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How Home Care Communication Adapts Over Time to Meet Clients' Needs: A Case Study of Home Care Constellations

by

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ABSTRACT

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Home care is an invisible, yet essential component of the health care system in Canada (Hewko et al., 2015). It is a complex, interdependent, and interactional process involving clients, families, and home support workers (HSWs) (Shaw et al., 2021) referenced as care constellations in this research. Every home care interaction involves communication (Gustafsson et al., 2021), therefore communication in home care is critical because it facilitates both task-based and psychosocial needs of clients being met (Höglander et al., 2020). Another essential principle in home care is the centrality of the client – namely person-centred care (PCC). Communication is a key component of a PCC approach, yet few studies have focused on communication in home care (Sundler et al., 2016; Kristensen et al., 2015).

Using longitudinal secondary data (28 semi-structured qualitative interviews) from the Home Care Pathways Project (Keefe et al., 2020) and framed by person-centred care and critical relational theory, this study examined communication within two Nova Scotian care constellations and how communication adapted over time. An additional research question assessed how and if factors such as societal, structural, political, and historical factors influenced communication within the care constellation. Data analysis of each case was performed using thematic and temporal analysis of the qualitative interviews. A cross-case analysis between the two constellations revealed similarities and differences in the themes.

Findings revealed three key themes. One temporal theme was identified in both cases: formal communication processes may or may not meet clients’ needs. Also, in constellation 1, the theme ‘the role of conversations in meeting clients’ psychosocial needs’ emerged and in constellation 2, the theme, ‘communication associated with maintaining independence’ was identified. The COVID-19 pandemic was a contextual factor that negatively impacted the health of both clients. Structural factors including a focus on safety, lack of accountability and time constraints were found to be barriers to client-centred communication. As noted in previous research, as the least powerful members of the caregiving network, HSWs and clients were the most depended upon for communication of clients’ needs (Funk et al., 2022).

Implications of the study include recommendations for how to improve the education and training of home support workers as well as policy changes to enhance the delivery of client-centred care at both the organizational and systemic levels. Although specific to Nova Scotia, the findings will be of interest to other jurisdictions looking to improve home care communication within a client-centred care model.

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Chapter 1: Introduction

Home care is an invisible, yet essential component of the health care system in Canada (Hewko et al., 2015). In 2021, approximately 6% (881,000) of all Canadian households reported having received home care services in the previous year, with a higher proportion reported in Nova Scotia compared with other provinces (8%) (Statistics Canada, 2022). Demand for home care services is expected to grow with the aging population and care needed, to become more complex (Ganann et al., 2019). Nova Scotia has an aging population with 22.2% of the total population aged 65 years and older (Government of Nova Scotia, 2022). In 2018, of the three million people in Canada who reported receiving care at home, most were female, and changes related to aging were the most common reason for care (Statistics Canada, 2020). Reasons attributed to the gendered use of home care services include that women access care earlier in their trajectory than men, perhaps because they are more familiar with and accepting of care due to the gendered role of caregiving, and have less medically intensive needs better suited to home care services compared to men (Gruneir et al., 2013). As well, older women are more likely to live alone and depend on a formal caregiver for help because they live longer than men and are often widowed (Reppas-Rindlisbacher et al., 2022).

Home care, is a complex, interdependent, and interactional process involving clients, families and home support workers (HSWs) (Shaw et al., 2021). Individually they may be referred to as actors in the process and collectively, as caregiving networks (Ris et al., 2019), care convoys (Lambotte et al., 2020) or care constellations (Keefe et al., 2020). Multi-level societal, family and individual factors influence home care such as the community, social relationships, informal support, personality and life experiences (Kemp et al., 2013). Important to the context of home care is the fact that the physical, social and symbolic meanings of home are contested as the client’s private home space becomes both the place of care (Wiles et al., 2012) and the place of work for HSWs (Leverton et al., 2019).

Overview of the Home Care System in Canada

Given that home care is not included in the Canada Health Act (Government of Canada, 2016), wide variations exist between provinces with the home care services that are offered (Cloutier et al., 2015). Assistance with the activities of daily living (ADLs) (e.g., dressing, bathing, toileting) and the instrumental activities of daily living (IADLs) (e.g., cooking, laundry and light housework) are generally provided by HSWs also referred to as home care workers, personal support workers, home health aides or other terms (Cloutier et al., 2015). Home care services in Nova Scotia include assessment, case management, nursing services and home support services including personal care, meal preparation, light housekeeping, and respite (see Appendix A) (Government of Nova Scotia, 2011). According to the Canadian Home Care Association (2011) the definition of home care in Nova Scotia is:

> an array of services for people of all ages, provided in the home and community setting, that encompasses health promotion and teaching, curative intervention, end-of-life care, rehabilitation, support and maintenance, social adaptation and integration, and support for the family caregiver.

In addition to assisting with ADLs, HSWs report that they also monitor clients’ symptoms (Sterling & et al., 2018), provide emotional support and navigate complex relationships as interrelated components of home care (Leverton et al., 2019). Official policy documents and job descriptions often focus only on the physical aspects of the work and neglect to include the emotional aspects (Denton et al., 2015). These non-clinical supportive home care activities are distinct from clinical home nursing services provided by licensed practical nurses (LPNs) or registered nurses (RNs) (Ganann et al., 2019).

The economic climate in Canada and the long-term durability of the healthcare system demand solutions as to how care will be provided for the rising number of older adults. Governments in Canada and around the world are creating home and community care policies that support aging in place (AIP) as vehicles to reduce health care expenses because long-term care (LTC) is very costly (Ouden et al., 2021). Aging in place, defined by the Canadian government as “having the health and social supports and services you need to live safely and independently in your home or your community for as long as you wish and are able” (Channer et al., 2020, p. 1), is the preference of most older Canadian adults (Lee et al., 2020).

Communication in Home Care

Communication is a complex phenomenon described as “the moment-by-moment exchange of thoughts, feelings, needs or other information between two or more people through speaking or non-verbal methods such as sign language, sounds, gestures, movements or expressions” (Ennis et al., 2019, p. 2263). It involves verbal and non-verbal actions between individuals in a relationship where one person sends signals interpreted by another person. Communication encompasses more than information exchange; it is also an acknowledgement of emotions (Ennis et al., 2019). Environmental, societal, political, and historical factors influence how verbal and non-verbal signals are perceived by individuals or actors (Ennis et al., 2019).

Communication within care constellations is facilitated by dynamic relationships built on trust essential for the care of clients (Reckrey et al., 2020). Every home care interaction involves communication (Gustafsson et al., 2021). The isolation of workers is a key feature to home care communication as working alone without face-to-face contact with other HSWs or a supervisor contributes to communication challenges with both colleagues and clients, and can negatively impact client care (Beer et al., 2014). Communication in home care is important because it facilitates both task-based and psychosocial needs of clients being met (Höglander et al., 2020). The alleviation of unmet needs in these areas may positively impact health outcomes of clients (Höglander et al., 2020).

The Aim of this Study

Previous research supports the need for further studies that focus on communication in home care because it can positively impact the health of clients, improve satisfaction with home care services (Sundler et al., 2016; Kristensen et al., 2015) and improve job satisfaction with HSWs (Butler et al., 2014). In this study, I will explore how formal communication practices meet clients' needs and adapt over time from the perspectives of home care clients, family caregivers, and HSWs. In my study, I have defined formal communication as administrative reporting mechanisms between HSWs and agency supervisors; assessment procedures; and processes that clients or family caregivers must follow to initiate changes to care plans. I will also explore the role of conversations in meeting clients' needs. Analysis of the perspectives of home care agency supervisors and care coordinators will further enhance the understanding of policies and practices that influence communication between individuals. I will also strive to understand if and how societal, political, and historical contextual factors affect home care communication.

Chapter 2: Theoretical Framework

This study was informed by person-centred care (PCC) and critical relational theory. I used a critical relational theory as a valuable lens to frame the analysis of person-centred communication practices in the home care of older adults, the factors that influence communication between actors (e.g., environmental, societal, political, and historical) and how communication adapts over time to meet clients' needs. To do so, I paid particular attention to instances of power imbalance in the relationships between the actors, their social position, and contextual factors including policies that guide the delivery of home care services in Nova Scotia. As well, as COVID-19 was a historical event that impacted all of society, the role it played in communication between the actors was of particular interest to my case study.

Person-Centred Care

Efforts to improve quality of home care services have been growing with policy makers implementing policies and practices within a person-centred care model (Backman et al., 2016), an approach synonymous with excellence in health care (O'Rourke et al., 2019). In more recent years, person-centred care has also become best practice for home care (Sanerma et al., 2020). Research has demonstrated that PCC improves quality of care and outcomes for older adults (e.g., improved functional abilities) (Ebrahimi et al., 2021). Positive effects of PCC for HSWs have also been demonstrated including greater job confidence, improved scheduling, and relationships with clients that support job satisfaction (van Diepen et al., 2020).

At the core of person-centered care is personhood, described by the late Tom Kitwood in his seminal work on PCC, as "a standing or status that is bestowed upon one human being by others in the context of relationship and social being” (Vernooij-Dassen & Moniz-Cook, 2016, p.667). Furthermore, McCormack, another primary scholar on PCC, posits that relationships are at the core of PCC (McCance et al., 2011). There is no one accepted definition of PCC, variations in understandings of how to operationalize PCC are prevalent (Ebrahimi et al., 2021; Entwistle & Watt, 2013) and the terms person-centred and client-centred care are often used interchangeably. Sanerma, Miettinen et al. (2020, p.369) in their integrative review of client-centred care in home care for older persons states that client-centred care is defined as:

> …an approach to practice established through the formation and fostering of therapeutic relationships between all care providers, patients, and others significant to them. It is underpinned by values of respect for persons, individual right to self-determination, mutual respect and understanding.

PCC also acknowledges family caregivers as members of care constellations with their own unique needs and abilities (Ebrahimi et al., 2021; Smith-Carrier et al., 2018).

Despite the widespread acceptance of PCC as best practice, it remains difficult to achieve in reality (Smith-Carrier et al., 2018). Barriers to implementation of PCC include the need for theoretical clarity for the development of practical approaches (Wilberforce et al., 2017). Several review articles have explored essential attributes of person-centred care in different healthcare contexts. Although various attributes of care have been set forth as important, there is no universal consensus on what constitutes PCC, and how to implement or measure it. Organizational structure including the culture and policies can also pose barriers to the implementation of PCC (Höglander et al., 2020; Kristensen et al., 2017). What is essential to client-centred care in home care for older persons include:

understanding the person; collaborating with and involving the client in care decisions and creation of care plans; relationship building both with the client and their family members; and communication in friendly, caring, and respectful interactions (Ebrahimi et al., 2021; Ezhova et al., 2020; Sanerma et al., 2020; Wilberforce et al., 2017). Evaluation of client-centred care should include clients' and family members' perceptions of quality of communication, participation, and trust (Sanerma et al., 2020).

History of PCC

Various nomenclature of 'centredness' has evolved over the decades but they all focus on a holistic view of the person and share the philosophy that individuals are unique and have agency (Wilberforce et al., 2017). Client-centred care originated first in psychotherapy in the 1940's and was highly influenced by Carl Rogers who was instrumental in altering how therapeutic relationships are construed (Rogers, 1956). Patient-centred care which followed client-centred care was first conceptualized in 1969 to mean "understanding the patient as a unique human being" (Santana et al., 2018, p. 430). Patient-centred care evolved into person-centered care in dementia envisioned by Tom Kitwood in 1988 as a theory that linked relationships, interconnectedness, and communication between people as fundamental concepts (Vernooij-Danssen & Moniz-Cook, 2016). In the early 2000's, person-centred planning which promotes choice and control over services in the context of the independent living movement was established (Wilberforce et al., 2017). By 2013, client-centred care was emerging as the preeminent philosophy in home care but communication challenges between practitioners and care providers was a challenge to its' full integration; nonetheless client-centred care provided hope to improve health outcomes and quality of life for older adults with chronic conditions receiving home care services (Wilberforce et al., 2017). To counter concerns with implementation of PCC, Nolan et al. (2013) developed the concept of relationship-centred care with the Six Senses Framework that values interdependence and reciprocal relationships, and promotes security, belonging, purpose, and achievement for all participants involved in the care of older adults. In my study, the terms person and client-centred care are used interchangeably to refer to the same concept that has a holistic view of the individual.

The Aim of PCC

The aim of PCC is to problematize the paternalistic assumptions and traditions of biomedicine with its' disease-focus and traditional roles with healthcare professionals as decision-makers and individuals as passive recipients (Naldemirci et al., 2018). Throughout the decades, PCC has created a culture shift from a provider-driven model of care to a model underpinned by "care that is respectful of and responsive to individual patient preferences, needs and values" (Olsen et al., 2019, p.1992) and includes the person's social and cultural background (Naldemirci et al., 2018). PCC also challenges the power dynamic between health care provider and client with a focus on individual autonomy and empowerment as well as empathy, respect, and shared decision-making (Ebrahimi et al., 2021). Although individualized care is one component, PCC places an emphasis on social and interpersonal relations (Naldemirci et al., 2018) with the goal being a meaningful life for the client built upon an interpersonal relationship (Ebrahimi et al., 2021).

Person-Centred Communication

Person-centred communication is defined as “a set of skills of the health provider demonstrated through verbal, paraverbal and non-verbal communication that facilitates person-centred care” (Hafskjold, Sundler et al., 2015, p. 2). Communication is an essential element of PCC (Gustafsson et al., 2021; Yue et al., 2020) and a prerequisite for quality home care (Leverton et al., 2019). The home is a unique and complex environment in which clients strive to maintain independence and HSWs must navigate challenges of providing client-centred care based on person-centred communication while maintaining awareness of power imbalances in the relationship (Sundler et al., 2016).

Although there is no consensus on best practices to enable client-centered communication in the care of older home care clients, the attributes of recognizing the person by showing interest in them; having a friendly approach and managing small talk; involving clients in their care by sharing and asking for their view and striving for equality; and listening and responding to emotions are considered central to client-centred communication (Sundler et al., 2020). As well, information sharing between home care clients and HSWs is critical to successfully assist with ADLs (Olsen et al., 2019) and information must be presented in a clear format (Wilberforce et al., 2017).

Critical Relational Theory

As home care is defined as a complex, interdependent, and interactional process between care constellation members (Shaw et al., 2021) and communication is a process between two or more people, a theory that illuminated relationships was deemed desirable and beneficial to the analysis. Relational theory was selected as it is a lens by which care can be examined as “acts take on meaning in relation to each other, to the patient’s needs and to the health-care systems and can be understood as the inter-relational achievements of people, as well as the technologies and concepts they use” (Bjornsdottir, 2018, p. 178) and as such, is very complementary to person-centred care. Person-centred care lacks theoretical development and therefore was insufficient as the sole theoretical approach to my study.

In their seminal work, Downie & Llewellyn (2008, p. 197) describe relational theory through the concept of self as “continuously shaped by the context of multiple relationships with other individuals and institutions - some of which can promote flourishing and some of which can oppress”. Relational theory also requires a look at the socio-cultural context (e.g., workload and policies) in which clients and HSWs find themselves in (Ward-Griffin et al., 2012), another important advantage of incorporating relational theory into my analysis.

Glasdam (2013, p.331) explained that critical relational theory as described by Bourdieu means to study the issue “in a relational way that takes into account the structural framework in which it unfolds” and to pay particular attention to the social position of the actors (e.g., their orientation that guides how they speak, think and live) as well as power in the relationship. The structural framework in my study includes the government and home care agency with the system policies and procedures, management practices, organizational culture and leadership that oversee the organization and delivery of home care services. The inclusion of contextual factors such as social, cultural, economic, and political factors in critical relational theories highlight potential changes to policies and practices that would better facilitate client-centred care (Durocher et al., 2015), the reason why the critical component of this theory is vital. As described by Funk et al. (2022), the critical relational lens focuses on the interdependent interactions and relations of actors in home care constellations and is relevant given the temporal nature of home care services, and the temporality of my study.

The purpose of a critical theory approach is to draw out themes during the analysis that are connected to unequal power relations (Lawless & Chen, 2019). Critical theory is differentiated from other theories with five distinct characteristics: It is grounded in political analysis of the commodity exchange economy of capitalism; it is concerned with providing understanding that frees people from despotism; humans support the philosophy that there is a better way to live; it is normatively grounded in a vision for a more democratic society; and the theory is only authenticated when the desired social change is attained (Brookfield, 2005). Critical theories are also grounded in assumptions including that people’s values and perceptions of themselves are products of social conditions; people frequently blame themselves for their oppressive circumstances; and critical theories can result in personal and structural transformation (Norris, personal correspondence, 2021, May 11), the ultimate intent of this study.

Chapter 3: Literature Review

In this section I review the literature on communication within care constellations from the perspectives of home care clients, family caregivers, and HSWs with a focus on how communication adapts over time to meet clients' changing needs and barriers to communication. I begin with literature on the effects of the COVID-19 pandemic on care constellations.

The COVID-19 Pandemic

In 2020, the world was dramatically altered by the novel coronavirus disease (COVID-19). The World Health Organization declared COVID-19 a global pandemic on March 11, 2020 (Cucinotta & Vanelli, 2020). Soon thereafter, the government of Canada took action to protect Canadians with the COVID-19 Emergency Response Act (Government of Canada, 2020). The province of Nova Scotia reported its' first presumptive case on March 15, 2020 (Government of Nova Scotia, 2020a) and declared a state of emergency on March 22, 2020 (Government of Nova Scotia, 2020b). The Nova Scotia government implemented several strategies including patient screening processes by frontline health care professionals; public health and infection control measures; sharing accurate, up-to-date information; and managing supplies and resources (Government of Nova Scotia, n.d.).

COVID-19 disproportionately affected older adults (Guest & Peckham, 2022; Applegate & Ouslander, 2020; Yang et al., 2021). Loneliness and isolation during the pandemic was a major public health issue (Guest & Peckham, 2022; Armitage & Nellums, 2020; Cheung et al., 2020) putting older adults at increased risk of cardiovascular disease, disability, cognitive decline and mental health issues and loss of autonomy (Ayalon et al., 2020; Prakash et al., 2021; Yang et al., 2021).

Furthermore, older adults receiving home care services and their families were affected by the pandemic (Eide et al., 2021; Pentaris et al., 2020; Phillips et al., 2020; Prakash et al., 2021; Weeks et al., 2021). Many individuals experienced a reduction or cancellation to homecare services because of home care staffing shortages and policies that prioritized clients' needs which resulted in unfulfilled household tasks, laundry and meal preparation and challenges in meeting basic needs (Federman et al., 2021; Pentaris et al., 2020; Rowe et al., 2020). Some clients also put services on hold out of fear of contagion (Rowe et al., 2020). In Nova Scotia, Department of Health and Wellness (DHW) implemented several policies around the delivery of care to clients in home care including the Emergency Response Level (ERL) protocol that determined the prioritization of services.

The increased responsibility to help clients meet their needs fell on family caregivers. Women, in particular, were expected to bear additional responsibilities outside work hours including unpaid care work of older adults within their families (Power, 2020). Some family caregivers reported increased psychological stress during the pandemic due to caregiving (Chan et al., 2020). Fear of infection along with mandates to social distance and restrict visits may have kept family members from providing care in some cases (Chan et al., 2020; Pentaris et al., 2020; Prakash et al., 2021). On March 22, 2020, Nova Scotians were asked to only leave home for essential reasons like grocery shopping (Government of Nova Scotia, 2020b). It was not until May 15, 2020, that the government introduced the family bubble, where two family households could come together without physical distancing. Individuals were asked to consider age and health of all members when choosing a household to connect with (Roth et al., 2020).

Home support workers were also affected early in the pandemic by staffing shortages, management issues (e.g., PPE supplies), and policies to screen clients and implement precautions in clients' homes (Rowe et al., 2020). On April 14, 2020, front-line workers in Nova Scotia including workers of home care agencies were required to wear masks (Roth et al., 2020). Two groups of clients devolved during the pandemic: those whose services were put on hold either by the agency or the client, and those who continued to receive services. HSWs reported a financial impact on their income as a result of having fewer clients on their schedule (Rowe et al., 2020). When HSWs did go into clients' homes to deliver services, they reported having to use detailed screening and surveillance procedures and PPE to protect both themselves and the client (Rowe et al., 2020). For clients who continued to receive services, HSWs reported concerns around physical distancing measures that prohibited comforting touch for clients and its' associated compassion as an impact of the pandemic (Eide et al., 2021; Markkanen et al., 2021). Some home care providers felt that while they provided life-sustaining care to people with chronic diseases, mental disorders and disabilities, their challenges were largely ignored by the policy response that overlooked the home care context (Chan et al., 2020).

Barriers to Person-Centred Communication within Care Constellations

Two significant barriers to communication with home care clients of relevance to my study include the organizational context and diverse communication competencies and limited disease-specific knowledge among HSWs.

Organizational Context

The ability of HSWs to deliver person-centred care depends heavily on the organizational context (Höglander et al., 2020) including the culture of home care organizations which can affect person-centred communication within care constellations (Kristensen et al., 2017). Typically, home care tasks are scheduled under tight time constraints that do not allow for relationships to develop, which is a barrier to communication (Breen, 2020; Jakobsen & Lind, 2022; Lundgren et al., 2020; Olsen et al., 2019). HSWs found communication improved when more time was allocated allowing them to tend to the person's social needs while not having to rush to complete their tasks (Nielsen & Jørgensen, 2016). Increased length of visits allowed for greater observation of the client's condition by HSWs and improved documentation of the individual's particularities (Aasgaard et al., 2014). Allowing time for relationship-building facilitates person-centred communication between clients and HSWs (Sundler et al., 2016).

HSWs cited lack of communication and information from the agency about changes to a client's condition as a barrier to communication. Poor communication between HSWs and their employer was found to negatively impact clients' service provision (Ganann et al., 2019) and was a key reason why workers left their jobs (Butler et al., 2014). Communication between workers of a client can be happenstance and how much is written down varies greatly (Bratteteig & Eide, 2017). HSWs were sometimes frustrated by the fragmented communication between team members especially if the client's condition deteriorated (Breen, 2020; Saari et al., 2017; Sterling & et al., 2018). HSWs coveted improved communication with peers and supervisors (Breen, 2020; Francescato et al., 2017) which was positively associated with job satisfaction and facilitated execution of the care plan (Vanderboom et al., 2014). Conversely, poor communication among team members created health care risks for the client (Ganann et al., 2019). Team meetings and other opportunities were cited as helpful to bring HSWs together to stay informed and problem solve (Breen, 2020; Francescato et al., 2017). HSWs also wished for improved communication around end of life and for the supervisor to provide them an opportunity to talk about their feelings (Gleason et al., 2016; Tsui et al., 2019). In addition to barriers at the employment level, communication barriers between government and HSWs also exist including lack of information shared about the client's diagnosis from the assessment process (Savundranayagam et al., 2020). The shortage of HSWs was considered a governmental barrier to the practice of person-centred communication (Savundranayagam et al., 2020).

Organizational policies and practices that focus solely on task-oriented communication obscure the significance of relationships (Tsui et al., 2019) and neglect to recognize that the client's ability to participate in their care and express their desires might depend on these relationships (Naldemirci et al., 2018). Task based policies also underrecognize the importance of relationships to HSWs and create incongruity with client-centred care dependent on compassionate, intimate one-on-one relationships (Tsui et al., 2019). Organizational policies that emphasize caring attitudes toward clients, value HSWs as important team members and encourage relationships, contribute to an organizational culture that facilitates best practices in communication (Johnston & Womack, 2015). Wilberforce and colleagues (2017) suggest that the policy context of organizations has focused too strongly on autonomy and individualism of client-centred care, negating the interpersonal and relational nature of home care work.

Varying Communication Competencies and Disease Specific Knowledge Among HSWs

There is a wide variety of communication competencies among home care staff (Gustafsson et al., 2021; Reckrey et al., 2020). Research has shown that student nurses and HSWs emphasized traits such as getting to know the individual, giving respect, listening, providing choices and responding to emotional expressions as important to client-centred care but the results revealed little understanding of the complexity of communication (Hammar et al., 2017; Olsen et al., 2019). HSWs also shared instances when they overrode decisions of clients because they felt they knew what was best for the client (Olsen et al., 2019).

There are many unpredictable variables in the home care environment including clients' needs that fluctuate suddenly (e.g., congestive heart failure) (Sterling & et al., 2018) or changes that are more subtle and difficult to recognize including depression (Jakobsen & Lind, 2022; Sims-Gould et al., 2013). HSWs vary in their knowledge of chronic diseases (Russell et al., 2017) and abilities to care for clients with specific conditions (Saari et al., 2017). It has been posited that communication training and disease specific information should be included in HSW training programs (Russell et al., 2017).

How Home Care Communication Adapts Over Time

As relationships between home care clients and HSWs are often long-term, HSWs are in an ideal situation to observe changes in clients' chronic conditions possibly influencing health outcomes (Denton et al., 2015; Reckrey et al., 2019). Continuity of HSW over time with the same client is a factor that enables HSWs to become familiar with possible changes to a client's health status and to respond appropriately (Aasgaard et al., 2014; Sims-Gould et al., 2013). Yet there is little research on how home care communication changes over time to meet the needs of older adults with chronic health conditions (Reckrey et al., 2020).

A longitudinal study by Ellington et al. (2018) examined changes to communication between home hospice nurses, clients with cancer, and family members. Conversation topics included education and training of family caregivers; everyday topics of gardening, food, memories and holidays linked to client and family wellbeing; and talk pertaining to both positive and negative emotions (Ellington et al., 2018). Over time, a variability in discussions was observed rather than any one particular pattern of communication which was thought to be reflective of the nurse attending to the fluid nature of the client's condition and situation dependent on multiple factors (Ellington et al., 2018).

In a narrative study of one woman's experience with home care, she expressed frustration with new HSWs who did not have the correct instructions to help her and feared that she would not get appropriate care if there were changes in her condition due to communication issues (Jakobsen & Lind, 2022). Despite the important role that care plans play in communicating client information, HSWs reported care plans frequently lack details and prevalent information necessary for the delivery of quality care especially as clients' needs change (Jakobsen & Lind, 2022; Saari et al., 2017; Sterling & et al., 2018). Care plans also tend to be strictly task-based with limited information on the individual's psychosocial needs (Lämås et al., 2021).

Results of studies that explored communication in care constellations over time found that communication about changes in a client's health was dependent on various factors including the specific health change observed and the perceived seriousness of the change (Reckrey et al., 2019; Sims-Gould et al., 2013). Sometimes HSWs chose not to report a change for fear of overstepping boundaries and the client being angry with them (Reckrey et al., 2020). Other times HSWs reported changes because they felt it was the right thing to do or because of the agency's communication protocol (Sims-Gould et al., 2013). Improved communication with HSWs has been found to be a factor that enabled agency supervisors to be more aware of unusual or unexpected changes in a client's health (Breslin & Wood, 2016).

Communication between family members and HSWs varied from daily communication and updates via phone calls, text messages or daily logs to communication that occurred only when there was a significant concern in the client's needs (Reckrey et al., 2020). Families, especially those who do not live with the client, shared their appreciation of HSWs who updated them on their loved one's condition (Sims-Gould et al., 2015). Communication between family caregivers and home care coordinators was found to increase when the client's needs changed which allowed for adaptations to services (McCaffrey et al., 2015). The presence of a family member increased communication between members of a caregiving network (Sanerma et al., 2020). For clients without a family caregiver, communication with the care coordinator was viewed as even more vital (McCaffrey et al., 2015).

Interventions including the expanded use of technology to improve home care communication are being explored (Reckrey et al., 2020). Benefits of technology include better access to information and electronic health records across care providers which may result in improved monitoring of clients' chronic health conditions possibly reducing hospital and primary care visits (Ganann et al., 2019). HSWs are increasingly using tablets and cell phones to communicate their client notes. While it is believed that advances in technology will support better communication, HSWs have also reported it to be a barrier (Chelongar & Ajami, 2021; Saari et al., 2017). Paper notes kept in the home are sometimes more accessible than electronic based records, and HSWs have varying level of capabilities when it comes to implementing and using technology (Chelongar & Ajami, 2021; Saari et al., 2017).

Home Care Actors' Perspectives on Communication

Home Care Clients

Communication featured prominently as a desired and important characteristic of home care services by clients (Dostálová et al., 2022; Haex et al., 2020; Lines et al., 2018; Stuck & Rogers, 2019) due to the role it plays in interpersonal relationships, social interactions and quality of life (Dostálová et al., 2022). Clients wanted HSWs to socialize with them in a friendly manner and show an interest in their daily lives and stories (Lambotte et al., 2020; Stuck & Rogers, 2019). Social interaction helped with the development of trusting relationships which contributed to clients' emotional security (Denton et al., 2015; Kristensen et al., 2017). Acknowledgement of emotions is important and according to clients, empathy underpins care relationships (Dostálová et al., 2021; Lines et al., 2018).

Clients with verbal communication challenges expressed the need for HSWs to understand their non-verbal communication with their eyes or body language and to respond appropriately to their needs which contributed to their perceived sense of safety

(Schaepe & Ewers, 2017). This was particularly critical to clients who could not speak due to ventilation (Schaepe & Ewers, 2017) and clients with dementia (Riachi, 2017).

Clients want to be involved in their care and for HSWs to be willing to collaborate with them reinforcing personhood and autonomy as important to care interactions (Sanerma et al., 2020; While et al., 2020). Longer visits have been associated with a greater degree of person-centred communication indicating that time is needed to individualize communication (Aasgaard et al., 2014; Höglander et al., 2020). As well, lack of continuity with HSWs affected communication because clients disliked having to continually explain their routines and preferences to different HSWs who did not know their needs (Reckrey et al., 2020). They also disliked not knowing the schedule for their care in advance (Dostálová et al., 2021; Lines et al., 2018).

Family Caregivers

Family members also foregrounded the importance of ongoing communication with HSWs as a factor that reduced their stress and burden (Shaw et al., 2021). There was an association between satisfaction with communication and family member’s overall satisfaction with home care services (Ayalon & Roziner, 2016; Sanerma et al., 2020).

Family members desired to be visible within the caregiving network to avoid feeling like the ‘third wheel’ and to have their own needs recognized (Anker-Hansen et al., 2018; Greenwood et al., 2017). Families appreciated friendly, caring conversations with HSWs who shared compassion and empathy for both the client and themselves and desired relationships with the HSWs (Anker-Hansen et al., 2018; Shaw et al., 2021). They wanted to be involved in decisions affecting the care of their loved one and to communicate their own solutions to issues that arose (Anker-Hansen et al., 2018). To help them with decision making, they expressed a desire for more information exchange with HSWs and education on the client’s condition (Anker-Hansen et al., 2018). Family members, like clients, also placed a high value on continuity of care and consistency of HSWs as a factor that facilitated collaborative relationships based on trust, crucial to family members and HSWs working together to share the care (Anker-Hansen et al., 2018; Ris et al., 2019).

Home Support Workers

Engaging clients and family in small talk and sharing in conversations served as an entry point to client-centred care (Breen, 2020). HSWs shared that having a personal dimension to the client relationship can overcome communication challenges (Yue et al., 2020). Companionship was also seen to benefit the mental health of clients who just needed someone to talk to; a familiar person that made them feel secure (Reckrey et al., 2019). Conversations on a personal level also created meaning for workers and improved employee engagement (Nielsen & Jørgensen, 2016).

In regard to person-centred communication, HSWs described traits such as using language that is non-patronizing as important (Breen, 2020), as well as gestures such as giving a client a hug and making eye contact (Nielsen & Jørgensen, 2016). Empathy and emotional support also figured prominently in their meaning of work and in their interactions with both clients and families (Nielsen & Jørgensen, 2016). Communication was described as the channel for developing trust through non-judgmental interactions with the client (Yue et al., 2020). Humor and open communication were also important to HSWs (Haex et al., 2020).

HSWs perceived that family members can either hinder or help the labor they perform (Sims-Gould et al., 2015). On one hand, HSWs found communication with family particularly important to meeting client's needs (Sims-Gould et al., 2015). On the other hand, communication with family was strained when family were critical, aggressive or verbally abusive of the HSW (Ganann et al., 2019; Macdonald & McLean, 2018) or asked HSWs to perform duties outside of the care plan (Macdonald & McLean, 2018; Olsen et al., 2019).

Gaps in Knowledge

Communication is an essential characteristic of person-centred care for home care clients. Research has established the importance of communication, both task-based and affective, to home care actors, yet research in home care communication is limited (Hoglander, 2020; Sundler et al., 2016). Scholarship supports the need for further studies that focus on communication as key to client-centred care for older adults (Stuck & Rogers, 2019; Sundler et al., 2016). There is also a gap in knowledge on how to achieve supportive communication within care constellations (Anker-Hansen et al., 2018; Keeling, 2014; Sundler et al., 2016).

As the demand for home care grows, the collaboration between clients, family caregivers and HSWs will become increasingly more important to how home care is operationalized (Anker-Hansen et al., 2018; Wittenberg et al., 2019). Furthermore, because older adults have less social contact as they age, quality interactions and information exchange with HSWs increase in importance (Kajonius & Kazemi, 2016; Walsh & Shutes, 2013).

This research will add to current knowledge of formal communication processes as well as conversations between the actors (home care clients, family caregivers, HSWs, agency supervisors and care coordinators) to meet the changing needs of home care clients over time. The findings will be useful for supporting changes in home care communication, and education and training of HSWs. Although specific to Nova Scotia, the findings will be of interest to other jurisdictions looking to improve home care communication within a client-centred care model.

My research questions are:

1. What are the formal communication processes that help (or hinder) clients' needs being met? How do conversations between members of the care constellation meet the needs of clients?
2. How do the communication processes between the actors adapt over time with clients' changing needs?
3. What are the specific factors (e.g., societal, structural, political, and historical) that influence communication between actors within the care constellation?

Chapter 4: Methodology

This chapter explains the methodology of my study including the background, design, data analysis, researcher reflexivity and ethical considerations.

Background

Framed by person-centred care and critical relational theory, I examined communication between home care clients, family caregivers, and home support workers (referred to as actors) over time. To do so, I drew on secondary data from the Home Care Pathways Study, a longitudinal mixed-methods study examining client pathways in Nova Scotia and Manitoba, consisting of three streams (data, policy and care constellations) (Keefe et al., 2020). The data for my study is from the care constellations stream (Nova Scotia component only) from semi-structured interviews conducted with the actors over three points in time; time 1 (T1) in 2019; time 2 (T2) in 2020; and time 3 (T3) in 2021. I also used policy documents collected by the policy stream to provide contextual information to help answer my research questions.

The term ‘care constellation’ was used by the researchers to describe a cluster of participants who are connected to the home care client in some way (Keefe et al., 2020). Each constellation has the client at the center. Other members of the care constellation included a family/friend caregiver (if available), a home support worker, care coordinator, and in Nova Scotia because of the contracted model of service delivery, the agency supervisor (Keefe et al., 2020). There were twelve care constellations in total, six each in Nova Scotia and Manitoba. The goal of the care constellations stream was to explore individual experiences of home care services from the different actors’ perspectives to understand how complex factors shape client pathways using a prospective qualitative comparative case study design (Keefe et al., 2020).

Care coordinators employed by Nova Scotia Health (NSH) assess clients for eligibility for home care services (Government of Nova Scotia, 2011). Care coordinators interested in participating in the Home Care Pathways Study helped with the recruitment of the clients who had to be aged 60 years or older, reside in the community, have a Cognitive Performance Scale score of 0-1, and had been receiving publicly funded home support because of chronic conditions for at least one month (Keefe et al., 2020). The focus was on clients with the potential to improve, maintain or decline over the next 18 months (Keefe et al., 2020). The client identified a family and friend caregiver as well as a home support worker who provided them with regular services (Keefe et al., 2020). The agency supervisor affiliated with the agency providing services to the client was also recruited (Keefe et al., 2020).

The policy stream of the Home Care Pathways Study contributed to the understanding of how policy can help shape client pathways through the home care programs in Nova Scotia and Manitoba (Keefe et al., 2020). Members of this stream analyzed key government documents including policies, guidelines and manuals that guide how services are assessed and delivered to home care clients and how decisions are made to change services over time based on clients' needs. Policies developed in response to the COVID-19 pandemic by the Nova Scotia government were also collected and analyzed.

My Study Design

My research used a longitudinal multiple case study design. Case study research has increased in popularity by qualitative researchers who now recognize it as a valid and diverse qualitative approach that uses multiple sources of information and methods of analysis to understand an individual case shaped by context (Hyett et al., 2014). Case study design with in-depth consideration of a bounded system (the case) and its' particularities delves into the historical, institutional and political contextual factors and physical setting with a case description and case themes as the outcomes (Hyett et al., 2014). Gerring (2004) proposes a definition of a case study as:

> an intensive study of a single unit for the purpose of understanding a larger class of (similar) units. A unit connotes a spatially bounded phenomenon—e.g., a nation-state, revolution, political party, election, or person—observed at a single point in time or over some delimited period of time. (p.342)

I followed the recommended steps of case study design by Stake (1995) to ensure that I had the best study design to answer my research questions and a high degree of rigour (as cited in Creswell & Creswell, 2007):

1. Decide if a case study approach is suitable to the research questions. This is true when there is a clearly bounded system (case or cases) for in-depth study at one or more points in time.
2. Identify the case or cases.
3. Collect the data from various sources of information including interviews, documents, audiovisual materials, observations, field notes and physical artifacts.

4. Perform an analysis of the data. Thematic analysis should include the context and setting of the case.
5. Write a case description and present the themes to demonstrate the complexity of the case.
6. If multiple cases are chosen, perform a thematic analysis across the cases (cross-case analysis) identifying themes that are similar or different between the cases.
7. Finally, report the meaning of the cases and implications.

Next, I will describe how I carried out each of the above steps in my case study design.

Identifying The Cases

The care constellations stream included twelve constellations (six each in Nova Scotia and Manitoba) (Keefe et al., 2020). I used Nova Scotia data only due to the scope and time constraints of my research. Guided by my research questions, the following criteria were used in the selection of constellations to include:

1) a home support worker was interviewed at all three points in time and
2) clients who were considered likely to decline.

It was ideal to have a home support worker interviewed at all three points in time to help identify the formal communication acts and role of social conversations between the actors as well as changes in communication between the actors over time. Clients classified as likely to decline had a greater likelihood of experiencing health changes that would result in changes to their home care services, important to answer the research question: How do the communication processes between the actors adapt over time with clients' changing needs? Of the six clients in Nova Scotia, one was likely to maintain; one had potential to improve; one was mixed (improvement to physical health but decline in mood); and three were considered likely to decline. Of the three clients classified as likely to decline, one was provided funding through the Self-Managed Care program to hire private home support workers prior to the T3 interviews, thus, two constellations met the criteria (referred to from here on as case 1 and case 2) and were used for my case study. According to case study methodology, two cases are sufficient; no more than 4-5 cases per study is recommended (Creswell & Creswell, 2007).

Data Collection

The care constellations sub-study was designed to follow clients over eighteen months to observe changes in their chronic conditions and home care services provided (Keefe et al., 2020). In a few constellations, there was a different HSW, supervisor or care coordinator interviewed at T2 or T3 than T1. For the two constellations used in my case study, a total of twenty-eight interviews were conducted (fourteen per constellation) with fifteen participants (see Appendix B).

Interview guides were developed for each member of the constellation (client, family/friend caregiver, home support worker, agency supervisor, care coordinator) and included approximately twelve open-ended interview questions designed to elicit information about the client's experiences with home care services, how services changed over time and the reasons for the changes. Several questions centred around communication. For example, clients were asked: how well do you know your home support worker? Are they comfortable making specific requests about their care? Family/friend caregivers were asked: do you recall having any new interactions or conversations with any of the client's home support workers since your last interview? Home support workers, agency supervisors and care coordinators were asked about the client as well as broader questions regarding policies that guide decision making and case management. They were also asked to identify, based on the client's current condition, if they thought the client would maintain, improve, or decline over time (See Appendix C).

Interviews were conducted in person at T1 and by telephone (following ethics approval) at T2 and T3 due to the COVID-19 pandemic. A four-to-six-month delay in conducting T2 interviews occurred due to the pandemic (as a result, the three interviews took place over twenty-four months rather than eighteen months). The audio-recorded interviews (with participant permission) lasted from ten minutes to one hour thirty minutes. They were transcribed by research assistants and reviewed for accuracy by the project coordinator. As a research assistant on the Home Care Pathways Project, I was involved in the primary research with the transcription of interviews at T2 and T3 as well as an interviewer at T3 and participated in the analysis discussions. Permission from the investigators for the use of the secondary data for the purposes of my research questions was sought and granted in March 2022.

Other Case Study Data

In addition to the data from semi-structured interviews conducted with the constellation participants, other data sources added depth to my case study including field notes from the two care constellations included in my study and policy documents. Field notes (one to two pages in length) provided additional information about the interview including the tone, context, and setting; participant actions, behaviors, and non-verbal cues; and other observations.

The Home Care Policy manual (which contains 65 policies) and home care agency level policies, of which there were six (see Table 2D) also provided valuable contextual information for the data analysis. Fourteen memorandums regarding changes to COVID-19 policies, information releases and guidelines enacted during the pandemic to maintain safety of clients and HSWs were also reviewed; nine of the fourteen were relevant for inclusion in the analysis (see Table 3D). The objective was to review the policies in relation to person-centred communication and critical relational theory to highlight organizational and system-level influences on communication within the constellations. Triangulation of the data from the interviews, field notes and policy documents allowed for a greater in-depth study of communication and the home care context important to case study design.

Data Analysis

The goal of data analysis was to answer my three research questions:

1. What are the formal communication processes that help (or hinder) clients' needs being met? How do social conversations meet the needs of clients?
2. How do the communication processes between the actors adapt over time with clients' changing needs?
3. What are the specific factors (e.g., societal, structural, political, and historical) that influence communication between actors within the care constellation?

In case study design, data is analyzed through a case description, case-based themes and cross-case themes (if more than one case is studied) (Creswell & Creswell, 2007). As is common with case study design, I used two methods of data analysis: inductive thematic and temporal analysis. The goal of within-case analysis was to be extremely familiar with each case as an entity (Eisenhardt, 1989). Cross-case analysis identified differences and similarities in themes between the two care constellations.

Thematic Analysis. Data analysis was performed using thematic analysis, an approach that can be used with different theoretical frameworks (Braun & Clarke, 2006) and commonly employed with case study research (Braun & Clarke, 2006; Creswell & Creswell, 2007). I followed the six steps recommended by Braun & Clarke (2006): I familiarized myself with the data; generated initial codes; searched for themes; reviewed themes; defined and named the themes; and produced the final report. The twenty-eight interview transcripts were uploaded to MAXQDA, a qualitative data analysis software and read several times. The software was used to code the data, develop themes, and write memos about emerging analytical insights on the interpretation of the data related to the theoretical perspectives of person-centred care and critical relational theory.

Temporal Analysis. A temporal analysis of the data added an important dimension to the study to understand how communication adapted over time with clients' changing needs. To identify temporal themes, I extracted excerpts focused on past communication and inductively developed themes which reflected the temporal aspects of the data (using the same steps as thematic analysis). I then compared the temporal themes of the T1, T2 and T3 interviews of each case to examine changes in communication over time to generate broader themes that transcended the longitudinal data (Granbom et al., 2014).

Lastly, to conduct the cross-case analysis I compared the themes (both general and temporal) between the two constellations for similarities or differences. The cross-case analytical data is presented in a table to show the relationship between the themes, a technique recommended when multiple cases are included (Creswell & Creswell, 2007).

Case Study Write Up

The results of my data analysis are reported in the case study write up using an adapted format by Stake (1995) that includes a description of the case and presentation of case themes (as cited in Creswell & Creswell, 2007). I describe the themes by triangulating the data from the different home care actors' perspectives to present the meaning. Following each theme, I explain contextual factors that may have influenced communication.

Researcher Reflexivity

Creswell (2005, p. 178) wrote, "qualitative researchers today are much more self-disclosing about their qualitative writings than a few years ago. No longer is it acceptable to be the omniscient, distanced qualitative writer." Creswell, in writing this statement referred to the place that the process of reflexivity now holds in interpretive qualitative research. Not only is it not acceptable to distance oneself as a researcher from the research and the writing of the research but to do so implies a lack of rigour in the research. Indeed, reflexivity and the transparency of the researcher's positionality is necessary to demonstrate the rigour of the study. Creswell (2005) continues to say that all writing reflects the researcher's cultural, social, gender, class, and personal politics, all of which is important as two individuals may interpret the same data differently. Within this positionality, writings are co-constructed between the researcher and the researched (Creswell, 2005). To practice reflexivity, the researcher must be aware of their own values, prejudices, assumptions, expectations and attitudes operating within their life view on an ongoing daily basis and acknowledge that their life view is embedded within the research (Davis, 1998).

My Positionality

My introduction to home care began in 2014 when my father received publicly funded home care services. He had dementia and was living alone at home. I called Continuing Care for an assessment, and I remember feeling confused as I tried to decipher the information. He received meal preparation services and shortly thereafter different home support workers arrived at various times of the day. I recall one home support worker who phoned me when they thought dad wasn’t eating enough. They returned the next day with homemade fish cakes with the hope that he would enjoy them. I loaned them a white purse for their son’s wedding and when they returned it to me, they told me all about the wedding. They joked a lot and dad enjoyed their sense of humour. On another day, I arrived at dad’s house to find him and another HSW in the kitchen. Dad was showing them how to prepare a poached egg, a cooking technique that was unfamiliar to the HSW. Both were enjoying themselves! Yet on another occasion I arrived to see a familiar face. The home support worker that day had provided services to my mother when she was palliative with cancer in 2006 and attended my mother’s funeral. “I recognized the house address when I saw it on my schedule!” they exclaimed. We caught up on their children and how much they had grown over eight years. My father liked each of these home support workers because they were kind, caring and respectful, key tenets of person-centered care. I recall how the communication with the HSWs made me feel reassured that he was well cared for during their visits; many of them seemed to embody person-centred care within their work by taking interest in getting to know my father and his hobbies (e.g., woodworking). When time allowed, one

HSW sat with him and looked at photos of the furniture he built over the years which gave meaning to his life and helped him to feel valued for his talents and contributions.

Communication with the supervisor and care coordinator however, often left me feeling frustrated that the services did not better meet his needs due to policy constraints. For example, light housework was only available if he also received personal care which he did not want. It was also very challenging to reach these actors by telephone and even more so to have a conversation in person. To my recollection over two years that my father received services, the agency supervisor never visited in-person; the care coordinator only visited once for the initial assessment.

Eight years later, the shoe is on the other foot, so to speak. Instead of being a family caregiver to a home care client, I am the home support worker to a ninety-two-year-old woman, the mother of a friend who called me unexpectedly one day and asked, “you wouldn’t consider doing home care for mom would you?” I had never done home care before, but I was willing to try! Two years later the arrangement is ongoing to the delight of everyone involved. I help her with personal care and light housekeeping and provide companionship. At times, she tells me stories about her deceased husband and how she is sad that those days are behind her. Initially, I was uncomfortable when she expressed emotions, but I learned to hold space for her as I knew it was an important aspect of my presence; she trusts me to confide her life stories to me and share intimate feelings. Emotional acknowledgement as part of PCC is highly important and I feel privileged to be part of her life in this regard. I try to embody person-centred care by communicating with her in a manner that upholds her dignity and respect. For example, I always give her choices. When changing her bed linens, I ask her to choose between two sets of sheets. If she does not want a shampoo with her shower, we do the shower only. When we watch television together, she chooses the show to watch. I feel as though I am a guest in her house and act accordingly. I do not touch her belongings or go in her bedroom without permission. Being a home support worker is a rewarding part of my life that I look forward to and I know my help has enhanced her quality of life. In reading the interview transcripts, I felt a connection to the HSWs who do very important but underrecognized work in our society. I also felt great empathy for the clients who, as older adults, are oppressed in society due to ageism.

I bring these two experiences to my research: my experience as a family caregiver who interacted often with home support workers and my present experience as a home support worker. I also acknowledge my white privilege and social status that make these experiences unique from individuals with other social identities.

Ethical Considerations

The Home Care Pathways study received ethics approval from Mount Saint Vincent University. Informed consent was obtained from the participants at all three points in time prior to each interview. Pseudonyms were used in my case study.

Approval for a secondary analysis of data from the Home Care Pathways care constellations stream (NS data) was received from the University Research Ethics Board of Mount Saint Vincent University in December 2022 (ethics file number 2022-124). A final ethics report will be submitted to the Research Office upon completion of this thesis.

Chapter 5: Results

This chapter presents the results of the data analysis of each case including a case description and presentation of the themes followed by contextual factors that may have influenced communication within the theme. A cross-case analysis follows the two case study write ups.

Description of Case 1

Judy, a 76-year-old female, is the home care client of this constellation. She had multiple chronic conditions including insulin-dependent diabetes, high blood pressure, psoriasis, arthritis, and chronic back pain. She had been receiving home care services for approximately eight years. She lived in a rental unit, described by HSWs as very cluttered, with her 53-year-old daughter Christine (her family caregiver) who worked in the hospital laboratory. Home care services began with a half hour five days a week (2.5 hours per week) for daily TEDS application and later increased to 1.5 hours daily three days a week for assistance with her shower (5.5 hours per week; services received at T1). Christine indicated she spent about twenty-five hours a week on caregiving tasks.

The COVID-19 pandemic began approximately six months prior to the T2 interviews. At T2, Judy stated that she had no interruption to her services during the pandemic. As a result of her annual reassessment by telephone, Judy received an additional three hours for meal preparation services each week which the care coordinator confirmed was because her back pain had worsened. At T3, Judy said she was hospitalized for over a month with a serious kidney infection. When Judy went home from hospital, her home care services remained the same. The supervisor and care coordinator did a joint reassessment after several complaints from HSWs about her behavior (e.g., increased aggression) and safety issues in the home. Shari and Karen were the HSWs in this case.

Theme 1: Formal Communication Processes May or May Not Meet Clients' Needs

Three formal processes were discussed by the actors as important in regard to communication about clients' services and possible changes that may be needed: progress notes by HSWs, annual reassessments by the supervisor and care coordinator, and the client's care plan. This theme highlights how communication vis-à-vis these processes either helped meet Judy's needs, or in some cases served a different agenda.

Progress Notes

HSWs, considered the "eyes and ears" of the home care organization were considered to be in the best position to report changes to client's health congruent with findings from previous research (Reckrey et al., 2019). Shari commented that her "whole job is progress notes" and that progress notes typically sent included changes to a client's behavior, skin integrity issues or housework not getting done. The supervisor said she relied heavily on "great progress notes from staff" to help her become aware of when a client may need a change in services. Likewise, the care coordinator confirmed that progress notes frequently led to client reassessments and service levels being adjusted before the annual reassessment due date.

Despite the importance of progress notes, the HSWs lamented they were not "always listened to." Shari conveyed she was responsible for sending feedback about clients to the supervisor but highlighted that she usually did not hear anything back, not even when a client died. She said, "feedback to us could definitely improve." Karen also talked about the lack of feedback: "…they tell us to put progress notes in, we put them in, and we put them in, and we put them in, and nothing gets done, so I don't understand it." This one-way upward flow of communication from the HSW to supervisor to care coordinator was commented on in the field notes as a point emphasized by HSWs (P. Irwin, personal communication, September 15, 2020).

Annual Reassessment

The agency supervisors and care coordinators indicated that the annual reassessment visit was the main opportunity to meet with clients to assess their current needs for services. Christine chronicled that when Judy first started on home care, she could shower by herself but as her back pain got progressively worse over the next two years, Christine found it "overwhelming" to help her. Personal care was subsequently added as a service at the annual reassessment. At T2, Judy said that meal preparation services were added at the annual reassessment as confirmed by the care coordinator again, because of Judy's worsening back pain. When asked if she felt listened to, Christine responded, "I do feel like I can…. bring concerns to people even the Care Coordinator. And it's listened to, and they'll do what they can to accommodate." Both Judy and Christine also seemed to understand who to call within the structure of the home care system depending on the concern that they had. Judy said that at times she contacted either the supervisor or the care coordinator depending on the perceived seriousness of the situation and, "if I have a major problem, I contact the Health Authority Care Coordinator. And she has more control than I do, and that you know, in quite a number of situations."

By T3, behavioral issues of both Judy and her daughter (e.g., increased aggression toward HSWs) and safety concerns in the home had escalated. Christine was on a four-month leave from work because of the stress of her job and her mother being in hospital. Following Judy's release from the hospital, the supervisor and care coordinator did a joint reassessment to address their concerns. The supervisor said they played "good cop, bad cop." The supervisor's desire to do a joint visit with the care coordinator may have reflected her perception that the care coordinator held more power as the person who determined a client's need for services. They both agreed joint visits worked well to resolve issues because they presented "as a united front." Through a critical relational lens, the use of the term "good cop bad cop" is alarming and denigrating as the approach used for problem solving. A joint visit implies the use of combined power as an instrument to enforce alienation between the client, the organization and system. In the description of the visit by the agency supervisor, there was no mention of the client's health, daughter's ability to continue as a caregiver, or the need for changes to home care services due to the client's declining functional abilities; the focus of her description of the visit was solely on behavioral and safety concerns.

Care Plan

Previous research with HSWs revealed that the care plan document is often focused solely on tasks and does not adequately communicate the needs of home care clients, especially psychosocial needs (Lämås et al., 2021) which was found to be true in this study. The HSWs talked briefly about the purpose of the care plan saying it was a list of tasks to complete with the time allocations. The supervisor indicated that she developed the care plan and then contacted the client for the home safety visit, a strong indicator that the care plan was not developed collaboratively with the client, contrary to client-centred care. The care coordinator said that the client could see the care plan in the folder, but it was not shared with them. A process whereby the care plan is developed in advance of a client meeting and not shared with the client perpetuates a biomedical approach to care, as opposed to a client-centred approach where clients share equally in decision-making and engage in conversations to aid in the assessment and delivery of services to meet their individual needs. The field notes commented that the most striking thing about the T3 interview was that even though the client was not well, and her daughter seemed distressed, no changes were made to the care plan during the joint reassessment visit by the supervisor and care coordinator (M. Hande, personal communication, July 23, 2021).

Contextual Factors that Influenced Communication in Theme 1

Contextual factors that influenced the formal communication processes in this theme include the COVID-19 pandemic, the structural framework of home care including several organizational and government policies, and the client's home environment.

The COVID-19 Pandemic

In the summer of 2020 at the time of T2 interviews, Nova Scotia was in the first wave of the pandemic. The highest daily case count was 55 new cases on April 22, 2020 (Roth, 2020). A letter sent on March 19, 2020, to home care agencies included a fact sheet to distribute to clients to address questions and concerns that clients and families may have about the spread of the virus and its' impact on their health and access to health care services (Nova Scotia Health, 2020a). It appears to have been the only direct communication with clients during the pandemic.

Home care services were prioritized according to Home Support Prioritization Protocols, and a Home Support Emergency Response Level (ERL) Guide developed by

Nova Scotia Health and home support agency representatives (Nova Scotia Health, 2020b). An ERL was assigned to every client by the home care agency in March 2020; it considered client needs, availability of supports, and home care tasks to be performed. An HSW indicated that clients with housekeeping services were lower priority. ERLs and priority levels were not communicated to clients (Nova Scotia Health, 2020b). The ERL code of this case study client is unknown; however, her services were not interrupted.

The mask requirement for all front-line workers in home care agencies was implemented April 13, 2020 (Government of NS, 2020c). When the HSW was asked about the impact of COVID-19, she said there were more screening and hygiene protocols including masks but otherwise things were "pretty normal." She said she did not discern any effect of the PPE on communication with clients.

The supervisor described the main impact of the pandemic on her role as needing to make sure HSWs had PPE. She also spent a lot of time coaching HSWs, some of whom she said were nervous to go into clients' homes (fear of contagion was not expressed by either HSW in this case). Annual reassessments were done by telephone to limit contact in clients' homes. When asked about the impact of COVID-19 on the mental health of clients, she said:

> …we're very task orientated and so the mental health aspect really doesn't come into play because it's not really part of our scope of practice…

Regarding Judy's mental health as a contributing factor to the aggressive behaviors reported by HSWs she replied, "there's nothing in the documentation from when she came out of the hospital or the updated service care plan that came from continuing care." Although the supervisor acknowledged that Judy's mental health issues were likely due in part to the impact of the pandemic, she dismissed them as irrelevant because she did not have training in mental health.

The main impact as described by the care coordinator was that she found assessments by telephone challenging during COVID saying, “it helps me to realize how much information I pick up just by observation and being in the people’s homes”.

Organizational and Government Policies

The structural framework of this case includes organizational and governmental policies that guide the delivery of home care services.

Client-Centred Care Policy. The client in this case (and case 2) received home care services from an agency within a larger organization which has a person-centred care policy that states:

> We believe everyone has unique values, personal history, and personality. We believe that each person has an equal right to dignity, respect and to participate fully in life. This philosophy is reflected in our values (people come first, we respect everyone, everyone plays a part, we promote social justice, we are all accountable and we can always do better). It is also reflected in the expectations we set for all our volunteers, staff, and members of our community. It is grounded in creating relationships between our clients, their families, and their caregivers. We believe family members or designates play a vital role in ensuring the health and well-being of their loved ones. It is the power of love.[1]

The HSWs and supervisor provided varied responses when asked what client-

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[1] Reference withheld to protect confidentiality.

centred care meant to them and how they enacted it in their role. For example, one HSW described client-centred care as being who the client needed her to be, either a granddaughter or a friend rather than just the care worker whereas the supervisor explained that the organizational practice of having supervisors oversee both HSWs and clients within their jurisdiction was how they ensured client-centredness.

Safety Policies. In association with the concerns that the home was a hoarding situationdue to the immense clutter, safety was discussed several times by the agency supervisor and care coordinator. At T3, the agency supervisor said:

> …the safety concerns were being brought forth from the staff that were visiting her because they're—it's just a hoarding situation. There's just so much stuff in this house…Judy would not be able to get down the stairs and out of her home if there was an emergency.

Government home care policies were reviewed pertaining to safety. The Nova Scotia home care policy manual includes several references to safety to ensure HSWs have a safe working environment. For example, to be eligible for home care services, the client's environment "must be safe and suitable for the provision of home care services, both for the applicant and for home service providers" (Government of Nova Scotia, 2011, p. 9). As well, the Occupational Health and Safety policy (Government of Nova Scotia, 2011, p. 81) stipulates:

> The District Health Authority is required to have policies and mechanisms in place to ensure the provision of a safe work environment for District home care

> staff and which comply with the requirements of the Occupational Health and Safety Act (1996, c.7, s.1).

Further guidelines on what constitutes “safe and suitable” could not be located within the home care policy manual and hence it is possible for individuals to differ in their interpretation of this term; what is suitable to one person may not be to another person.

Lack of Policy Pertaining to Progress Notes. Progress notes were described by HSWs as the main mechanism used to inform the other actors of changes to a client’s health. Despite the importance of progress notes, there appears to be a lack of guidelines or specific policy regarding their use; the only reference to progress notes was in the client records policy of the home care policy manual which states an adequate client record should include progress notes (Government of NS, 2011, p. 43). Without further information and training regarding the utility of progress notes, it would be very difficult for HSWs to ascertain the circumstances under which progress notes should be sent; the use of progress notes as a communication process would be left to their personal discretion. It is uncertain how many progress notes were sent pertaining to the client’s health but the only known progress notes discussed by the actors were in regard to safety issues and skin breakdown.

Annual Reassessment Policies. The reassessment policy of the home care program (Government of Nova Scotia, 2011, p.) states that “the assessment process will provide a comprehensive, multi-dimensional account of the individual’s situation, including the person’s functional abilities and home environment.” Arguably, the joint assessment at T3 did not achieve this goal as there was no mention from the actors regarding Judy’s functional abilities or the possible need for additional services to address changes to her health. The home care policy on assessment and service authorization process states that the assessment process must explore alternatives to meet identified needs, including referrals to other appropriate agencies and/or other District Health Authority services (Government of NS, 2011, p. 25). In Judy's case, exploring mental health services and respite for the caregiver may have been appropriate.

Respite Policy. Respite needs of caregivers are determined through the client's assessment (Government of NS, 2011, p. 53). Respite as a core home care service is cited in the home care policy manual as being "to support the family environment by allowing primary caregivers time to attend to personal matters or to obtain needed rest and relief" (Government of Nova Scotia, 2011, p. 52). However, this component of the assessment seemed to be lacking as there was no attempt to assess this client and her family caregiver for respite services. From an ideological perspective, it seems that the actors were hegemonized to believe that it was the role of the daughter to care for her mother without a break despite working full-time and having her own health issues which perpetuated long-held societal views of women as primary caregivers.

The Home Environment

The home, described as a "hoarding situation" by both the HSW and supervisor, is highlighted as a key contextual factor of relevance to this case. Interestingly hoarding and hoarding disorders as psychological disorders are more prevalent in individuals with cardiovascular disease, diabetes, and chronic pain (Sordo Vieira et al., 2022), conditions that Judy lived with. Whether the house was legitimately a hoarding situation or not is unknown. The interviewer's field notes indicate Judy was at ease with all the stuff, and easily moved about the house but noted that Judy "observed me closely to assess my comfort level in her home because she knows that what is comfortable for her does not work for everyone" (M. MacDonald, personal communication, September 13, 2019). The only action that was noted to come out of the reassessment visit was that clutter by the back entrance needed to be removed, which seems to indicate the inability of the actors to pinpoint exact safety risks, perhaps pointing to an unconscious bias toward the lifestyle of the client.

Theme 2: The Role of Conversations in Meeting the Client's Psychosocial Needs

This theme addresses the role of conversations between the client and HSWs in helping to meet the client's psychosocial needs and how the COVID-19 pandemic impacted this important communication process.

Importance of Conversations

Conversations between Judy and HSWs were a main communication process that supported her psychosocial needs. Judy wanted to sit and chat at the breakfast table with the HSW prior to her services commencing, which provided her with connection, interest, and companionship. Shari's perspective at T1 was that Judy was "very talkative" but not unlike all her clients:

> I would say she's pretty similar. Um, I mean she doesn't have any like extraordinary needs. She loves to talk. I would say most of my clients do…yeah, I would say very average. I go in, we chat. We chat about our families or our day, or our weekend.

Shari explained that technically, she was not supposed to talk about her personal life but said, "how can you take care of somebody for years and say like don't ask me questions. I can't tell you if I'm married or not type of thing. I break those rules" which speaks to the long-term relationships often established between HSWs and clients (Denton et al., 2015). Olsen et al. (2019) found that HSWs balance boundaries and rules of the home care context with their interpretation and enactment of client-centred care similar to Shari's explanation.

However, Judy's desire for companionship became a contentious issue between T1 and T3 because time was not allotted in her care plan for this purpose. She was deemed to be non-compliant with her responsibility as a client to use service time according to her care plan. By T3, the agency supervisor and care coordinator conducted a joint reassessment visit to address safety issues as well as to reinforce the need for her to behave appropriately and comply with the policy regarding client responsibilities.

Impact of COVID-19 on Conversations

The pandemic was a key issue that impacted conversations within the care constellation. Karen, the HSW at T3 lamented:

> …they're not ready to just get up off the chair and jump in the shower. They may—and they don't feel comfortable some of them, so they may need that five, 10 minutes to warm up and you know, but uh, it seems like that kind of has gone by the wayside that they don't even want that to be a—to be with anybody anymore. There's no time—they—it goes back to the whole COVID thing that I explained to you before with all the PPE and stuff. It's gotten to where we just go in, we do our thing, and we get out. They're no conversation, there's no nothing.

She also added, "in the beginning it was, you know, get in and get out and just do what you have to do—don't stay anywhere any longer than you have to." This finding is aligned with the literature where HSWs expressed concern for the lack of compassion shown for clients during the pandemic (Eide et al., 2021; Markkanen et al., 2021). As the interviewer commented in the field notes, on one hand there were people who were experiencing loneliness who needed to talk but on the other hand conditions made it more difficult for conversations to occur under the COVID-19 context (R. Burke, personal communication, July 13, 2021).

Ambiguity Regarding the Role of Companionship

In addition to the impact of the pandemic on conversations, the HSW went on to describe the ambiguity she detected regarding the role of companionship in the delivery of home care services. She said:

> I actually heard one care coordinator say to a client "we don't have time to go in there and talk to you"…and I've actually heard other people's supervisors say that as well. We don't have time to go in there and talk to people and wait for them to eat breakfast, but then other people, they'll—the same people will say stay the full time, find something to do, just you know, even if it's just sit and talk with them. [laughing]…I get that we don't have time to sit and talk to people, but the funny thing was when I took this course and I know things have changed, but eight years ago when I took the schooling for this or nine years ago now, one of the things—it was a whole chapter that we went over, and it was companionship. And it was like some people just want to sit and talk.

HSWs have cited empathy for older adults as a reason why they like their work and were happier when they could express empathy (Strandberg et al., 2012) as was apparent with this HSW. However, barriers to empathic communication include care plans that focus solely on meeting the physical needs of clients with little time available for socializing with clients (Strandberg et al., 2012) which was the situation in this case. Judy's care plan did not include fifteen minutes to chat at the kitchen table while she tested her blood sugar prior to taking her shower.

Contextual Factors that Influenced Communication in Theme 2

Contextual factors that influenced communication related to conversations include the COVID-19 pandemic, the home care policy on client rights and responsibilities, and lack of time allocated for conversations in the delivery of home care services.

The COVID-19 Pandemic

The home care agency of this study made it mandatory for HSWs to wear a shield in addition to a mask on December 24, 2020. The HSW complained about the effect of PPE:

> …a lot of our clients cannot see what we are saying, they can't hear us, it's absolutely brutal. If anybody has any kind of sharing issues at all, it's just desperate, like, and—and so, that causes you not to talk as much sometimes, right, because you—they can't hear you. And it's so frustrating because you're saying something three or four times and they're like, "What? I can't hear you. I can't hear you" and you know, so eventually what happens for some of these hard of hearing clients, you just start to talk less.

The HSW also noticed "a lot of loneliness" and that sometimes you have to let "somebody pour out their hearts while you're doing your duties while you're there." From a client-centred perspective, she understood the importance of attending to the psychosocial needs of clients and the need for empathic listening as an enabler of client-centred care (Dostálová et al., 2021; Lines et al., 2018).

Client Rights and Responsibilities Policy

The Client Rights and Responsibilities policy states that client responsibilities include being "available for service at the scheduled time, as agreed" (Government of NS, 2011, p. 24). It further states that:

> In situations where clients do not carry out their responsibilities, the District Health Authority will take all reasonable steps to:
>
> a) communicate client responsibilities, as indicated in Section 4.3.1 above to clients and staff.
>
> b) eliminate or minimize factors, within its control, that contribute to inappropriate behaviour.
>
> c) use restrictive actions only when all positive processes have failed.
>
> d) integrate these actions into the plan of service as necessary; and
>
> e) document the situation and actions taken (Government of NS, 2011, p.24)

From a client-centred perspective, the steps lack inclusion of the client and their family caregiver in a meaningful way in finding a solution to help them carry out their responsibilities. It is also interesting to note the term "positive processes" and the lack of detail as to what that entails. Although it seemed as though the approach taken in the joint reassessment visit was disciplinary by nature, it is evident that the supervisor and care coordinator acted according to the policy to remind Judy of her responsibilities.

Furthermore, it is important to note that companionship is not one of the four home care support services provided to clients nor is time allocated for conversations as part of the delivery of the assessed home support services which include personal care, meal preparation, light housekeeping, and respite (Government of NS, 2011, p. 50). Although the care coordinator did not refer specifically to companionship or lack of time in the schedule for clients and HSWs to socialize, she did note her need to adhere to policies that restricted her ability to help clients:

> I'd like to be able to help people more than I can at times but I'm limited a lot by policy and procedure so that can be frustrating but…there's only so many tasks that our home support workers do and according to our home care policy um there are a number of individuals that need help with not just ADLs but IADLS so they need…I don't know there's just certain things like very specific things that some clients need help with that I just can't accommodate because you know home supports, they only do respite care, personal care, meal prep, and light housekeeping.

Description of Case 2

Susan, a 59-year-old female, is the home care client of this case. She had COPD, fibromyalgia, and depression, and was on oxygen full-time. Her services included one hour a week for light housekeeping (to clean the bathroom and mop the floors) and oxygen which she had received for about five years. Susan was involved in many activities in her new building where she had recently moved and had a social network of support. Her sister Denise assisted with grocery shopping but could not provide further help because of her own health problems. She was not involved with Susan's home care services.

At T2 Susan described her health as "going downhill". She experienced more pain when she became breathless and was isolated in her apartment because of COVID-19.

Her home care services were put on hold for six weeks during the first wave of the pandemic. By T3 she was hospitalized for gout. As a result of an assessment by the hospital care coordinator, she received additional services including personal care and the IADL program for assistance with grocery shopping. She said she spent most of the time sleeping and only left her apartment when she was “forced to go out like to get groceries.” Despite the decline in her health and increase in services, both the supervisor and care coordinator commented that she was doing fine and that there were minimal changes to her services which they related to her perceived desire to be independent. Rebecca and Lisa were the two HSWs in this care constellation.

Theme 1: Formal Communication Processes May or May Not Meet Clients’ Needs

Similar to case 1, progress notes, annual reassessments and the client’s care plan were identified as the formal communication processes between the actors. This theme explores how these processes may or may not have been effective in identifying changes needed to the client’s home care services.

Progress Notes

As noted in previous research, as the least powerful members of the caregiving network, HSWs and clients were the most depended upon for communication of clients’ needs (Funk et al., 2022). At T1, Rebecca confirmed that progress notes were the only means of communication with the supervisor regarding clients. The care coordinator concurred that they usually learned of changes needed to clients’ services by progress notes.

Lisa, the HSW at T2/T3 also reiterated that she did not communicate with any other HSWs; all communication was sent by progress notes to the supervisor, or she occasionally left a note in the care plan for the next HSW. She noted during the interview her observation that Susan's COPD had progressed and although saw a difference in Susan, remarked "she's pretty independent…she's not going to sit in the chair and give up." She confirmed the care plan was the same, and she had not recommended any changes. The supervisor rationalized the lack of feedback from HSWs as meanig that Susan was fine:

> I would say she's maintaining but staff have the ability to file reports with every visit. If they notice concerning um, signs or behavior of some clients and we really don't have feedback from them, which, you know, to me as a supervisor indicates that things are ticking along quite well. If they did have some significant concerns, then they would be sharing them with me.

Annual Reassessment

Depression is a common but undertreated condition in older adults which can influence an individual's willingness to communicate (Asan et al., 2018). By T2, Susan's health had changed considerably, and she described herself as though "I'm pulling myself away and kinda shutting down." The interviewer commented in the field notes, "the intersectionality of mental and physical health cannot be underestimated. I believe this client's physical decline is accelerating due to depression that may not be managed" (M. MacDonald, personal correspondence, June 19, 2021). In regard to the annual reassessment with her care coordinator, Susan said:

> I haven't seen her in a while really because of this virus. Now she did, there's a new one that called me, I don't know, uh, a month ago, said she was taking over for the other lady and uh, she might have asked me a few questions and…I really

> can’t remember. I don’t know what we talked about to be honest. My memory’s starting to go and like she may have asked me do I have any problems, I don’t know. I didn’t get into it with her.

The care coordinator confirmed her reassessment was done by telephone and nothing had changed:

> Uh no, no, she’s getting the exact same service. She’s independent with her…with her ADLs and IADLs so that didn’t change. Because that didn’t change, she didn’t need any, just any other services that we could offer, so she continued on with the same service of home oxygen and the same amount of home oxygen.

The supervisor indicated that in addition to progress notes, she learned of changes to a client’s health and potential needs for services through annual reassessments. However, during the pandemic, reassessments were not always done due to other priorities such as delivering PPE to HSWs and “coaching, counselling, supporting” the HSWs through this difficult time.

Susan’s sister Denise confirmed Susan’s services were stopped for “quite a long time” during the early part of the pandemic which was a problem because of her inability to do housework. The supervisor felt Susan did fine without services, however, in contrast, she also said that during Susan’s annual reassessment by telephone, Susan indicated her disease was progressing and had inquired about meal preparation services again. All of the actors, other than the family caregiver, perceived Susan coped well without services.

Between T2 and T3, Susan was hospitalized for one week because of gout that caused extreme pain and mobility issues. According to Susan, the hospital care coordinator assessed her and recommended one hour per week for personal care and assistance with grocery shopping through the Continuing Care IADL program. About the one hour of personal care, Susan said:

> I did, I did get them to uh, she gave me an hour when I was in the hospital. I don't even know when that was, but she gave me…an extra hour a week for personal care so I don't know, I tried like doing the shower thing, they could help me there, but I just, it doesn't work for me right yet [laughs slightly]…But uh, they do my laundry and all that and take my garbage and uh, they cook up a little bit of potatoes and carrots so I can have some for a couple of days.

Unfortunately, assistance with grocery shopping only occurred once as the onus was on Susan to make the arrangements through the IADL program and her calls went unanswered. The care coordinator indicated she would talk to her boss in regard to a suggestion by Susan that her groceries be delivered; this request was outside of the normal operationalization of the IADL program. Unfortunately, Susan did not hear back. This example highlights system constraints including policies and power that sit with other individuals not familiar with the client which put limits on what is possible (Funk et al., 2022). It also highlights a lack of accountability, a finding in an independent auditors' report in 2017 that noted weaknesses in DHW and NSH policies and procedures for ensuring services are received by clients (Office of the Auditor General, 2017). This scenario reflects how the delivery of home care services through the current structural framework did not consider her situation and limitations. Although approved as a service, Susan had to perform a significant amount of work to access and receive the service, not manageable by her because of her limited energy reserves. In this respect, it is a "one size fits all” approach to home care that is not client centred. From a critical perspective it also does not account for different social positions of clients, some of whom if they had previously experienced oppression within the health care system, may not feel comfortable phoning a government agency to make service arrangements.

The HSW, agency supervisor and care coordinator were unaware of the reason for Susan’s hospitalization and presumed it was due to COPD. The care coordinator discussed a system called *One Content* which gave her access to a client’s health record and recent medical history that she reviewed prior to each reassessment “to get a snapshot” of the client’s health. However, her lack of knowledge about Susan’s hospitalization indicates she did not refer to it prior to Susan’s reassessment nor did the reassessment itself capture any recent health history from Susan. The process of checking this system to inform and guide the care coordinator failed Susan at a critical point in time.

When asked how frequently clients were reassessed, the care coordinator said, “normally once a year unless there’s changes that need us to go out.” Despite Susan’s hospitalization that resulted in changes to her services initiated by the hospital care coordinator, she was not reassessed any sooner by the care coordinator (of this care constellation).

Care Plan

When asked about changes to Susan’s care plan at T3 in regard to the hospitalization, the HSW replied she “did not know anything about that”. She was unsure why Susan’s services had been increased but surmised it was because she needed more support for whatever reason. The supervisor explained she developed the care plan based on the client’s diagnosis and authorized services but said she was unaware of Susan’s oxygen requirements.

The supervisor believed that the pandemic had no effect on Susan’s wellbeing or services as evidenced by her statements “things hadn’t changed a whole bunch” since T2 and “there’s not been any issues or interruptions with her service.” The care coordinator concurred that she had recently done the reassessment and agreed that “nope, there’s really no change” and “the only change I see is that now she has the IADL program”. The perception that Susan was fine and that her services remained the same reflects ambiguity on the part of the actors as Susan’s services were increased as a result of her assessed needs while in hospital.

Instead of doing well as perceived by the actors, it sounded like Susan was close to dying. The lack of consciousness around her dire state may have been due to a culmination of several factors identified in this study including the lack of progress notes on this client; her reluctance to ask for help and desire for independence; a family caregiver who was not heavily involved; changes in her health that affected her ability to communicate (e.g., depression and breathlessness), and the negative effects of COVID-19 on the formal communication processes.

Contextual Factors that Influenced Communication in Theme 1

Contextual factors that influenced the formal communication processes to determine necessary changes to the client’s home care services include COVID-19 related changes to home care policies and the case management policy within the home care policy manual.

The COVID-19 Pandemic

Between March 19, 2020, to September 30, 2020, fourteen memorandums were sent from the Department of Health and Wellness to NSH Continuing Care and/or home care agencies, to notify of new policies or changes to existing policies that affected the delivery of home care services to clients (see Appendix D) many of which related to funding increases to programs (e.g., Supportive Care Program). The impact of COVID-19 is evident in this case as a key contextual factor that negatively affected the client's care and the communication processes to ensure that services met her needs. Despite clients being prioritized during the pandemic according to the ERL prioritization code that included factors such as informal support of the client (Government of NS, 2020b), it seemed that by all accounts, Susan was deemed low priority because she "only" received light housekeeping. However, one can imagine that not having your bathroom or floors cleaned for six weeks would be problematic.

It is unknown how much communication took place with clients to get a true sense of how well they could manage without their services and if they had family caregivers to help. The supervisor explained there was not much interaction with Susan during COVID because "we had had it on hold for a time um, during that same time for those same reasons that we were kind of pulling out all non-really essential care for a time". Despite the ERL memorandum stating that care coordinators will check-in with clients who had hours reduced or service put on hold more frequently, especially those assigned a higher ERL (reference), the care coordinator explained that the agency did not put clients on hold but that those receiving light housekeeping still received some services, just fewer visits. This explanation, however, contradicts comments from the supervisor and Susan’s sister that Susan did not receive services for six weeks.

According to the care coordinator, the policy directive in April 2020 (at the time of Susan’s reassessment) was for reassessments to be conducted by telephone and verbal consent to service changes was to be obtained (Government of NS, 2020d). In July 2020, NSH developed a protocol for resuming in-person visits by care coordinators (Government of NS, 2020e). Had Susan’s reassessment been done in person rather than by telephone, the care coordinator may have seen firsthand the challenges she had in breathing which prevented her from being able to leave the apartment for groceries. Regardless, as indicated in the field notes, “a person with a complicated health profile must have all clinical and personal factors considered in their care and this does not seem to be happening for this person” (M. MacDonald, personal correspondence, June19, 2021).

The IADL program policy is not included in the Home Care Policy manual so details of the program and how it operates are unknown. Funding to the IADL program increased during the pandemic (Government of NS, 2020g) which may have been why Susan was approved for the service. Unfortunately, Susan’s phone calls to the IADL program to book assistance with grocery shopping went unanswered. On one hand funding was increased to make the program more accessible but, on the other hand, resources to accommodate the increased number of clients did not appear to have been available. It is plausible that administrative staff were seconded to help with the pandemic response in other parts of the system or they were overwhelmed with increased demand for services. In fact, the 2021-22 annual report of NSH confirms that a special team of additional administrative staff was created to alleviate the workload of public health offices in the spring of 2021 (Landry, 2021). The care coordinator talked about her increased workload which she attributed not only to policy changes during COVID-19 that broadened eligibility for more clients to access supports (e.g., Supportive Care) but also because of the increased demand for services due to the aging population. She may have neglected to get back to Susan due to her large caseload, indicative of an under resourced home care system that cannot meet all of the demands.

Case Management Policy

Case management as a core service of the home care program is very relevant to the context of this theme:

> “Case management” includes assessment, service planning, care coordination, and monitoring and evaluation of the effectiveness of the service plan. Case management is a collaborative, client-centred process that is continuous across provider and agency lines. Case management addresses the health and well-being of clients, while promoting quality care and cost-effective outcomes (Government of Nova Scotia, 2011, p. 34)

Furthermore, it states that “the purpose of case management is to develop an approach that improves access to coordinated and integrated health services that are client-centred, community based and that meet the client’s health needs” (Government of Nova Scotia, 2011, p. 34). One of the principles of case management is that it “fosters good communication, cooperation and collaboration among service providers, clients and communities” (Government of Nova Scotia, 2011, p. 35). Interestingly, this is one of only three times communication is referenced in the Home Care Policy manual and one of only a few instances where the term client-centred is explicit. It is evident that the monitoring and evaluation components of Susan's service plan based on good communication and collaboration were not fulfilled, leaving her in dire circumstances as she tried to fulfill the basic human need for food. Also, from a client-centred perspective, it could be said that her dignity was not preserved as her need for assistance to meet a basic instrumental activity of daily living remained unmet. The field notes indicate that the interviewer found it difficult to listen to her extreme struggle to get groceries (M. MacDonald, personal correspondence, June19, 2021).

Theme 2: Communication Associated with Maintaining Independence

Susan's desire to be independent was closely associated with her reluctance to bother people. At T1, emotionally she said, "the more independent I can be, the less I need-, I always feel like even though they don't make me feel that way, I feel I am putting people out. And I don't want to do that." She later added:

> …I get on that [the scooter] and I feel like there's absolutely nothing wrong with me. Like, I could cry. Just what a difference it makes to my life. I'm so independent that like this just takes me over the top to be able to do it myself.

To be independent, Susan required oxygen and thus she tried to negotiate the number of portable oxygen tanks she was allocated monthly. At T1 she explained she requested more portable tanks because she was going to social activities in her new building and pulmonary rehab appointments, so the care coordinator gained a policy exception, and she was allotted thirteen tanks. When asked what she would like to see changed or different about home care services she said:

> …I would often inquire like with the oxygen people, well, I'm only allowed ten a month, I mean I couldn't afford to pay them twenty extra for each tank. So, I said, "What about the people that are allowed ten a month but don't leave their apartment? Can I use her ten a month, like-?" She said, "Well, don't work that way." But, like, why not? Like, you know, to me that would be a good idea like, you know?

Despite Susan's desire not to bother people (including service providers), she presented this novel idea to increase her oxygen. I believe this was because had she been successful, it would have facilitated her independence; oxygen was literally her lifeline for being able to do ADLs and IADLs. At T2 Susan described her efforts to be independent in grocery shopping:

> Now last week was the first week I tried that online grocery stuff…I was pretty happy with it…I felt like, like I was going to get more independent and stuff because like, I mean it's hard to ask someone to go to the grocery store and pick out your meat you know or to pick out the exact things that you want…and it feels like I'm putting too much pressure on them to get exactly what I want so doing it online really like I was impressed.

It is unknown how the other actors in the care constellation became aware of Susan's desire for independence, but they frequently described her as a client who was mostly independent in her ADLs and IADLs. The HSWs at all three points in time described Susan as "very independent". At T2, in response to whether Susan would maintain or decline, the HSW said:

> I think she might maintain…like she's pretty independent…she sets her mind to something, like she still tries to do stuff that she could do before and I think that's probably where I'm, I'm seeing and hearing the breathing but yeah…I would say that she'll do everything she can to maintain. Like she's not going to sit in the chair and give up kind of thing.

At T2, with a lack of attention to the fact that Susan tried to negotiate more oxygen tanks, the care coordinator stated:

> …she's getting the exact same service. She's independent with her ADLs um, and IADLs so that didn't change. Because that didn't change, she didn't need any, just any other services that we could offer, so she continued on with the same service of home oxygen and the same amount of home oxygen.

Lastly, at T3, rather than recognizing gaps in communication in the home care system as the reason why Susan might not have as many services as needed, there was a sense that Susan's independence was to blame for her unmet needs. The supervisor said:

> …she's still, you know, quite independent and prides herself to her detriment on, you know, being as independent as possible, so the only increase has been, you know, to relevant kind of every second week housekeeping. She now has weekly to be inclusive of everything.

Contextual Factors that Influenced Communication in Theme 2

Contextual factors that influenced communication with the client include the home care policy; the home oxygen policy; and HSW flexibility.

Client Independence as a Goal of the Home Care Policy

Helping to maintain client independence is referenced several times in the home care policy manual. In fact, the purpose of home care is: “Home care helps people of all ages who need assistance to maintain their optimal wellbeing and independence at home” (Government of Nova Scotia, 2011, p. 1). As a home care client, Susan’s desire for independence was well aligned with the system goal of helping people to maintain independence. However, Susan did not equate her desire for independence with a lack of desire for relationships. On the contrary, she seemed to enjoy interactions and relationships very much. I suspect she may have been open to conversations with the agency supervisor and care coordinator around her care and how best to approach her services to achieve her goal of independence. However, it seemed that the home care system actors were concerned with respecting Susan’s desire for independence and to do so they minimized communication with her, perhaps as part of their understanding and actualization of PCC.

To better meet the shared goal of client independence, system actors need to learn that home care clients have shifted their understanding of living independently to include support from services involving collaborative, interdependent relationships (Compton et al., 2020) akin with the philosophy of client-centred care. Autonomy as a key tenet of client-centred care along with independence is associated with maintaining quality of life (Dostálová et al., 2021). Ultimately, the key tenets of PCC such as autonomy and respect do not preclude important communication with clients from taking place.

Home Oxygen Policy

The Home Oxygen Service Policy Procedures and Guidelines state that "the objective of home oxygen therapy is to improve health and increase participation in activities of daily living" (Government of Nova Scotia, 2016). After the initial referral is made by a physician, a continuing care coordinator determines a person's oxygen therapy needs through the assessment process. The program provides a maximum of ten oxygen tanks per month (Home Oxygen Services Procedures and Guidelines, 2016). It was apparent that Susan needed to negotiate this life-saving service for herself with results that did not always meet her needs not atypical as individuals with COPD often have unmet needs (Crawford et al., 2013). The care coordinator said she was "way over policy limits." During the pandemic, a memorandum was sent stating that "exceptions to the Home Oxygen Program will be supported" (Government of NS, 2020f) so it is confounding that Susan's oxygen was decreased at this point in time. Although the policy was flexible in allowing more than the maximum monthly amount the fact that there is a cap on oxygen that limits a client's ability to live fully without having to turn down oxygen for fear of running out lacks dignity and defies the principles of client-centred care in regard to respecting personhood and treating clients as unique and holistic individuals.

Flexibility by the HSW

From the policy perspective, it is relevant to note that core home support services include personal care, meal preparation, light housekeeping, and respite (Government of Nova Scotia, 2011, p. 52). Furthermore, it states that light housekeeping "includes assisting with and/or teaching self-care techniques for instrumental activities of daily living in the areas of general household cleaning, laundry, and changing linen" (Government of Nova Scotia, 2011, p. 50). Although Susan was assessed for personal care and not meal preparation, the HSW did not mind preparing vegetables for her and might have rationalized that it was acceptable to exchange personal care for meal prep as both are core services illustrating the flexibility in the relationship between the two least powerful members of the care constellation.

Cross Case Analysis

A cross case analysis of the similarities and differences between the case-based themes will be discussed next.

Table 2

Cross Case Analysis of Case-Based Themes

		Themes	
Home Care Actor	**Type of Theme**	**Case 1**	**Case 2**
Across All Actors	Temporal	Formal Communication Processes May or May Not Meet Clients' Needs.	Formal Communication Processes May or May Not Meet Clients' Needs.
Client	Thematic	The Role of Conversations in Meeting the Client's Psychosocial Needs.	Communication Associated with Maintaining Independence.

Cross-Case Overview

The two cases have similarities as well as differences. In terms of characteristics, both clients were female, received home care services for more than five years and had multiple chronic illnesses. By T3, both had been hospitalized and experienced changes to mobility. Their mental health worsened over time, perhaps as a result of isolation during the pandemic and underlying health issues. Both had family caregivers who had mental and physical health issues of their own. In regard to their home care services, the client in case 1 initially received 5.5 hours per week for personal care and TEDS which was later increased to 8.5 hours per week to include meal preparation while the client in case 2 initially received one hour per week of light housekeeping which was later increased to two hours per week for personal care and assistance with groceries.

Contextual Factors that Influenced Communication

The ERL code assigned to the two clients of my study is unknown but the client of case 1 continued to receive services (TEDS and personal care) while the client of case 2 had her light housekeeping services cancelled for about six weeks despite her inability to perform housework. Although both clients experienced isolation and loneliness the supervisors in both cases perceived that the home care clients were not affected by the pandemic. They talked about the main burden on their role being the distribution of PPE to HSWs and the ongoing communication with HSWs who were emotionally drained. Only one of the four HSWs perceived that communication with clients was impacted; the other HSWs felt that other than the mask mandate, delivery of care was not affected. The three care coordinators spoke of an increased workload primarily due to policy changes that widened the eligibility for clients to access financial support; otherwise, little effect of COVID-19 on clients was mentioned. The main effect on their role was that reassessments, which they all agreed were the main connection to clients, were done by telephone.

A key contextual difference between the two cases was their living environment. Whereas the clutter in Judy’s home was a constant source of tension, Susan’s apartment was tidy. Judy and Christine were characterized as non-compliant with the rules because they utilized time incorrectly and created an unsafe work environment. Susan on the other hand was characterized as a client with minimal needs who was very appreciative, and visits were positive. Exploring the home further as a contextual factor that impacts communication would be an interesting implication of this study.

Cross-Case Similarities in Themes

The same temporal theme transcended the two cases: formal communication processes may or may not meet clients' needs. In Judy's case, formal communication at times helped to meet her needs (e.g., annual reassessments resulted in additional services), but there was also evidence of how this process served a different agenda (e.g., enforcement of policies to gain compliance around time utilization). In Susan's case, services did not change as a result of reassessments by the community care coordinator, only by the assessment done by the hospital care coordinator. Also, progress notes did not serve her needs. In fact, they had the opposite effect; in default of progress notes the adage that no news is good news permeated the case whereas in reality she was far from doing well.

Cross-Case Differences in Themes

The key difference found in the analysis of the clients' interviews was in communication related to their individual needs. As described in the theme 'the role of conversations in meeting the client's psychosocial needs', Judy enjoyed conversations with HSWs at the breakfast table prior to her services commencing. Unfortunately, this need could not be met as companionship is not a core home care service and there was a strict need for the HSWs to adhere to the time allocations of her assessed services. The ongoing situation created tension among the actors, eventually leading to the risk that her services would be decreased if she did not adhere to her responsibility as a client to be prepared for services to begin when the HSW arrived.

The above theme contrasts with a key theme from Susan’s interview, ‘communication associated with maintaining independence’. This theme was closely tied to her desire for independence, a key factor that seemed to influence the communication between the actors. It seems plausible that they minimized communication and perceived Susan to be fine because they wanted to respect her right to independence.

Chapter 6: Discussion

There is limited research on home care communication and even fewer longitudinal studies that examine communication over time. The aim of my study was to explore how formal communication practices help meet clients' needs and adapt over time from the perspectives of home care clients, family caregivers, and HSWs as well as contextual factors that influence communication. A person-centred care and critical relational theoretical approach illuminated important findings related to home care communication and how it was impacted during the COVID-19 pandemic.

Critical Relational Theory

Critical relational theory contributed a critical perspective to communication between the home care actors. In this study, I used critical relational theory to focus the analysis on revealing inequalities in power relations between the actors. In Nova Scotia, the Department of Seniors and Long-Term Care establishes policy for home care services, while the Nova Scotia Health authority is responsible for the employment of care coordinators who assess clients for needs, determine eligibility for services, and perform annual reassessments (Keefe et al., 2022). Not-for-profit and for-profit agencies provide home care services for NS public home care. The hierarchical nature of the system was commented upon by the actors on several occasions with the care coordinators referred to as "top bosses" revealing the perceived awareness of the unequal nature of the care constellation members. HSWs discerned themselves as the least powerful members as evidenced by their comments regarding the lack of communication which devalued them as team members.

Engaging clients in decisions regarding their care seemed to exist to a minimal degree in this study. Rather it seemed as though the clients acted autonomously to overcome their lack of agency to effect true change over services delivered within the power structure of the organizational and political context of home care. Although both clients demonstrated an ability to negotiate the conditions of home care services based on need, they did so with differing degrees of success. As relational theory examines care as the “inter-relational achievements of people” it can be thought that the client of care constellation 1 may have had a greater degree of success because of the relationship between herself and her daughter. Together, as “one voice” they were able to communicate somewhat effectively to have the client’s needs met and participate as more equal partners in the care constellation on an ongoing basis. The fact that the client of care constellation 2 did not have a family caregiver who participated in the delivery of home care services seems to have positioned her as less able to negotiate the power relations of the home care system.

Also, in light of critical relational theory, particular attention must be paid to the social position of the actors. The client in care constellation 1 had been a small business owner which would have required her to have communication skills and interact with a wide range of individuals. Her daughter had a university education and worked within the healthcare system. She articulated her comfort in speaking with health professionals and thus was able to advocate for her mother. This orientation guided how they thought, spoke, and lived. The power differential between the client and caregiver and the formal actors may have been minimized because of their social position, skills, education, and prior work experience.

Also, of importance to the context of home care and relevant to this constellation was the fact that the client’s private home space was judged as a hoarding situation which contested the physical, social, and symbolic meaning of her home. The daughter was criticized by an HSW for not doing more to tidy the house and care for her mother. I postulate the role that stigma towards people with mental health issues played in this case. Although awareness of mental health has increased tremendously, mental health stigma still exists within our society. Was the home truly a hoarding situation or was it a societal bias toward how they lived? Had the daughter not been considered lazy would respite have been assessed as a service for the client?

The client of the second constellation had a high school diploma, worked in food services, and lived in a rooming house for many years thus indicating her lower socioeconomic status. Her personality trait of not wanting to bother people may have been part of her upbringing and prior life experiences, and reflective of the societal ideology that people in poverty are responsible for their own circumstances. This is consistent with an assumption of critical theories that people often blame themselves for their oppressive circumstances. People living in poverty often live with a “learned helplessness” that can generate apathy and hopelessness as well as the belief that they are powerless to exert change over their own lives; an external force has power over them (Gibson & Barr, 2017). In the case of this client, hopelessness was articulated, and she may have been uncomfortable communicating with the agency supervisor and care coordinator who were of a different social class than herself. With a societal bias toward low-income individuals, she may have been hegemonized to believe she should not ask for more, question authorities or pursue challenges related to lack of communication (e.g., IADL program).

Lastly, although both clients had chronic diseases, the impact of the conditions on their lives was different. A condition such as COPD that affects the energy of an individual and leaves them breathless should be considered as a direct factor that impacts their communication abilities. What these differences between the clients' socioeconomic backgrounds, relationships and health tell us is that communication is indeed a complex, interdependent, and interactional process (Shaw et al., 2021) affected by many factors at interplay between individuals, their relationships, community, and society.

The COVID-19 Pandemic

A key contextual aspect of this case study was the COVID-19 pandemic that continued throughout T2 and T3. Findings revealed that the agency supervisors and care coordinators viewed the pandemic as having a negligible effect on clients and family caregivers, an important factor that impacted their communication with these actors. For example, they felt that client 2 did fine without her services for six weeks and her depression due to social isolation went undetected; there was also no expressed need to follow up with her during the interruption to her services to ensure she was okay contrary to the ERL protocol. As for case 1, there was little consideration given to the fact that the family caregiver was a frontline healthcare provider who, like themselves, faced considerable stress during the pandemic.

Researchers emphasized the critical need for home care services to continue to be delivered during the pandemic (Jang & Kim, 2020; Naharci et al., 2020; Prakash et al., 2021). However, this did not necessarily occur as clients in Nova Scotia were prioritized according to the ERL protocol (Nova Scotia Health, 2020b). Clients who "only" received light housekeeping such as the client of case 2 were considered low priority. Regardless of the amount of service, future prioritization of clients in this manner (due to a pandemic or otherwise) needs to attend more closely to the individual's circumstances so that their basic ADLs and IADLs are not jeopardized. As well, early research revealed that older adults were not immune from the effects of the pandemic; they indeed were affected by isolation (Guest & Peckham, 2022) consistent with my findings that revealed both clients expressed feeling lonely and isolated with limited social contact. As is true throughout most organizations and systems, there is a fundamental need for both the home care agency, government, and health authority to review policies and procedures enacted during the pandemic, to reflect on what worked and what did not work from the perspective of all of the actors in home care so that knowledge based on experience can lead to positive changes should another global health crisis occur again.

Structural Factors that Influenced Communication

Three factors related to the structural framework of home care strongly influenced communication between the actors in the two care constellations: focus on safety, lack of accountability, and time constraints.

Focus on Safety

There was somewhat of a 'one and done' attitude after the initial assessment with clients unless there were problems to be solved. When conflicts or problems existed, communication focused on meeting the agency and system level communication needs, namely, the enforcement of policies to gain client compliance and reduce liability risks. In this regard, policies directed how communication adapted and under what circumstances. The paternalistic approach to delivery and oversight of clients' services in case 1 became more punitive over time as tension escalated. Communication did not adapt to productively resolve conflicts; rather the attitude that the client was misusing time and needed to comply with policies guided the tone and content of the messages conveyed by the actors.

Safety is unquestionably an important issue; however, in case 1 the focus on safety irrefutably took precedence over other salient concerns including unmet needs of the client and family caregiver (e.g., burnout). The lack of concern for caregiver burnout in case 1 despite obvious signs of distress was alarming as her ability to continue to care for her mother at home was questionable but disregarded by the actors. This study reinforces the long-recognized need to attend to family caregivers as valuable members of the care constellation.

The focus on safety concurs with literature that found health professionals often prioritize safety over client needs and preferences (Durocher et al., 2015). Balancing the need of safety of HSWs with autonomy of clients is one of the challenges of client-centred care unique to the context of home care (Silverglow et al., 2022). However, safety and client-centred care do not need to be at odds with one another (Silverglow et al., 2022). Although safety is most often conceptualized in terms of physical risk reduction, other dimensions of home care safety include emotional, psychological, social and functional (Lang et al., 2014). The home care agency and home care system in Nova Scotia could potentially improve quality of care by expanding the concept of safety to include these other dimensions found to be important to clients, family caregivers and

HSWs and relevant within a client-centred approach to services (Lang et al., 2014; Silverglow et al., 2022).

Lack of Accountability

Three closely linked formal communication processes were identified in the analysis as important to how clients' needs were met: progress notes, reassessments, and care plans. Progress notes pertaining to specific client issues identified by the HSWs (e.g., changes in behavior) were highly depended on within the organization and system for triggering a potential need for an earlier reassessment which may then lead to changes to a care plan.

However, policies to meet the client's needs over time, including the reassessment policy, were not adhered to by the agency supervisor and care coordinator likely due to reasons related to the pandemic, time constraints and system overwhelm. However, lack of accountability by system actors has been reported as an ongoing issue with the need to improve transparency, accountability, and communication to ensure home care clients and families receive timely services as key priority actions for home care in Nova Scotia (CARP, 2021). Under certain circumstances reassessments are supposed to take place earlier than the annual due date, including client hospitalization, mobility, or behavioral changes, noted as a fundamental way in which communication between the actors adapted to meet client's changing needs. This flexibility of the reassessment protocol was also noted by Funk et al. (2022). The adaptation to the timing of the reassessment is included in government home care policy. Specifically, the reassessment /revision of service plans policy (Government of NS, 2011, p. 38) states: "additional case reviews or reassessments must be conducted if the condition or situation of client changes." The agency policy states that interim visits by the agency supervisor are determined by the needs and complexity of the client. Both clients were hospitalized, however, earlier reassessments did not take place. When reassessments at T3 did occur, adaptations to the service and care plans were not made and services remained the same. Both clients experienced unmet needs that were not grasped during the reassessments, a risk to aging in place, exemplifying the importance of reassessments as a formal home care communication process that should be attended to as best as possible.

As an important formal communication process to inform of changes to clients' health, the ambiguity around progress notes for either client had a negative cascading effect throughout the organization and system, especially in case 2 where actors assumed "her services were ticking along well." The expressed lack of progress notes by the supervisor seemed to be a barrier that strongly influenced how this client's reassessments and need for services were approached, even when services failed to deliver (e.g., IADL program). This study provides strong evidence that progress notes alone are ineffective as the formal communication process by which changes to a client's health are communicated; a progress notes policy is warranted; and the close adherence to the adage 'no news is good news' in the absence of progress notes needs to be dismantled in home care communication. As well, the unaccountability of supervisors to the HSWs in regard to progress notes and any subsequent outcomes of the notes, was a factor that HSWs described as needing to change; they desired feedback and greater communication as valued members of the care constellation. Practical steps such as acknowledging progress notes, personally informing an HSW of a client's death and ensuring HSWs understand the reason for changes to a client's care plan could begin today.

Time Constraints

Salient findings associated with time were uncovered by the analysis including time allocation of tasks, which was a key barrier to client-centred communication. Tension around time grew during the pandemic. McDonald et al. (2019) explained that client-centred care takes time but “time is the enemy of day-to-day person-centred care provision in systems…that promote time-specified visits to service users.” Time was most certainly the enemy for the client in case 1 and the source of strain in the care constellation as she was accused of misusing this valuable resource. It can be argued that resolving issues around time as proffered by McDonald et al. (2019) is essential to the provision of client-centred care. Allowing more time with each client could also have a very desirable retention effect as an important contributor to job satisfaction of HSWs. The shortage of HSWs and the time/task allocation model are undoubtedly complex issues to change within the home care system, however, acknowledging time as a resource that facilitates client-centred care based on trusting relationships would be a positive first step.

Challenges with Operationalization of Client-Centred Care

Both clients received home care services from the same agency which has a person-centered care policy. Although the agency’s policy states that person-centredness is expected of all staff, it falls short of explaining how the approach is to be achieved, a major gap in the policy and barrier to the operationalization of PCC. Although some aspects of client-centredness were revealed in the results including empathy and listening, none of the actors conveyed a deep understanding of the key tenets of client-centred care as included in the organization’s policy such as the importance of personal history, respect, dignity, social justice, relationships, and family. A client-centred approach must permeate an organization with management leading by example with practices that embody the principles of client-centred care (Johnston & Womack, 2015). Without further guidelines and training on PCC, the actors, in particular the HSWs responsible for the care of clients, cannot be faulted for their varied understanding or approach (or lack thereof) to client-centred care. Further development of procedures and guidelines are needed by the organization to overcome this barrier along with training on PCC.

Limitations of the Study

A limitation of this study is the use of secondary data that was not attained for the initial purpose of examining communication. Further qualitative and/or mixed methods research that attends to client-centred communication would further add to knowledge and best practices to ensure home care clients and family caregivers receive quality home care services, and HSWs find reward and satisfaction in the essential work they perform. A second limitation of the secondary data used in my study was that demographic information about the home support workers was not collected. Therefore, important factors that may influence communication between members of the home care constellations including the language, culture and background of home support workers were not included. As many home support workers are racialized immigrants, the inclusion of these factors will be critical in future studies of home care communication.

Research on how to operationalize and measure client-centred communication is needed as well as research that examines communication training within a PCC model.

Implications of this Study

Implications of this study include the enhancement of knowledge and skills through training of HSWs, agency supervisors and care coordinators on common chronic conditions of older adults, including mental health conditions; and client-centred communication skills. As well, with the inclusion of contextual factors in the critical component of this study, three potential changes to policies to better facilitate client-centred care are highlighted: review and revise the home care policy manual to align it with a client-centred care model; development of a formal policy for progress notes; and provide time for conversations within the current delivery model of home care services.

Training on Client-Centred Communication Skills

As communication is an essential element of PCC, and HSWs vary in their communication skills, communication training that embodies the importance of listening, showing empathy, engaging in small talk, being friendly and responding to emotions needs to be included in further training. A PCC policy statement alone will not ensure the delivery of PCC to the clients.

Training on Chronic Conditions

The analysis revealed a lack of knowledge of the clients' chronic diseases, in particular, COPD and depression. Both clients were believed not to be complex cases by the agency supervisors and care coordinators despite the multiple chronic conditions that they lived with that caused deterioration to physical and mental health over time.

It is unknown at what stage of COPD Susan was at, however, it was evident (and as she said herself) that her condition was getting worse with progressive difficulty in breathing and increased dependency on oxygen. However, her dramatic need for increased oxygen over time was not associated with the need for changes to any of her home care services. A better understanding of COPD as a terminal condition characterized by a gradual decline in health that progresses to end stage over time with the eventual need for palliative care (Sigurgeirsdottir et al., 2019) may have changed the trajectory of how this client was approached. This important finding is supported by research that has found that care of COPD clients tends to be sporadic, fragmented, and reactive (Crawford et al., 2013).

Furthermore, the need for emotional support by COPD clients is well documented as is the high prevalence of depression, anxiety and lack of energy to communicate (Gardener et al., 2018), which were also observed as factors that negatively affected this client's ability to communicate and interact. Studies have also found the need for clients with COPD to have someone be "their voice" when energy is insufficient (Gardener et al., 2018). I postulate how the home care system while respecting clients' wishes as to whether or not a family caregiver is involved, could encourage a client to include a family member for reasons given above; this very much already occurs with clients who have dementia.

This study also lays bare important deficiencies in the agency and system's abilities to effectively care for clients with mental health conditions. Sadly, in case 1, the supervisor deemed herself unable to help with the client's mental health issues because of her paucity of training in this area. In case 2, the client's mental health issues went completely unrecognized by the actors. As statistics indicate that nearly twenty percent of care recipients received help because of mental health problems (Statistics Canada, 2020) there is an urgent need for training on mental health issues to ensure this growing population receive necessary home care services and referrals to other appropriate organizations.

Home Care Policy Changes for Consideration

This study highlighted three areas for consideration to improve client-centred communication within the home care policy framework of Nova Scotia: an overall review of the home care policy manual to align it with a client-centred care model; the development of a policy for progress notes as an important formal communication process; and time allocated for conversations to meet psychosocial needs of clients.

Philosophy of Home Care. It appears that the NS Home Care Policy Manual has not been updated since 2011 (apart from an addendum to reflect changes to the health authorities). The philosophy of home care does not currently reference client-centred care and client-centredness is only mentioned a few times throughout the manual. The health authorities throughout the province claim to subscribe to client-centred care since the expansion of the Home First model in 2012 (Keefe et al., 2022). However, there is a need for the Department of Seniors and Long-Term Care who fund and oversee government funded home care agencies (Government of NS, n.d.) to update the home care policy manual to align it with a client-centred care philosophy if that is indeed the model of home care in Nova Scotia.

Progress Notes. Despite the agreed upon importance of progress notes by all the actors there appears to be a lack of guidelines or specific policy regarding their use; only one reference to progress notes was located in the home care policy manual in the client records policy (Government of NS, 2011, p. 43). A formal policy could help reduce the ambiguity that HSWs seemed to have around the utility of progress notes. Critical as the formal communication process that precipitates additional reassessments under specific client conditions that potentially lead to changes in the client's care plan, it seems judicious to recommend further attention be paid to this process within both the home care organization and government.

Time for Conversations. Time spent on conversations between clients and HSWs would help to meet important psychosocial needs of clients as well as build necessary trust between clients and HSWs, essential for client-centred care. As home care clients often have limited contact with other people, they benefit from social interactions with HSWs which can have a positive effect on their physical and mental health and behaviors. Conversations and time spent in social interactions also help facilitate client-centred care.by providing HSWs with the time needed to learn about clients and to understand their needs so they can then report changes to the supervisor and care coordinator in progress notes. HSWs also find meaning and a source of enjoyment in conversations, an important factor to their retention in a system that is severely understaffed.

However, the home care structure in Nova Scotia currently does not allocate time for socialization or conversations, a barrier to client-centred communication and care. Attending more closely to the benefits of this type of communication within the care constellation and finding ways to overcome this current policy limitation could reap many rewards including HSW recruitment and retention, a key area of concern within the system.

Conclusion

Home care communication is a complex, interdependent, and interactional process between clients, family caregivers and home support workers (Shaw et al., 2021) referenced as care constellations in this research. Using longitudinal secondary data (28 semi-structured qualitative interviews) from the Home Care Pathways Project (Keefe et al., 2020) and framed by person-centred care and critical relational theory, this study examined communication within two Nova Scotian care constellations and how communication adapted over time. It also assessed how factors such as societal, structural, political, and historical factors influenced communication within the care constellation.

Three formal communication processes were found to help meet clients' needs: progress notes, annual reassessments, and the care plan. However, factors including time constraints, lack of accountability and a focus on safety negatively influenced communication and were barriers to how these formal communication processes adapted over time. As a result, both clients had unmet home care needs that put their ability to age-in-place at risk. With a critical lens, other factors were also identified as influencing communication between the actors including the social position of the clients; their personality; relationships (or lack thereof) with a family caregiver; their home as a contextual factor; and possibly, stigma and discrimination by the formal actors toward mental health issues. COVID-19 of course was an unprecedented event in history that impacted the clients in this study through isolation as well as through the effects of policy changes that prioritized service delivery.

Implications of this study could lead to enhanced knowledge and skills of staff with training on mental health issues and client-centred communication skills. Reducing services to clients who exhibit behaviors related to mental health may be an outcome if they do not adhere to policy requirements (as seen in case 1) but ultimately this approach does not serve the client or the system well if the client cannot remain at home without the provision of home care services. A different approach is needed.

If client-centered care is to take hold in Nova Scotia, the structural framework with its close adherence to a task/time model needs to be critically reexamined as time is a necessary resource for client-centred care. With a critical perspective, possible policy changes to home care have been highlighted to better align the framework with a client-centred care model. The home care agency of this study is well positioned to further commit to client-centred care with its current policy and philosophy by developing operational guidelines and through the provision of training on client-centred communication skills.

This study makes an important contribution to the literature on home care communication and how communication could improve to better meet clients’ needs within a client-centred care model. In particular, as a longitudinal study, it helps to fill a gap in understanding how communication adapts over time and the impact of the COVID-19 pandemic on communication within care constellations.

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Appendix A

Definitions of Key Terms

As per the Nova Scotia Home Care Policy Manual (2011, p. 53):

Light housekeeping includes assisting with and/or teaching self-care techniques for instrumental activities of daily living in the areas of general household cleaning, laundry, and changing linen.

Meal preparation includes assisting with and/or teaching self-care techniques for instrumental activities of daily living in the areas of nutritional care, menu planning, and meal preparation.

Personal care includes assisting with or supervising activities of daily living in the areas of hygiene, toileting, dressing, feeding, and mobility.

Respite is any combination of services provided specifically for the purpose of giving relief to the family or other non-paid caregivers of a dependent person who lives at home. The objective of respite services through home care is to support the family environment by allowing primary caregivers time to attend to personal matters or to obtain needed rest and relief.

As per the SEAscape Procedures (2018):

A Care Plan documents a summary of the client, authorized services to service providers, applications for certain services where required, and units of service funded by Continuing Care.

A Service Plan is the authorization component of the Care Plan, relating to one particular discipline and the related tasks authorized and approved for delivery.

Appendix B

Table 1

Length of Semi-Structured Qualitative Interviews

Actors		**Length of Interviews**			**Notes**
		Time 1	Time 2	Time 3	
Case 1	Client - Judy	67 minutes	51 mins.	47 mins.	
	Family Caregiver – Christine	49 mins.	42 mins.	70 mins	
	HSWs- Shari (T1, T2) Karen (T3)	27 mins.	65 mins.	63 mins.	*T3 – HSW was on sick leave.
	Care Coordinators	30 mins.	61 mins.	No interview	*T3 – care coordinator was on parental leave.
	Agency Supervisors	43 mins.	58 mins.	55 min.	*T3 – a different supervisor
Case 2	Client - Susan	26 min.	34 min.	30 min.	
	Family Caregiver – Denise	12 min.	34 min.	N/A	*T3 interview not transcribed due to poor audio quality.
	HSWs – Rebecca (T1) Lisa (T2, T3)	22 min.	28 min.	23 min.	
	Care Coordinators	47 min.	33 min.	43 min.	*T3 – a different care coordinator
	Agency Supervisor	36 min.	32 min.	46 min.	
Total	Twenty-eight interviews with fifteen actors				

Appendix C

Sample of Interview Guide Questions

Home Care Clients

Time 1

1. Have you been able to make changes to your Home Care services? (e.g., level, timing, workers)
    a. Can you tell me about a time you tried to make a change? How did that go? Can you tell me about any other times you tried to make a change?
2. Do you know your care coordinator?
    a. If yes – probe for how often they see them, for what reasons, etc.
3. How well do you know your Home Support Worker? [Probe for how well they communicate if they are comfortable making specific requests about their care.]

Time 2

1. Do you recall speaking with or seeing your Care Coordinator, since we last met? [Probes: phone? Annual reassessment? Reason for contact? Who initiated contact? Feel that concerns were addressed?]
2. A) Would you say you are a person that feels comfortable asking for help from your Care Coordinator? [Probe – try to understand why they are comfortable/uncomfortable, nuances]; B) What about asking for help from your family/friends – are you generally comfortable doing this? [Probe – try to understand why they are comfortable/uncomfortable, nuances]

Time 3

1. Thinking about the *types of home care services* you receive, have these

services changed over the past 6 months?

Can you tell me more about how this changed? Why did the service change? Was this because of COVID-19 or something else? Who initiated the change? How do you feel about this? How has this/these change(s) affected your daily life? *(Interviewer may want to reference types of services client identified at T2)*

2. Have your *types of workers* changed over the past 6 months?

   Can you tell me more about how this changed? Why did this change? Was this because of COVID-19 or something else? Who initiated the change? How do you feel about this change? How has this/these change(s) affected your daily life?

Family/Friend Caregivers

Time 1

1. Have you been able to make change to the client's home care services? (e.g., level, timing, workers)
   a. Can you tell me about a time you tried to make a change? How did that go? Can you tell me about any other times you tried to make a change?
2. How well do you know your family member/friend's care coordinator or home support workers? [Probes - how often they interact with them, for what reasons, what kinds of things they discuss together]
3. How well do you understand available care options for your family member?

Time 2

1. Do you recall having any new interactions or conversations with any of [client's] Home Support Workers since your last interview? [Probe for examples, who initiated it, what it was about, outcome]
2. Do you recall having any new contact with [client's] Care Coordinator since the last interview? [Probe for examples, who initiated it; what it was about, outcome]
3. Since the last interview, have you had any new input into the home support that [client] receives? [Probe – explain; did it have an impact?] Would you say it's important to you, to have a voice in the care plan or assessments, or not? [Probe – why/why not].
4. IF APPLICABLE: Would you say you feel comfortable making suggestions to the Care Coordinator? [Probe why/why not?]
5. From your perspective, has anyone in the home care system expressed an interest in either learning about or supporting your own needs as someone who helps [client]? [Probes – for instance, did anyone actually assess your needs in some way? Is this important to you? Why/why not?]

Time 3

1. Do you recall having any new interactions or conversations with any of [client's] Home Support Workers/Continuing Care Assistant since your last interview? [Probe: Examples, who initiated it, what it was about, outcome]?
2. Do you recall having any new contact with [client's] Case Coordinator since the last interview? [Probe: Examples, who initiated it, what it was about, outcome]?
3. Since the last interview, have you been able to provide any new suggestions to the Care Coordinator or home care agency into the home support that [client]

receives from home care? [Probes: Explain; did it have any impact, why/why not]?

Home Support Workers

Time 1

1. So, can you generally describe what a typical workday looks like for you? [Probes for everyday practices, procedures; follow-up on phrases that seem taken for granted or unclear]
    a. Is this more or less the same with this particular [client]?
2. What guides or structures your work with clients? (Probes: What boundaries are there on what you can or cannot do with [client], e.g., care plans, no-show policies)
3. Do you talk much with clients? [If YES: Probes: for what purposes, how often]
4. Do you talk much with family caregivers? [If YES: Probes: for what purposes, how often]

Time 2

2. When other home support workers share the same clients as you, how do you communicate with them about the care you provide, if at all? [probe for examples-communication medium, content of communications]
3. Are you able to communicate information about a client to other health care workers, such as nurses (e.g., if a client also receives nursing services as part of home care]? How does this communication happen?
4. What happens when you have a client who needs more care? What do you do? What can you do? [Probes – can you give an example; can you explain]

Time 3

1. Reflecting on the time since that last interview (*provide date*), have you noticed any changes in [client]’s need for home support? [Probes: Explain, why, how home care or the client/family has responded to this]?
2. Do you know whether there have been any changes to their care plan since that time? [Probes: More or less service, new service, different workers, scheduling change, etc.? Why and how these changes came about? How do you think [client] has experienced these changes? How have these changes affected you, if at all]?
3. How would you describe your approach to providing home care for clients in general?

Appendix D

Table D1

Home Care Policies Included in Data Analysis

Source	**Policy Title**
Home Care Agency	Person Centered Care & Service Delivery Client experience/quality procedure Collection and follow-up of process of client comment cards Distribution Of Client Comment Cards Home Visit to Client by Home Care Supervisor Post Discharge Feedback Form
Home Care Policy Manual, Department of Health and Wellness	Section 1.0 Introduction • 1.1 Purpose of Home Care • 1.2 Objectives • 1.3 Philosophy Section 2.0 Client Access to Service • 2.1 Service Availability • 2.2 Coordinated Access • 2.6 Priorities Section 4.0 Client Rights Section 4.3 Client Responsibilities Section 5.0 Assessment Process • 5.1 Assessment and Service Authorization Process • 5.4 Assessment Process Section 6.0 Case Management • 6.1 Case Management Section 7.0 Service Plan • 7.1 Development of Service Plans • 7.2 Service Plan Participants • 7.3 Reassessment/Revision of Service Plan Section 9.0 Types of Care • 9.3 Chronic Home Care Section 10.0 Home Care Services • 10.2 Home Care Services • 10.4 Home Support Services • 10.5 Additional Home Care Services

	Section 17.0 Occupational Health & Safety • 17.1 Occupational Health & Safety Section 18.0 Incident Reporting • 18.1 Incident Reporting
Department of Health and Wellness	Home Oxygen Service Policy
Department of Health and Wellness, Continuing Care	SEAscape Procedures Version 5.08

Table D2

COVID-19 Memorandums

Issued by	Issued to	Subject	Details	Date
DHW and CC	Home care agencies	Home Care Client Letter and Fact Sheet - COVID-19	Letter to clients to assure that everyone is working together to contain spread of the virus; follow public health guidelines; communicate with Care Coordinator re concerns; will try to provide home care and community services to meet essential needs; home care workers will ask screening questions. Fact sheet on screening and testing protocols, good hygiene practices, make a plan, get accurate information.	March 19, 2020
NSHA	Home care agencies	Prioritization of Home Support Service Delivery	All home support clients must be assigned an Emergency Response Level (ERL) based on an assessment of client needs, availability of support, tasks required;	March 22, 2020

			includes an ERL guide for urgent to non-urgent levels based on criteria for client need and informal/formal supports with recommended action during COVID-19. Includes protocols for assigning ERL, triggering use of ERL, communication, and monitoring.	
NSHA	Continuing Care staff	Temporary Changes to DHW policies/ programs	Home First/IADL: NSHA encouraged to explore all options through these programs to support discharge of patients from hospital and to avoid admission for those at home; Equipment Programs: NSHA enabled to make reasonable exceptions to equipment authorizations as needed including the Home Oxygen program; Red Cross will get	April 5, 2020

			additional funds for purchase of beds and increased home delivery costs. Supportive Care Program: maximum monthly funding temporarily increased to $1000 (50 hours)	
DHW	Continuing Care	Exemptions/ Changes: Home First, IADL Program and SCP	Policy exemptions to increase flexibility; Home First and IADL funding: can be used for client specific needs that arise as a barrier to discharge from hospital and fall outside of current policies (e.g. home support, nursing, home oxygen); Supportive Care Program: funding increased from $500 to $1000 (25 to 50 hours) April 1-June 30; signed agreement remains in place; must submit receipts that funding was spent on approved services	April 6, 2020

NSHA	Continuing Care Staff	Verbal Consent and Signatures on Program Applications and Financial Documents	For clients who can't scan/email/fax signature for consents, program applications and financial documents - verbal consent can be obtained over the telephone and requirement for signatures on these documents can be waived for duration of pandemic; witness to verbal consent may be required depending on the risk; verify client identify with two client identifiers; ensure client understands agreement; keep written record of consent; follow up with written consent ASAP	April 27, 2020
NSHA	Continuing Care Staff	Temporary Changes to DHW policies/programs- Update	Approval for policy extension to CC policies/programs/budgets post June 30th. Home Support for Assisted Living Clients: Funding can continue to be provided to support clients	June 17, 2020

who live in assisted living facilities and whose home support services were put on hold or reduced due to facility policies restricting access to visiting health care workers; provided on a case-by-case basis, until September 30 or until assisted living facilities re-open to DHW funded home support services (whichever comes first). Home First / IADL: continue to explore all options through Home First and IADL Funding programs to support the discharge of patients from hospital and to avoid hospital admissions for those living at home. Supportive Care Program: maximum monthly funding amount that was increased up to $1000 (~50 hours of care) will continue

			until July 30th. Acute Oxygen Service in LTC: Approvals for acute oxygen services can continue until Sept. 30th, as required, based on client need.	
DHW	Home care agencies	Home Care Service Resumption	At this time there does not appear to be a need to continue to restrict or reduce service levels; NSHA will work with agencies to discuss operational challenges; limitations to reinstate services due to staffing; continue with current practice using a progress note if changes to a clients' service authorization is warranted, CC will evaluate/assess what care is needed and update authorizations as appropriate.	July 6, 2020
NSHA	Continuing Care Staff	Resuming Community-Based Service Delivery in	In-person visits within Continuing Care can now safely be	July 15, 2020

		Continuing Care	resumed/increased. All Continuing Care staff whose role includes making in-person visits with clients (i.e., home care nurses, community rehabilitation staff in Central Zone, community-based care coordinators, and behavioral health staff) are expected to begin resuming these visits within the next two weeks following protocols.	
NSHA	Continuing Care Staff	Protocols for Resuming Home Support Services	Continuing Care Protocols for Resuming Home Support Services include Services will resume primarily to existing clients first; agencies will continue to prioritize service using the prioritization protocols and ERL guide upon receiving updated service plans; responsibilities of the Care Coordination	July 29, 2020

Manager and the Care Coordinator. Service plans that have not yet been submitted to home support agencies due to service reductions during the pandemic will begin to be submitted at a manageable intake level.