Abstract

Community nurses face many challenges when trying to practice evidence based, person-centred care. Ongoing concerns regarding the impact of the 2013 Francis Report (Ford and Lintern 2017) suggest that individualised and holistic care is an impossible dream; one made harder when the client appears uncooperative. This paper presents a case study which sets out how some of these challenges were met in a potentially difficult situation experienced by a student nurse and her mentor in practice, in which the student was supported to further examine and explore issues that may have influenced the situation. In this instance the solution came with the recognition that the client had expertise and knowledge that needed to be taken into account alongside that of the nurses looking after him. His care became a partnership, not an imposition of expertise; a principle which is transferrable to many other situations. Underpinning it was the recognition of our shared humanity; where lies the essence of truly holistic care. Student nurses learning this, through the guidance and support of their mentor.

Key Words
Person centred care, humanised care, power, vulnerability, nursing values, community nurses

Introduction
Caring for someone is not the straightforward task it first appears (Theodosius 2013). Recognising that everyone has individual preferences and personalities and putting them at the heart of nursing care is essential (Todres et al 2009; Borbasi et al 2012; Hemingway et al 2012) but, for many reasons competing priorities intervene to prevent the provision of fully humanised care.

How we, as a society and as healthcare professionals, care for the more vulnerable was brought into sharp focus by the Francis Report (2013). In it Francis describes a culture of lack of care perpetuated by a focus on finance at the patients' expense. He holds senior management to account for ignoring the warning signs in favour of pursuing national productivity targets. Again in February 2017, Francis warned that another care scandal is inevitable if the NHS continues its same preoccupation with finances and external targets instead of prioritising patient care (Ford and Lintern 2017). This is endorsed by Professor Peter Griffiths who fears that the lessons learnt are too soon forgotten, particularly those regarding safe staffing ratios (Merrifield 2017). Add to this concerns about 'bed-blocking' and older people feeling that they are somehow not worth high quality care (Storr et al 2013) and it is easy to understand how some older patients might well feel very vulnerable if they find themselves in need of on-going healthcare. Yet everyone has individual preferences and personalities and recognising these and putting them at the heart of nursing care is essential (Todres et al 2009; Borbasi et al 2012; Hemingway et al 2012). It matters that care is compassionate, humanised and empathic, and uninhibited by market forces (Flynn and Mercer 2013).

It is against this background that we discuss Jim's story (Table 1) and through it explore some of the factors that contribute to the provision of high quality care. We suggest that truly humanised care is not only a moral, professional and legal obligation but is also ultimately guided by the personal commitment of, and decisions made by, the healthcare worker (Mee 2013), who, at a personal level may themselves also experience vulnerability and oppression as they strive to meet competing demands (Heaslip and Board 2012).

It will be argued that this that directly affects the quality of care provided and is, in turn, dependent on a high degree of self-awareness and courage underpinned by unconditional positive regard of both self and client, which perhaps explains how care can be of such variable quality even in the same environment (Mee 2013) and which has led to the cultural pressures of which Francis (2013) speaks.

Nurses' challenges: Courage to practice with humanity

The community nursing team met at 08.30 to discuss the day and any particular concerns. They were evidently concerned about Jim's apparent non-compliance and ill at ease at his recent official complaint. This was regarding a visit made by the community nurses some weeks previously when his wife had been unwell and was asleep upstairs. Jim felt that the two nurses who had visited had been noisy and inconsiderate and had woken her up. This had generated a sense of hesitation and unease amongst the team who sought to justify their clinical decisions as if these were paramount. Caution was advised but there was no clear idea of how best to proceed. It was going to take courage and willingness (Thorup et al 2011) to take the next steps in caring for Jim.

My first encounter with Jim was thus not personal but by reputation, as we discussed Jim's needs prior to visiting him. The way the team and their environment is structured proved very helpful in that the team is free from the constraints and interruptions of ward work. Theirs is a supportive culture in which each team member's opinion is heard and valued, where no-one hesitated to voice their fears and doubts about the letter, so they were able to seek solutions together. In effect, this discussion provided time to allow the initial anxiety evoked by the letter to subside; and provided a space which served well in overcoming the initial, very human, fight or flight response that might otherwise have prevailed. As Goleman (1995) suggests it takes a high degree of emotional intelligence and self-awareness to look at a complaint and greet it with gentleness and openness, especially when feeling threatened.

It would have been very easy to have dismissed Jim as awkward and uncooperative and to have overlooked how much his current situation affected his actions. As such it would have been a fundamental attribution error on the nurses' part which could have resulted in reactive defensiveness and dehumanisingly reductionist care (Jones 1979). Instead the nurses provided holistic, person-centred and knowledgeable care which we wish to explore using Todres et al (2009) humanising care philosophy (Table 2). A question that needs posing was what did the angry tone of the letter conceal? Jim's need for security, one of Maslow's (1954) fundamental human needs, was sorely shaken. The numerous locks and bolts in his property suggest that security is especially important to him. Also shaken was his sense of identity and 'personal journey' (Todres et al 2009, Borbasi et al 2012). It was going to take skill, empathy and willingness to find a solution and establish good communication with Jim, and bring about a positive and therapeutic relationship that was genuinely compassionate and humanised (Galvin and Todres 2012).

Central to this was recognition of Jim's personhood, a concept rooted in both Western and Eastern philosophies and taken up by many philosophers since. Carl Rogers (1961) refined this to 'unconditional positive regard' which accepts the person regardless of what they say or do and which enables them to move out of their 'difficult place to somewhere better (McLeod, 2014). Ferguson et al (2013: 286) argue that doing so reinforces the personhood of all participants and, 'makes the world of difference to how you feel'. It is the complete antithesis to objectification and dehumanisation evident in Todres et al's model (2009).

Jim's challenges: Power, vulnerability and control

Bearing all this in mind it became possible to seek other explanations for Jim's initial anger. Perhaps he felt powerless in the face of his and his wife's failing health and advancing age. Erikson (1995) sees a 'key task in old age' is to resolve the personal crisis, which he called 'integrity versus despair', as crucial to a 'satisfactory adjustment in old age' (Wondrack 1998:109). It is a 'final consolidation' where life has had meaning and 'death loses its sting' (Erikson 1995: 242). These can manifest as a loss of personal journey and meaning (Todres et al 2009).

It is also possible that Jim felt unsettled by social changes that have undermined the gender power imbalance that would have been the norm in his youth, or even his perception of an uncaring attitude from the nurses. Jim was evidently accustomed to being in control of his health and his household yet he was powerless in the face of his current health issues and dependent on the nurses' interventions. Power has a significant role in the interaction between healthcare professionals and their clients (Thompson 2012). Used coercively it may lead to unfair treatment, discrimination and 'oppressive consequences' (ibid p16), which is where dismissing Jim as a 'troublemaker' might have led. Perhaps remembering the medical dominance prevalent in his youth (Willis 2006), which sees the disease rather than the person, Jim felt a need to exert his power and assertiveness in pursuit of his own goals.

Though not extensively defined in research literature there is a common understanding of vulnerability as susceptibility to harm or injury, either physical or psychological (Heaslip 2013; Silva et al 2014). It is a very personal perception of one's situation (Rogers 1997). Vulnerability may have been the root of Jim and his wife's distress. Previously so independent they now had to face their need to be reliant upon the Community nurses and even allow them into their home which, relative to any others in the area, was a fortress. A sense of control is central to one's feeling of vulnerability (Rogers 1997). Already challenged by the loss of control due to debilitating illness Jim and his wife now have to open their home to strangers, further reducing his sense of control. Perhaps it was an attempt to regain control that lay behind his apparently contradictory practice of cutting away the bandages – they were 'too tight'. Whilst Jim had listened to and understood the nurses' rationale for the tight bandaging, he chose to ignore the advice he was given. By loosening the bandages he was exerting some control over his health and healthcare experience.

Recognising experience and expertise

Discussion brought about a 'partial agreement' (Wondrack 1998: 45). Ignoring Jim's early barbed remarks negated his hostility and kept communication alive and, in the course of several visits, the balance of power subtly shifted. Jim felt he had regained some control over his situation and so his sense of 'agency' was restored (Todres et al 2009). Additionally it was gradually becoming clear that Jim's wife appreciated the nurses' company, which Jim noticed and responded positively to. Negotiation that is based on trust built up over time is acknowledged to be an effective way to bypass or challenge discrimination and oppression (Thompson 2003). It redresses power inequalities whilst fostering individual agency (Todres 2009) and so permits the delivery of effective treatment. Foucault describes such power interplay as 'a property of interactions between individuals, groups or institutions' (Thompson 2003: 53); here aided by the culture prevalent in the community nurses' environment together with a personal willingness not to allow discrimination to creep in nor to form judgements based solely on previous experiences (Thompson 2003) - in this case Jim's initial letter of complaint.

Throughout all the interactions with Jim and his wife there remained an underlying resistance to any hint that others might hold power over him. He was, perhaps, continuing to anticipate, and reject, any attempt by the nurses to take the expert high ground in the treatment of his leg ulcers. In this there appeared to be a mismatch between the nurses' and Jim's ideal of the desired outcome. Wielding power *over* is something that healthcare professionals may find they are doing, possibly unwittingly (Corless et al 2016), bringing unwelcome echoes of coercion (Ryden and Willetts 2013). As a product of a patriarchal society Jim might be reluctant to accept authority especially when held by women (Roberts et al 2009 cited in Dubrosky 2013).

Ryden and Willetts (2013) draw a distinction between 'power to', which speaks of ability, and 'power over', which implies a dominant or coercive relationship. Jim was more accepting of the nurses' power *to* connect with him; perhaps he recognised that he was being valued and respected. Komatsu and Yagasaki (2014) describe this process of connection and shared action as realising patient potential through which the patient regains control of his daily life. Finding out what is important to the patient leads to personalised care, improves the quality of the patient-nurse relationship and determines how therapeutic the encounter will be (ibid). This may mean nurses setting aside previously held treatment goals (Fackler et al 2015) in favour of a medically less satisfactory outcome that better meets the needs of the patient at the time (Houston and Cowley 2002) as happened here.

So it was that Jim was empowered to become a partner in his own care and his 'participatory competence' was acknowledged (Houston and Cowley 2002: 643) and an outcome achieved with which Jim, who now felt in control over how his leg ulcers should be managed, was content. Cooper and Scammell (2013) describe anti-oppressive practice as an empowering partnership with service users; one which is achieved through critical reflection, advocacy and negotiation. Although Jim's treatment was superficially sub-optimal when set alongside the most recent developments in leg-ulcer care, it was an anti-oppressive partnership. However beneficial anything else might have been it may well have been viewed as 'unwelcome abuse and coercion' (Heaslip and Ryden 2013 p41) by Jim: and certainly would have merited the disapproval of the Nursing and Midwifery Council (2015).

It took courage on the nurses' part to face the uncertainty about how Jim would react when next they visited. They returned in spite of their uncertainty, bolstered by previously having had a safe place to voice their doubts and find support. Thorup et al (2011) describe this as empowerment to care and, in turn, empower others.

Conclusion

Within community nursing practice, there can be 'difficult to manage clients', yet often our professional response is to manage the behaviour without necessarily exploring the factors which may underlie this. What we are hoping to address in this paper, is the realisation that often behaviour is complex and multi-faceted influenced by personal beliefs and values. In sharing Jim's story we hope to illuminate possible reasons behind potentially 'challenging' behaviour by examining what it is to be human and our human need to hold on to power and also be treated with respect and dignity as befits our shared humanity. That it remains possible in a post-Francis world suggests that perhaps not all the lessons are forgotten. It is testament to the sensitive recognition of Jim's vulnerability by the nursing team and their courage that the eventual outcomes met both his and the nursing objectives.

As Thorup et al's (2011) study suggests it is possible for both healthcare professional and patient to experience vulnerability and oppression but, with sufficient reserves of self-awareness, emotional intelligence and personal commitment on the part of the professional, both may be overcome. Providing humanised care to Jim was challenged by his early confrontation. Had the initial reaction to respond in similar vein been allowed then the outcome might have been very different. Instead Jim was offered calm and considerate care that met him, as a person, his needs, as a patient and the demands of evidence-based care.

The provision of humanised care is thus complex, and demands both emotional and courageous commitment. It necessitates a high level of curiosity, emotional intelligence and determination to make morally and professionally right choices in the delivery of care, coupled with a reflective understanding of the equally complex interplay of structural, cultural and personal factors (Willetts et al 2013). Above all, it needs to be based on the fundamental principle that everyone, worker and patient alike, is worthy of unconditional regard. They form a powerful combination when put at the heart of nursing care.

Key Points

- Lessons need to be learned from the Francis Report to avoid such dehumanising practice occurring again; it is therefore important that teaching approaches by mentors in community settings provide opportunities to examine and explore the application of personalised care through the review of client case studies.
- Compassionate care has to take account of individual's life-world experience and concerns as well as examining our own attitudes and beliefs.
- Meeting each individual's needs takes time, courage and imaginative understanding. Together they make it possible to deliver safe, evidence based care as a partnership of nurse and patient.
- Recognising our shared humanity is at the heart of humanised care.

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Table 1: Case study of Jim

Box: Case study

Jim (a pseudonym to preserve confidentiality (NMC 2015)) is an elderly gentleman who lives with his wife in a privately owned house within a small 1960s development at the edge of an established and bustling village. They are very security conscious and have metal grilles at the windows – unlike anyone else in the neighbourhood – and double locks on the outside doors. Jim has been under the care of the District nursing team for the last couple of weeks due to bilateral venous leg ulcers, for which the District nurses are visiting twice weekly.

His wife has myasthenia gravis, which results in her feeling very tired at times, she is cared for by the same GP and is also known to the district nursing team who have visited her in the past. Although she is currently feeling very tired Jim will ask her to do all manner of small tasks about the house, though he does acknowledge that he is her carer, or was until his leg ulcers prevented him from getting about. She generally takes his demands with good grace. Both are aware of increasing frailty and the threat of dependence on others due to advancing age. Jim finds the unwanted untidiness of the house and garden oppressive.

Since his problems with leg ulcers Jim has stayed downstairs, sleeping on the sofa. He refuses to go outside at present as no shoes will fit over his feet, due to his swollen legs and bandages. His legs have been very oedematous but are much improved now with compression bandaging which he tolerated for 2 or 3 weeks but has since refused to wear on the grounds that it is too tight. He grumbles about the slow healing but acknowledges that the bandages he shuns would improve his ulcers much more quickly. He has previously refused to wear compression stockings. He was driving until very recently and hopes to get back to it but clearly does not see this as a short-term goal.

Telling Jim what to do is counter-productive. He makes up his own mind about what is right – or not – and refuses to reconsider. Humour proved by far the best route to arriving at an amicable compromise over the 'tight' bandaging. It is unclear if it is a compelling need to make his own decisions about his treatment – where he is quick to offer his opinion - or a lack of understanding of his condition that drives his attitude. Sitting in his chair and issuing instructions seems to keep him occupied. He has recently written a letter of complaint to the nurses.

Table 1: Todres et al. (2009) Conceptual Framework

Conceptual framework of the dimensions of humanisation by Todres et al. (2009)	
Insiderness	Objectification
Agency	Passivity
Uniqueness	Homogenization
Togetherness	Isolation
Sense-Making	Loss of Meaning
Personal Journey	Loss of Personal Journey
Sense of Place	Dislocation
Embodiment	Reductionist body