STRIKING A PROFESSIONAL BALANCE: OLDER RURAL PATIENTS' PERSPECTIVES ON HEARING ABOUT THEIR NURSES' LIVES

Sophie Corbett, Fiona Williams

Sophie Corbett is an Elderly Care Nurse working in Shropshire; Fiona Williams is a Research Fellow at the dot.rural Digital Economy Hub, University of Aberdeen

Email: fiona.williams@abdn.ac.uk

ABSTRACT

Close relationships between older adults and their health care professionals in community settings can enhance well-being and support positive health in older age. In rural areas health care workers may know their patients socially as well as professionally and roles are mediated. This paper reports findings from 16 qualitative interviews with older adults and health and social care professionals in rural areas of Wales. The study found that the sharing of non-clinical information in rural home care situations is both likely and desirable; supporting the sense of social connectedness experienced by the older adult, contributing towards the development of the nurse/carer –client relationship and improving older adult well-being. However, it is recognised that there is potential for boundaries to become blurred and in some situations nurses and carers may need support to negotiate the divide between appropriate and inappropriate disclosure while maintaining a close relationship with the older adult.

KEY WORDS

Professional boundaries; nurse/carer - older adult relationships; rural

KEY POINTS

- Social connectedness is important for the well-being of older adults.
- Older adults value the social connectedness provided by their nurses' and carers' visits.
- Social connectedness is enhanced through longer-term caring relationships.

- Nurses and carers may face challenges around maintaining appropriate professional boundaries, especially in rural areas.
- Some sharing of personal and social information by the nurse or carer contributes towards the development of the nurse/carer - older adult relationship and improves older adult well-being.

INTRODUCTION

Social connectivity, a by-product of on-going relationships between two or more people within a community (Lucas, 2013), can have significant benefits to an individual's health (Wenger, 1997). In reducing the risk of social isolation, low self-esteem, loneliness and depression, social connectivity is associated with 'successful ageing' (Nolan, 2001). Combating loneliness in the community has received a great deal of attention in the media, particularly against the backdrop of an ageing population and social networks that diminish with age (Gierveld, 1998). Older people may become isolated due to: migration patterns, for example, having to move away from their 'home' community to enter sheltered or supported accommodation (Farmer et al, 2009); losing access to transport (due either to physical disability or inaffordability); or through existing co-morbidities such as chronic pain or Chronic Obstructive Pulmonary Disease (Skingley, 2013). These factors may be further compounded in rural areas where shops and recreational services are located a car or bus ride away and where communities are depopulated during the day due to the younger, working age population commuting away for work (Commission for Rural Communities, 2012).

Evidence suggests that older adults value regular visits from someone local with whom they can exchange 'news' and chat, and that this connection provides social contact to those whose mobility is restricted (Farmer et al, 2009; Heaslip, 2013). Older adults have rated the psychological support provided by their community nurses as being equal in importance to their clinical care (Sargent et al, 2007); indeed, relationships with carers and nurses may be crucial to the maintenance of social contact (Lucas, 2013). Nurses have described their relationships with their elderly patients in home

settings in terms of 'professional friendships' (McGarry, 2008) while older adults sometimes use 'kin-like' analogies to describe their feelings of emotional closeness and shared history with their nurses and carers (McGilton & Bocart, 2007; ibid).

However, while the value of engagement with others in meaningful relationships is recognised, there can be tensions in managing the boundary between professional and ordinary forms of friendship in practice (McGarry, 2008), particularly in rural areas where the health care providers may live in close proximity to clients and may move in the same social circles (Malone 2012). Drawing upon data from a recent Research Council UK funded project, this paper considers professional boundaries in a rural context from both older adult and health and social care provider perspectives and discusses the terms 'appropriate professional boundaries' and the 'needs of the patient' within these parameters.

CONTEXTUALISING THE NURSE / CARER-OLDER ADULT INTERACTION

Nurses aim for 'patient-centred communication' in their interactions with patients, defined by Stewart et al (2000) as providing a "relationship that focuses on the well-being of the individual". Disclosure of personal information to patients is not generally considered to be appropriate or therapeutic within the nurse-patient relationship and there have been a number of recent cases where nurses have been disciplined by the Nursing and Midwifery Council (NMC) for over-stepping this mark (Griffith and Tengnah, 2013). In addition, there are issues of personal privacy and personal safety that further warn the nurse against straying into personal territories, for example, nurses may feel anxious about divulging information that may lead to their address being found out in case this information is used to harass or recriminate. The NMC (2010) defines unprofessional behaviour as a "failure to keep appropriate professional boundaries" and elaborates to advise that the nurse should "refrain from undue familiarity" (NMC, 2012).

In rural areas it is acknowledged that health care workers may know their patients socially as well as professionally and that their professional role within the community is often visible and well known (Allan et al, 2008; Malone, 2012). 'Benign' boundary crossing in these instances, where some of the health care worker's personal information may be already known to the patient, may be unavoidable (Malone, 2012) and, it may be argued, enhance the healthcare workers' understanding of the context of their patients' lives and contribute to the strengthening of the nurse-patient relationship (McGarry, 2008). Conversely, boundary violations impair judgement and objectivity and have clear potential to be harmful to the client and the professional relationship (op cit). Negotiating the difference between the two may create tensions for the health care worker (ibid) and, within the context of the rural community nursing environment, this raises questions. In cases where the nurse-patient relationship can last months and potentially years, where the nurse and the patient may know each other outside of the healthcare environment and/or live within the same community - where does the professional boundary lie between what is acceptable and unacceptable disclosure of personal information and could it be argued that a certain level of sharing and engagement on the part of the nurse may be of benefit to some patients? Similarly, and equally as important, what is the patient perspective on this situation?

METHODS

EXPLORING OLDER ADULT PERSONAL AND SOCIAL INTERACTION

The data presented in this paper was gathered as part of a collaborative study between the University of Aberdeen and the Wales-based Institute of Rural Health. The study entitled - 'Technology to support Older adult Personal and Social interaction' (hereafter TOPS) was supported by the award made by the RCUK Digital Economy programme to the dot.rural Digital Economy Hub (award reference EP/G066051/1). The project was developed on the premise that personal and social interaction with providers is normally unplanned, a side-effect of care provider visits to

individuals' homes, not designed or costed as part of service provision; and as such often overlooked in the design of healthcare technologies. The aim of TOPS was to explore the nature and value of the relationship between older adults in chronic pain living in rural areas, and their health and social care providers, and to better understand the potential effect of technology, specifically eHealth technology, on that relationship. To address this aim, home-based observations and semi-structured interviews were conducted in remote and rural Scotland and Wales. This paper draws upon the Wales data component as derived from 16 semi-structured interviews and ten home care observations between older adults experiencing chronic pain and their health and social care professionals in rural Wales. Specifically, for this paper the personal and social interaction data is considered within the context of professional boundaries from both older adult and health and social care provider perspectives.

On being granted the necessary ethical approvals to proceed, purposive sampling was used to select two cohorts of study participants (in this case based in rural Wales):

a) Ten older adults aged between 60-79, living in a rural area, experiencing chronic pain (defined as pain or discomfort, that has persisted continuously or intermittently for longer than three months) and currently receiving regular (weekly) in-person visits to their home by health/social care providers.
b) Six health and social care providers (four community nurses and two carers) providing nursing or personal care to the older adults interviewed. These nurses/carers were observed during a home visit to the older adult and interviewed afterwards.

An overview of the circumstances of study participants is provided in Table 1. These individuals were all recruited through local community nursing teams.

Table 1: An overview of older adult and health and social care participants in the Wales study

No.	Sex / age	Health condition	No of years experiencing	No of years in area	Lives alone/ with	Care provided: formal	Health and social care provider interviewee

			pain		partner		information
1	Male Age: 60s	Motor Neurone Disease	1-5 years	Whole life	Lives with wife	One carer visits 3x daily	**Health and social care provider 1** Carer Years as carer: 1 Years in area: whole life
2	Male Age: 70s	Arachnoiditis	20+ years	20 years	Lives with partner	Community nurses visit once a week	**Health and social care provider 2** Community nurse Years as nurse: 16 Years in area: 10
3	Male Age: 70s	Spinal Stenosis & corda equine	20+ years	25 years	Lives with wife	Community nurses visit once a week	**Health and social care provider 3** Community nurse Years as nurse: 25 Years in area: 8
4	Female Age: 70s	Multiple Sclerosis & arthritis	11-15 years	9 years	Lives with husband	Two carers visit 2x daily Community nurses visit twice a week	**Health and social care provider 4** Community nurse Years as nurse: 30 Years in area: whole life
5	Female Age: 70s	Leg ulcers	1-5 years	Whole life	Lives with husband	Community nurse visits every other day	**Health and social care provider 5** Community nurse Years as nurse: 33 Years in area: whole life
6	Male	Parkinsons, spinal	1-5 years	1 year	Lives with	Two carers visit 4 x a	**Health and social care**

	Age: 70s	injury			wife	day	**provider 6** Carer Years as carer: 1 Years in area: 10
7	Male Age: 60s	Consequences of broken spine in youth. Leg ulcers	20+ years	25 years	Lives alone (divorced)	Two carers visit 3x a day	Observation without interview
8	Female Age: 70s	Muscular dystrophy Bipolar disorder	6-10 years	10 years	Lives alone (widow)	Mental health charity support worker visit once a week Home help once a week	Observation without interview
9	Female Age: 70s	Leg ulcers	6-10 years	Whole life	Lives alone (widow)	District nurse visits every other day	Observation without interview
10	Female Age: 70s	Multiple Sclerosis	20+ years	20 years	Lives alone (widow)	Two carers visit 3x a day District nurses visit daily	Observation without interview

On acquiring informed consent from all participants, ten older adults experiencing chronic pain and six health and social care professionals (four community nurses and two carers), all living and/or working in rural Wales, were interviewed (between February and July 2013). The interviews investigated the experiences of those living with and/or managing chronic pain and the nature and perceived value of the health/social care professional-patient interaction. Interviews lasted for between 30 and 70 minutes and were digitally recorded and transcribed verbatim.

All interview transcripts and observation notes were anonymised and then managed and analysed using Nvivo 9. Qualitative data analysis adopted an 'analytic hierarchy' design (Spencer et al, 2003) which enables an iterative analytical process that is open to emergent themes while maintaining links with the original data and context. A number of categories were revealed and combined into themes.

FINDINGS

Three interrelated themes are visible in the data. The first of these considers the development of the relationship between the health and social care professional and older adult over time and the interplay of factors that combine to form the relationship. The second theme elaborates on the home visit based interactions that take place within the relationship, in particular the value of non-clinical social components. Thirdly, the professional boundary issues that arise from the relationship and home visit interactions combination are discussed from both nurse/carer and older adult perspectives. For purposes of anonymity, person names included in the quotations used to illustrate findings have been replaced with randomly allocated pseudonyms.

EXPLORING THE STRENGTH AND LONGEVITY OF CARING RELATIONSHIPS

The close relationships that develop between older adults and their carers in community and long term care settings have been recognised within the nursing literature as providing therapeutic value to patients and professional satisfaction to health care professionals. McGilton and Boscart (2007) found that 'knowing each other' and 'feeling connected' are fundamental to the establishment of close relationships between carers and older adults in long term care, and furthermore that it can be very upsetting for older adults to feel that care providers are not interested in forming a close relationship with them, for example through only asking care-related questions. In the TOPS interview data, the older adults repeatedly express strong feelings of social and emotional connectedness with their health care providers, often established over long periods of time, and not necessarily solely within the confines of a chronic illness situation. With the exception of one older adult, all of the interviewees had been living for many years in their communities and sometimes knew their health care providers in previous, healthier days:

> *I mean Kerry, I've known since she was a little girl of about eleven years old. Bryony, she used to go to school with my kids. … I've known these people all their lives.* (Older adult 7)

Having fewer health and social care providers and knowing them for longer was associated with stronger relationships. For those being visited regularly, having as many as 10 – 12 'known' carers did not appear to hamper the development of strong relationships between the older adult and their carers, although within that pool the older adult would generally express some personal preference for particular carers on the basis of shared interests, length of time of knowing them, a special rapport or appreciation of specific caring or professional qualities.

The nurses themselves reported low staff turn-over within their teams and each had a minimum of ten years of experience of working within the same community which meant that they had often had experience of supporting the older adults, or other members of their family, over more than one occasion of illness.

SOCIAL CONNECTION: THE 'VALUE' OF NON-CLINICAL CHAT

Non-clinical chat encompasses a wide range of topics of mutual interest to both the older adult and the health care professional. Topics mentioned by the participants of this study included: community 'happenings' for example, new building developments, county shows; news or 'gossip' already in the public domain i.e. the local press, concerning local people; topics of common interest such as gardening or the impact of the weather on livestock or crops; and updates on family members or activities such as weddings, holidays and children. McGarry (2008) found that community nurses felt better able to understand their patients as individuals through nursing them in their own homes, surrounded by all the artifacts of a lifetime's interests and relationships. The home-based observations carried out as part of the TOPS study support this finding, with nurses and carers seen to make conversation in response to environmental prompts that would be unavailable to them in a hospital setting.

The health and social care professionals recognised the link between social isolation and chronic pain and perceived their company and conversation as having a therapeutic value in its own right, helping to provide a distraction from pain and supporting the well-being of their patients:

> *If they don't see many visitors they can get set on pain sometimes, don't they, so usually … you come in - 'hello, how are you nurse, good morning' and you try to say about the weather and different things and sometimes they forget about their pain, you know? So you wonder sometimes how much is the pain pain or is it company they need?* (Health and social care provider 4)

> *I guess because you are providing the treatment and you've built up a relationship and you tend to chat to them about their lives and their families and they talk to you and I just think it's important that you don't just go in and actually [just] do the visit and dressing and don't …. you know you just can't, it's part of the treatment basically and makes them feel better.* (Health and social care provider 5)

Research has highlighted the value of distraction and humour in improving psychological well-being (Blomqvist and Hallberg, 2002) and in managing chronic pain (Houston et al, 1998). Acute and severe pain can make a patient withdrawn and uninterested in general conversation, whereas chronic, unrelenting pain is 'lived with' and techniques for dealing with this type of pain, including humour, conversation, distraction activities and meditation were all mentioned by the older adults in this study as means of dealing with their situation.

> *It's nice to get away from the subject of what you've got wrong with you because …. you are in pain all the time so you can't really forget that you've got something wrong with you but it's nice to have a different outlook and a different conversation to what you normally have.* (Older adult 5)

No longer able to fully participate themselves, the older adults valued the social contact with their nurses and carers in terms of feeling connected with life outside the home and for providing an opportunity to experience the world through another's eyes via a 'normal conversation':

> *I see the carers as really an anchor to reality. These are ordinary bods out there doing things who bring their world into me…* (Older adult 6)

The health and social care providers themselves expressed sensitivity to this desire on the part of their patients to hear about the outside world and tried to feed that interest:

> *I've got a little lady who lives not far from the church, now she used to be a regular church warden but she can't get there any more so I always try and find out if there's something going on, like there was a flower festival there … and try and tell her about that. You can see her face lightens up when you tell her, and it does help to talk about something else.* (Health and social care provider 6)

It was perceived by the health care providers that taking the time to chat for a few moments also demonstrates to the older adult that the professional values them as an individual, especially since it is appreciated by their patients that they have a busy and heavy workload.

> *If they are very busy I don't expect them to stop five minutes and talk but they always just seem to find time… they just tell you a bit of news, which is good, because if you don't see a lot of people five minutes makes a lot of difference, a lot.* (Older adult 9)

'Having time' in the sense of being interested in someone or making them feel valued is described by McGarry (2008) as conducive to the development of close relationships between the patient and health professional, a scenario favoured by a home (care) environment where relationships can develop over long periods.

MAINTAINING APPROPRIATE BOUNDARIES

Research suggests that boundary crossing between personal and professional aspects of the nurse-patient relationship may be commonplace in home care situations (ibid) and unavoidable in rural practice, although this does not equate to inappropriate behaviour; Malone (2012) states, in fact, that these could be considered a 'normal and healthy part of rural living'. The nurses and carers in this study identified a number of situations where they faced professional boundary decisions, firstly establishing a balance regarding the amount of information that older adults may be requesting and how much the nurse or carer is willing or able to divulge about themselves:

> *From a professional point of view, you don't really want the patient to know too many details about you … But they will ask you 'have you got children nurse?' and then when you say yes you have, they ask 'how many?', 'and you know 'what are their ages?' and then 'what are their names?'. Do you go as far as that?* (Health and social care provider 3)

The nurses and carers use their professional judgment and experience to determine how much information to provide and assimilate factors such as how well they know the older adult already and the likelihood of this personal information being shared with others.

A second boundary issue concerned situations where patients may know of other older adults being visited by the nurse or carer and may ask for an update; the health care professionals were very clear as to how they should behave in this situation:

> *… patients do like to bring personal information into the conversation that isn't their personal information but it concerns their neighbour for instance ... and that is where I do become very professional and try to point out to them that I can't tell 'Mrs Jones' about their medical situation or what we do for them and so therefore I wouldn't like to speak about 'Mrs Jones' to them.* (Health and social care provider 3)

However situations do occur in rural areas where it can be difficult to determine what is or is not 'crossing the line' especially if there are some recognisable benefits in adopting a pragmatic stance:

> *... the patient we've just seen now used to be the milk woman so she used to say 'well I don't know, Mrs So and So's curtains are drawn' … And sometimes perhaps we'd just say to her 'she's in hospital' so she'd stop delivering the milk until …. You know? It's not confidential… it is confidential but you know what you can say to certain people and it's just … you wouldn't want the milk stacking up or something.* (Health and social care provider 5)

The health care professional may have to take a disclosure decision on the basis of expediency which may be at odds to a 'black or white' understanding of professional boundaries. Mediating the difference between a *boundary crossing* and a *boundary violation* takes both skill and experience, and should be carried out on a case-by-case basis dependent on context (Malone, 2012). Clearly, this will be negotiated to some extent by the personal preferences of the health care professional and their understanding and interpretation of a given situation.

DISCUSSION: STRIKING THE BALANCE?

The nurse/carer and older adult relationships observed in this study had mostly developed over a lengthy period of time and were strengthened by a common knowledge of a rural community in which professionals and clients lived and/or worked. The findings suggest that sharing 'some' personal and social information during the nurse/carer and older adult interaction helps to build trust and can establish common ground for conversation about non-health related subjects. This in turn makes patients feel valued, and has the potential to improve social connectedness and psychological well-being. This concurs with other studies in this field, for example, McGilton and Boscart's (2007) research into the nature of relationships between carers and residents in residential care settings found that the carers who reported having more close relationships with residents, were also more likely to say that they had more conversations with residents about each other's families and personal matters.

Nurses can become very close to their patients in long-term caring relationships and this closeness is, on one hand, one of the great rewards of community nursing practice, but as highlighted in this study such relationships can provide challenges for the health care provider in trying to maintain professional boundaries, keeping their own personal life private and protecting the confidentiality of their other clients within the same community. "Boundaries are mutually understood, unspoken physical and emotional limits of the relationship between the patient and the nurse" (Farber et al, 1997) and elderly patients are extremely vulnerable to boundary violations. The difference between a caring relationship and an over-involved one is narrow and may be particularly difficult to negotiate in rural communities where social, business, and caring relationships commonly overlap.

These challenges are not fully considered in British nursing literature and there is a danger, within the current climate of recriminations about poor standards in health care settings, that nurses could become inhibited in their interactions with patients for fear of behaving inappropriately. A close nurse-patient relationship should be the strived for aim of health care professionals' interactions and nurses may need support in developing the skills to recognise the difference between appropriate and inappropriate self-disclosure. Equally, the social value of the health care professionals' visit in supporting the well-being of older adults being cared for in the community is underexplored at a time when demand for community-based health services for the elderly is increasing.

This paper reports data from a small scale study that took place within a stable rural community with low rates of inward and outward migration and with few alternative options for health-care professional employment. It is recognised therefore, that some of the issues relating to long-term caring relationships and rural personal/professional overlapping relationships may not have resonance in all settings. However, it is likely that the findings are relevant to community nursing

environments where older adults are socially isolated and dependent on their health care professionals for social interaction.

CONCLUSION

Caring for chronically ill older adults in rural communities creates a different set of conditions to those which exist in acute care settings. Relationships can last for months or years and may have a long-standing non-health setting dimension, as such professional and private boundaries can become blurred. However, nurses should feel confident that being sociable and having non-clinically orientated conversations can be important for supporting psychological well-being amongst their older chronically ill patients and this can hold as much therapeutic value as the intervention itself. The caveat is that it is crucially important that the community nurse understands what is meant by 'professional boundaries' and the difference between appropriate and non-appropriate self-revelations.

Since close relationships between older adults and their health care professionals have been found to enhance well-being and to support positive health in older age, nurses should be encouraged and supported to develop these relationships to the extent that they feel comfortable. In some working environments staff are rotated regularly in order that close relationships do not have a chance to develop – an approach deemed to protect staff from distress in the event of their patient dying. Health care professionals themselves may pull away from relationships to protect themselves from becoming hurt although the counter scenario might be for employers to acknowledge the emotional connection of involvement and to support staff as necessary. Findings from this study demonstrate that there are compelling arguments to support the development and nurturing of close nurse-patient relationships and that such relationships can benefit both health care professional and patient.

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