient and themselves. The patients and families who are firmly opposed to these forms of medicalization of their domestic environment run the risk of having their request for home care quite simply rejected outright. One of the nurses encountered declared in no uncertain terms: « *Let me tell you, we refuse to take on nursing care in a home without a medical bed, and we tell them: "yes, we'll take you on board for nursing but we must have a medical bed."* ».

## DISCUSSION

In the field of home care, the independent nurses, without a doubt, play a privileged role alongside patients and their relatives: their relationships with them are both direct and personalized. This proximity constitutes a serious advantage when it

comes to carrying out the care work. Independent nurses know only too well the living environment of their patients, their habits, their track record of their illnesses and their life, etc., all these elements contribute to the personalization and humanization of the care. In this respect, the organizational procedures of independent nurses favor the continuity of the care procedure of people suffering from long term weakness (continuity, which the home care services find more difficult to ensure).

However, working in a domestic context obliges the independent nurses to deal with and negotiate with the people in their care and their entourage. On that level, the private nurses have more of an advantage in terms of resources in comparison with their counterparts employed by home care services in that they have greater autonomy in their relationships with the patients. Nonetheless, such negotiations have their limits which are mostly due to the difficulties of expressing the professional versus the profane knowledge and know-how in terms of the care provided.

Furthermore, the independent nurses act in an environment which may increase the constraints and tension with their client patients. Today, in greater numbers (there are around 110 000 in 2015 compared with 62700 in 2005), and each carrying out more acts of care provision, the independent nurses are effectively subject to significant pressure from the control of expenditure in health care by the government and health insurance organizations. In its last annual report on social protection expenditure, the Court of Auditors indicates « an uncontrolled progression » of expenditure in independent nursing care and recommends « taking measures of regulation without further delay» <sup>[2]</sup>. The professional organizations, who did not fail to react to this report, remind us that it was the Public Authorities who requested the development of home care and that the private nurses were the key actors of this evolution. Feeling under attack, the profession is attempting to demonstrate that its interventions participate in the continuity and quality of the care provided and in broader terms to the security and quality of life of the people being cared for.

## REFERENCES

1. National Insurance for the Salaried workforce. Improving the quality of the health system and mastering expenditure; proposals made by health insurance for 2014. 2013:210.
2. Court of Auditors, Social Security. Report on the application of law for the financing of the social security. 2015:301.
3. Douguet F and Vilbrod A. The profession of independent nursing. Paris: Seli Arslan; 2007:287.
4. Cresson G and Mebtoul M. Family and health. Rennes: EHESP, 2010.
5. Fernandez F, et al.. The social language of emotions. Paris: Economica, 2008.
6. Strauss A, et al. Social organization of medical work. New Brunswick and London: Transaction publishers. 1997:313
7. Le Breton D. The sociology of the body. Paris: PUF, 2012.
8. Pennec S, et al. Negotiating health care. Rennes: PUR, 2014:283.