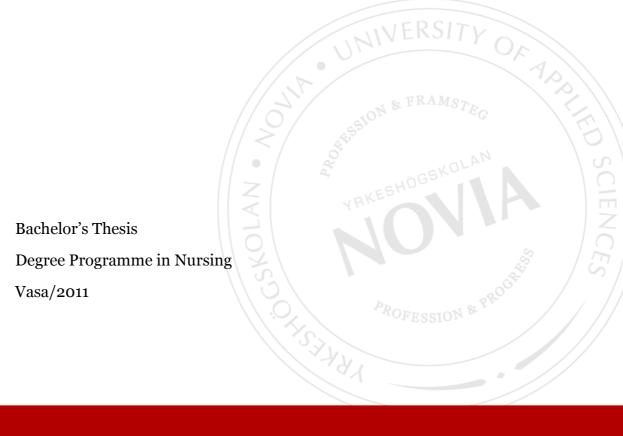


Choosing A Holistic Care Approach For The Elderly

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Summary

The concept of holistic care in today's nursing helps to enhance the total well-being of the patient. Portraying the human being only by his present needs is insufficient. Every individual is unique and should be cared for as an entity comprising of body, soul and spirit.

The objective of this thesis is to gain more knowledge and to shed additional light on the concept Holistic Home care for the elderly within the home setting from the perspective of the care givers.

Six groups of homecare givers participated in an interview study. Open individual semi-structured and group focused interview were conducted. A qualitative content analysis was used to analyze the interviews. The findings were summarized into six categories and one overarching theme. The results indicate that, the perceived possibility of being treated with dignity and respect is closely connected to how the caregivers cared for their elderly patients. In addition, caring for the elderly in totality is also the paramount desire of most of the participants.

Language: English Key words: Holistic, caring, homecare, healthcare and elderly, satisfaction and wellbeing.

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1. Introduction

The need for homecare might continue to increase as over the next decade as the elderly population is increasing and people are finding reasons to take care of their aged at home. As the location of care continues to move closer to home, it is crucial that the implicit qualities that are valued within the nurse-patient relationships in this context are recognized and made more definite at both the organizational and policy level (McGarry, 2008).

The caring relationship between a nurse and a patient is vital for the total wellbeing of the patient. Patients require a caring relationship, which enables enhanced conscious awareness of life and health experiences. The nature of the relationship is to be able to relate to each other and be harmoniously attracted in having a meaningful and social relationship (Berg & Danielson 2007). The caring relationship is identified as being restricted to time and circumstances where the nurse promises the patients care in which the patient's story is shaped by the nurse's involvement, by which the unique human being is shaped as a whole of body, soul and spirit. This according to Berg and Danielson influences both the patient and the nurse and is essential for affirmation in a way that enables support for health and well-being. The relationship promotes health and healing channels because; it involves the true and absolute needs of the patient.

Mok and Chiu (2004) viewed nurse-patient relationship as central to the practice of nursing. According to the study of Mok and Chiu, being connected with nurses gave patients someone to depend on, someone they could confide in and express their deeper feelings. The most essential of all was, through their relationships with nurses, they accustomed themselves as people who mattered. However, the nurse-patient relationship is dialectic in nature; it entails both closeness as well as space (Halldorsdottir 2008).

Caring science is fundamentally about enhancing knowledge of what constitute ideal, good health, caring for patients as whole person's and the avenues to attain this. Therefore, the act of caring for others could be seen as a means of rending comfort, which is paramount to the persons or patients-nurse relationship and helps the patient feel revived when in an unstable condition (Fagerberg & Kihlgren, 2001). It is

essential that caring constitute a loving heart, values and responsibility of patients well-being. Watson in Fagerberg (2001) urged the essential of humanistic care, which is a human to human relationship between a care giver and the patient.

Leathard and Cook (2009) stated that, the purpose of holistic care is to enable a person to achieve and maintain a condition of well-being in which self healing competence of body, mind and spirit can advance easily. They recognized attentive or empathic presence or relation as the seal of holistic caring.

Caring is the meaning of nursing practice as stated by Steele-Moses et al (2011). It brings the functional dimension of professional nursing and it is an essential predictor of satisfaction. Caring is important to an individual's general feeling of wellbeing, emotional security, and satisfaction. The authors explained that, humans have a certain set of desires, therefore are able to know and understand when they feel cared for, which notably enhance a sense of their safety. Satisfaction occurs when this expectations or desires complement the attitude received.

Mathes (2011) stated that, caring goes beyond being physically present with a patient. It pertains to the satisfaction and sense of well-being of the patient and to a personal achievement of the nurse in carrying out humanistic trait of caring.

"...Without caring, nursing is a list of tasks waiting to be completed..."

Hence, when the patients - nurse needs are satisfied, it enhances the relationship and satisfaction flourishes. Steel-Moses also explained further that, listening is an essential element in caring attitude and relationship building. It requires understanding on being present, silent to observe, listen and to be heard within the element of trust and respect (Steel-Morse et al 2011)

1.1 Aim of Study

The study is ordered by Medibothnia (see appendix 3A and 3B) with an overarching theme: Leading for a change, placing the elderly in the center. The objective of this study is to gain more knowledge and to shed additional light on the concept Holistic

Home care for the elderly within the home setting from the perspective of the care givers.

The study aims to explore the nature of the care relationship within the home setting between community nurses and elderly¹ people to examine the impact of care relationship on the way care is provided in this setting.

1.2 Research Questions

The thesis seeks to answer the following questions:

- What are the perceptions of the caregivers regarding holistic home care to the elderly?
- How is holistic care manifested in the home care setting?

2. Literature Review

The respondents gathered information from earlier researches concerning the link between holistic care and well being of the elderly receiving care at home. Ebsco and Cinahl were used as the database for gathering research information and key words such as Holistic, caring, homecare, healthcare and elderly, satisfaction and wellbeing, were combined during the search process.

2.1. The Concept of Aging

According to Tabloski (2010, pp 3-5), old age was based on diagnosis and treatment of diseases relating to aging. However, the focus has change in recent times and the study of gerontology has advance in a way that attention is being drawn to enhancing the health of the aged holistically. This also includes physical, mental, emotional and spiritual well-being. Tabloski explained further that, it is essential for nurses to acknowledge their individual understanding of aging and thereby exhibit

¹ Elderly refers to people aged 65 and over.

the necessary skills required to provide the desired gerontological nursing care to their patients. Nevertheless, the aim for the nurses must not be rooted in only improving the length of life but also to improve quality of life.

Human life is a cycle that constitute crisis such as accidents and illness. These encounters have diverse effect on the way the individual evolve and can create diversity in their personalities which intend have an influence on the aging process (Wadensten 2003).

The everyday life of the aged and their significant health needs are substantially different from that of an adult or a child. Therefore, the healthcare provider must have an education in providing the unique and complex health requirements of the aged. It is essential that nurses or health providers working with the elderly realize and understand aging in order to enhance optimal physical, mental and spiritual health in the aged (Tabloski, 2010).

In gerontological care of the aged, emphases is laid on promoting quality of life and wellbeing. This differs from geriatric nursing in the sense that, geriatric care is disease centered whilst in gerontological nursing the care giver plays the role as a helper, an advocate, healer, educator and innovator. The emphasis of the care is more on supporting function and not only on treatment of disease (Wadensten, 2003).

Gubrium and Holstein (2000) explains that research has shown that, variety of care being delivered to the aged is being organized in the household or home environment settings. Care delivered in the home setting is also to the aged who are chronically ill, impaired or the aged who have functional limitations. Care delivered in the home setting in time past, had been based on enhancing instrumental care and by so doing emphasizing doing-for over being-with. Aging is part of life and a developmental processes not a physical necessity or an accident.

2.2 Value of Care Relationship

Trojan (2003) conducted a study to explore the nature of relationship between the care giver and the elderly within the home setting and the impact this relationship has on the care the elderly were receiving. The results of this research showed that,

nurses used the place of care to emphasize their personal and professional value and the inner meaning which underpins the practices of the care they give. Some of them felt that, the routines in the institutional environment and nursing homes left the elderly feeling isolated or they simply were generally being part of the routine or task of care.

According to Trojan's study, nurses saw the elderly as individuals through their environment which was the home, and the artifacts that connect them as individuals with a life history which was an important facet of their role. The nurses also confessed that listening to the elderly person talking about their life experiences was clearly an enjoyable part of their work. The nurses also felt that they learnt something from the encounters which helped them to really understand the person they were caring for. Trojan in this research, referred to the power that the home exerts as retaining a sense of personal identity.

The concept of time was a central feature of this research both in the ordinary sense and also in the sense of 'having time', a reference to feeling valued or being interested. Time was used by the nurses to describe the quality of care interactions in a number of ways, for example, as a commodity, a quality or value, enabling nurses to have 'time to nurse 'or 'time to listen' Similarly, the elderly also spoke of time as a scarce commodity within other settings they had experienced. They together with the nurses described how first assessment were regarded as a way of establishing and developing a relationship between them. They described it as a seed sowing process and hoped they always nurture or grow future relationships (Trojan, 2003).

In the study, crossing of boundaries between personal and professional phases of the relationship between the nurse and the elderly was a common place. Which does not in any way suggest that the nurses were acting unprofessionally, but rather, it was the way in which they accomplished their role and also nurture the seed they sowed, that is the relationship? These findings suggested that, the relational aspects of the nurse-patient relationship held the greatest significance for both the elderly and the nurse. This gap, the nurses claimed, they always bridge in order to provide holistic care to the elderly. (Trojan, 2003).

According to Halldorsdottir (2008), the development of a nurse-patient connection from the patient's perception is seen as a dynamic process involving six inter-related phrases: reaching out, removing the masks of anonymity, truthfulness, reaching a level of unity and true negotiation of care.

Reaching out, initiating connection. This connection can be initiated by the nurse or the patient and the connections fail to develop if there is lack of response from either side. Reaching out is usually done by the nurse asking questions that are specific to that individual patient and though the connection does not develop beyond this first phase the reaching out is appreciated. However if the patient is the one reaching out, the nurse can respond by listening. Reaching out requires communication, verbal or nonverbal and successful completion of this phase means that the connection develops beyond the first phase towards the second phase, removing the masks of anonymity (Halldorsdottir, 2008).

Removing the masks of anonymity; This means removing the stereotypes of patients and nurse resulting in mutual acknowledgement of personhood, which is a phase in the nurse-patient relationship where both nurse and patient recognized each other as persons. Mutual acknowledgment of personhood involves mutual communication of acceptance, as well as acceptance of each other's uniqueness as persons. This phase acknowledges the bond between the nurse and the patient (Halldorsdottir, 2008).

Acknowledgement of connection: Indications for acknowledging that a connection has developed is that the nurse responds personally to the patient. Extra detailed indicators include verbal and nonverbal expressions, such as eye contact, body language, warmth in the voice and nature of questions asked. However the strongest sign is that the nurse responds in such a personal and caring way to patients that, they start to feel special. The effect is that the connection advances to a higher level and reaches the level of truthfulness (Halldorsdottir, 2008).

Reaching a level of truthfulness: The advancement of the nurse-patient relationship to this level indicates that the patients feels safe enough to open up and speak the truth to the nurse about his or her present condition and how the patient feels about it which may be essential to goal-directed care. Reaching a level of truthfulness also means that the patient feels safe to share and ask for explanation. This also means that the nurse is willing to be involved in embarrassing situations without making the patients feel too embarrassed about it. It is seeing patients as they are, and accepting them that way, even when it means something unpleasant. The nurse respects the patient as a person and calls the patient by name and the connection reaches the level of solidarity (Halldorsdottir, 2008).

Reaching a level of solidarity: Through the disclosure involved in the level of truthfulness a level of unity is reached where the patient feels that the nurse is on his or her side. The patient starts to have a sense of equality in the relationship and feels like a 'normal human being'. The sense of perceived, sense of disaffection or isolation disappears and the sense of vulnerability is relieved. The patients feel legitimized as a patient and as a person and are relieved to have the sense: 'I am not alone in this' (Halldorsdottir, 2008).

True negotiation of care: only when the nurse-patient connection has developed towards this level is there a foundation for true negotiation of care. Through getting to know the patient and developing a nurse-patient connection the nurse is better able to understand the patient and the patient's world. This understanding enables the nurse to work with the patient as an equal towards their common goal-the patients increase well-being and healing. In helping the patient, the nurse does not impose own ideas but competently works with the patient in negotiation of care. One important task included in this phase is that the nurse is supportive without nurturing too much dependence (Halldorsdottir, 2008).

Although the nurse (competent, caring and wise) is both with the patient and for the patient, the nurse maintains separateness during the relationship development. This separateness is what constitutes a comfortable distance of respect and compassion, an element of the nurse-patient relationship which has to be present to keep the relationship in the professional field (Halldorsdottir, 2008).

According to Halldorsdottir, in order for a nurse-patient relationship to be truly life giving the nurse must be a life-giving person. Being a life giving nurse or person means to have a positive and cheery disposition and a 'lightness of being' most often accompanied with a true warm sense of humor. They seem to have lenient compassion for their fellow beings; irradiate love and spread its rays to people they meet and are able to willing to support them when they are in need. They are gently, kind and calm in heart, seem to have modest view of themselves and never look down on others. They utter words of life for the benefit of others and seen to be full of benediction and to have within them goodness itself.

2.3. Meaning of Caring as Perceived By Elderly People

Harrefors et al. (2009), describe how the elderly wanted to be cared for from the perspective of being ill or being dependent and needing. The findings of this research were interpreted into one main theme: Maintaining the self and being cared for with dignity to the end. This theme was built from three others. Thus, being at home, as long as possible, being cared for professionally at home or in a nursing home when advanced care is needed and the fear of being abandoned. There was an overspreading concern of the risk of not being noticed or viewed as an individual and becoming nobody with any meaningful relations as the scenarios changed from being dependent to being totally independent.

The elderly in this study expressed their wish to be home as long as they together with their partners could support each in a perspective of being in need as they viewed the home as the best place for care. Of course they did not want to be at home when there become severely ill or lonely, but in general they felt more secured and cared for there in the home. Looking at a situation of being in need of extensive care and living at a nursing home was connected to many different kinds of feelings and fears. Some feared to be alone when dependent on care from total strangers; they perceived it to be a horrible situation. Some also feared being alone and without partners, friends or family and just waiting on some caregiver to come and take care of them. What if they waited and no one came, some expressed (Harrefors et al. 2009).

The desire to be treated as unique persons and to maintain the self no matter their weaknesses and illness, state of mental alertness or living situation was really important to these elderly. It seemed that the more care needed, the more vulnerable these dear ones became. An outmost threat was the thought of not being able to express their needs and how, when and in which way they would need and wanted care, when they are in the hands of a stranger in a strange environment (Harrefors et al. 2009).

There was an irony in their reflection about their trust in other people caring for them. The elderly in the study wanted to be taken care of, but they did not want to entrust their life to unknown caregiver who may fail to treat them with the dignity and respect they deserved. To them, being treated without dignity meant not being recognized as a unique person and not being able to relate to persons they knew. Thinking about this definitely made them resentful and irritated.

The elderly in the study realized that they were thrown into the existing healthcare system where there are few other alternatives in case of being dependent of care. To them, maintaining their self esteem meant other things such as, to be able to live in their homes as long as possible together with family members and when in need of extensive care, to be cared for by someone who could assist them in maintaining their self, recognize their spiritual, psychological and physical needs (Harrefors et al. 2009).

The human care according to Van-Manen (2002), involves someone to belong to and someone who can confirm that you are important, loved and very special. The findings of this study definitely agreed to this view. Being treated with dignity presupposed that, the nursing staff is educated and has knowledge about the history of the person.

To maintain and retain dignity, everyone must be seen as a unique being. When nursing staff treat the patient with autonomy, Randers and Mattiasson (2004) think that, the patient's integrity is protected and as a consequence, their dignity is maintained and furthermore, respecting the elderly patient's social self would reduce feelings of loneliness, isolation and seclusion. If the nursing staff is not able to meet these needs and desires, then the patient could feel violated if their self is ignored. Talking about this according to Randers and Mattiasson gives a good reason for paying attention for the special vulnerability of our elderly.

Eriksson in Alligood and Tomey (2010), the human being's absolute dignity involves the right to be confirmed as a unique human being. Dignity² is primary to the wellbeing of individuals and as such pertinent to health care settings. Human caring is the moral ideal of nursing whereby the end result is the protection, enrichment and

² Oxford English dictionary describes dignity as the state or quality of being worthy of respect.

maintenance of human dignity. Thus a patient's dignity is a personal notion that maintains and makes for human care; a nurse looking after a patient without being humane treats the patient as an object, without dignity (Matiti and Trorey 2008).

According to Webster and Bryan (2009), respect is an essential component of maintaining the dignity of older people. It is of paramount importance that nurses communicate with older people in a manner that demonstrates respect, rather than taking a superior approach, which contributes to a lack of dignity. Dignity is maintained by allowing the patients to stay in control o their situation.

Haddock in Webster and Bryan (2009) shows that a studied patient's dignity in a rehabilitation ward reveals that nurses experienced conflict as increased workload affected patient's dignity and self worth. For care to improve, health care professionals need to focus on what older people want as opposed to what healthcare professionals think older people want. For instance, a person who is unconscious, dying or have severe dementia would not be able to control their situation. In this case, dignity can be maintained through staff showing respect for the patient and involving family members and friends to ensure patients personal needs are met.

2.4 Communication in Care Delivery

Communication has been identified as one of the essential element of nursing elderly people. According to Caris-Verhallen et al. (1997), communication is a valuable tool in providing and assessing the tangible needs of elderly patients and thereby enhancing care that is tailored to individual patients needs. Communication can be conveyed by touch, facial expression, eye contact, posture, gesture, physical appearance which is non -spoken.

Communication can also be through pitch, intonation, speech rate and fluency, which is the spoken. Benson in Caris-Verhallen et al (1997) stated that communication is part of a nurse's role as they communicate with a variety of patient. Furthermore, nurses have variety of communication goals such as exchanging information, giving explanation, negotiating and decision making about nursing goals, building a good personal relationship, assessing the nature of a specific issue, providing care and showing empathy.

However, these goals require different communication strategies. According to Buttorff and Morse in Caris-Verhallen et al. (1997), there are four behavious in four contexts of care and this are doing task which is basically centered on task excluding the patient. The goal here is just to get the job done. There is barely any real interaction or just little with the patient. The second category is doing with. This is both task and patient centered. The idea or object is to involve the patient and there are two-way interactions about the care, patient's needs and instruction. Doing for is the task centered on the patient, here the patients has the opportunity to direct their own care and as they would like it to be and this enable communication about care or social talk.

The last is doing more, which establishes relation and the care is focused on the patient as a person. The nurse or health provider here tries to understand the patient's experience of illness and treatment. Communication at this stage is intensive and with emotional support. Understanding and respecting the values of the person and their expressed needs is the root of person-centered care.

The above cited behaviors in the context of care fall within instrumental and effective behavior. Doing task and doing with comprises elements of instrumental behavior while doing more is effective behavior. According to Severinsson and Lutze (1999), in providing effective care to enhance the needs of people, effective communication is a prerequisite. However, communication is unique to each person, whereas some people are easier to get in contact or interact with, it would be different for others.

Moreover, being conscious to patients individual needs do not in a way structure practical issues but it also basic to the knowledge of actual and personal care. Dialogue between the nurse and the patient becomes an essential barometer of the quality of care in terms of the well being of the patient (Severinsson & Lutzen, 1999).

According to Gilvnia et al (2009), nursing requires being there or close to the patient more time, the caring that aims to establish bonds, promote the encounter, build relationships and get to know the other. The care should be human and holistic,

under an integrated approach, which does not exclude the emotional care, more extensive and personalized to patients, generating quality support.

However, the nursing actions only mean something when the care results from an interactive process, where the intention to take actions and the knowledge of what is expected from each one in the caring process is manifested. Thus, caregivers should use communication as an instrument to humanize the care, dialoguing with patients, aiming to clarify doubts. The dialogic interaction between the caregiver and the patient receiving care presents itself as a possibility to build humanized caring practices; thus, the communication importance is undeniable with regard to its incentive to humanization and nursing care, once it enables a better understanding of the needs patients have due to their vulnerability. (Gilvnia et al, 2009).

2.4.1. Ethics and Caring Conversation

According to Fredriksson and Eriksson (2003), a caring conversation is that which the nurse makes room through the culture of caritas for a suffering person to retain his or her self-esteem, and thus makes a good life reachable. The caring conversation addresses the caring and nursing ethics about what nurses ought, may, or should not do. In caring and nursing researches, the ethical discussion has commonly been focused on actions, such as the feeding of the elderly, dying persons, and the use of restraints. However, during the last decade the interest in relational ethics has increased.

Kvale in Fredriksson and Eriksson (2003) states that conversation occurs within three different contexts. The is first being ontological, which is conversation as human reality, epistemological, which is conversation as a specific mode of gaining knowledge, methodological, which is conversation as a method or technique. However, a fourth context was added which is the ethical and it is conversation as something good. The author's stated that this, has given rise to a number of research questions connected with the conversation context: ontology (i.e. what is the patient's world like?)Knowledge (i.e. how do we know what a patient is experiencing, e.g. suffering), methods (i.e. how to help patients to express suffering

and deal with it) and ethics (i.e. what sort of person should I be and how do I engage myself in a caring conversation?).

Fredriksson and Eriksson (2003) seek to answer two research questions regarding ethics of the caring conversation. The first being what sort of person should the nurse be and how the nurse engages in caring conversations with suffering others? The ethical intention is 'aiming at the "good life" with and for others, in just institutions'. Good life comes primary because it is the very object of the ethical aim. Whatever the image each individual has of a full life, this apex is the ultimate end of our action.

The good life as a nurse, as sketched above, presupposed self-esteem and autonomy, which, in turn, unfolds in the second components of caritas. The mediating feature that binds the components together is formulated in the Golden Rule which is known from the biblical passages in Mathew (7:12) and Luke (6:31): 'Do to others as you would have them do to you.' Fredriksson and Eriksson reformulated this Golden Rule which states in order to hold others in esteem; 'I' must hold myself in esteem. Self-esteem was earlier described as the outcome of the self-interpretative process revolving around life as a whole and choices made in connection with practice.

However, in order to evaluate one's actions, autonomy is presupposed. When we universalized self esteem as a norm on the moral plane, it becomes self-respect. In succession, esteem for other becomes respect and in the same way we put up autonomy as a moral norm, it becomes responsibility. What remains is the way back to actual situation in which the practical wisdom of the nurse enables him or her to act respectfully and responsibly. On how the nurse should connect in caring conversations with suffering others, the golden rule serves as the mediating element when caritas is well thought-out as the norm of reciprocity. (Fredriksson & Eriksson, 2003)

2.4.2 Meaning of Presence in Caring

Presence is a concept that is difficult to describe. According to Finfgeld-Connett (2006), presence has often confused with other concepts such as caring, empathy,

therapeutic use of self, support and nurturance. However, despite the lack of clarity, presence is a component of several nursing frameworks. Presence is an interpersonal process that is characterized by sensitivity, holism, intimacy, vulnerability and adaptation to unique circumstances. It consists of a process in which patients demonstrate a need for and openness to presence.

Fredriksson (1999) classified presence into two aspects; "being there" and "being with". The authors described being there as an interpersonal and intersubjective phenomenon where presence signifies being present for someone. However, presence is not only about being physically present but also exhibiting an understanding and the way communication is being mediated. Being there requires the nurse to be attentive or posses the act of listening and also there must be a need from the patient, which formulates the patients' questions of the need of a presence of a nurse. The attention of the nurse can be described as an answer to the need of the patient. This kind of presence is described as an intervention or action, something the nurse does to the patients with the hope of achieving some aim such as support, comfort or encouragement to diminish the intensity of undesired feelings.

The other aspect which is "being with" depicts a different structure as to "being there" where there is a question of a need and an answer, it in a form of a gift and invitation. This relate to the nurse giving his or herself and being available and at the disposal of the other person wholeheartedly. If the patient accepts this invitation, he or she would invite the nurse into their situation in order to see, share, to touch and to hear the brokenness, vulnerability and suffering of another. When the nurse in turn accepts this invitation, presence as "being with" is taking place which means that the nurse enters the patients' world and will remain with the patient, enduring ones feeling of discomfort and awkwardness and in the process, exposes ones humanness and offer comfort. In this presence the patient is able to put word to feeling and thoughts and to interpret and him or herself in a new way that leads to acknowledging solutions, seeing new directions and making new decisions and choices (Fredriksson ,1999).

This act of gifting and invitation encompasses respect and responsibility in that it acknowledges the patient vulnerability and the patient's choices t accept or reject the gift. The healing power of vulnerability comes as an outcome of the nurses'

readiness to be there in the midst of venerable situation rather than saying the right thing. The power of presence as being with lies in making available a space where the patient can be in deep contact with his or her suffering, share with a caring other and find her or her own way ahead. These two categories of presence represent varying degrees of intersubjectivity. The nurse and the patient are not only there to each other as roles, but in addition present as a whole person (Fredriksson, 1999).

2.4.3. Meaning of Touch in Caring

Touch is an essential element of human life; humans are touched and touch others all through their existence. Touching is seen as a form of communication and it has been approved that physical touch is an important and common component of nursing care that nurses touch within the caring perspective. As comfort is one of the essential elements of caring, caregivers in the process of caring engage physical touch as the main behavioral mode to provide comforts of patients (Sunk, 2001).

Sunk (2001) also explained further that, physical touch in caring was acknowledged as a process in helping patients attain not only comfort but also a sense of wellbeing. It maintains psychological, spiritual, and mind-body wellbeing in patients. Physical touch in caring enhances the transfer of positive affection between the caregiver and the patient. It also conveys respect by caregiver to the patient and help channel positive feelings.

However, Fredriksson (1999) described various categories of touch which is contact and non-contact touch. Contact touch pertains to skin to skin whilst non- contact touch refers to eye contact, frowning etc. In this research our main area of touch is concern with touch of caring. Caring touch as explained by Fredriksson, is a framework of non-verbal communication and it has also been characterized as 'positive affective touch' 'expressive touch' 'nonprocedural touch' and comforting touch. Touch as noted is a way of communicating caring between a caregiver and patient. The outcomes of caring touch such as comfort, security, enhancement of self esteem helps creates a connection between the caregiver and the patient, thereby enabling the caregiver acceptance of the patient as a unique person.

Gleeson and Timmins (2004) also explained further that, as caregivers attend to basic, physiological and safety needs of patients, they employ a great deal of touch. This, the authors claim places the caregivers in a prime to use this touch to address patients higher order needs. Expressive or caring touch such as patting or holding a patients hand serves to improve the well -being of the elderly.

All humans have love and esteem needs and everyone has a desire to feel loved and to belong, and this needs require that we receive attention and recognition from others. According to the patients view in Gleeson and Timmins study, the patient described the touch of nurses as warm, gentle and comforting and hence contributes to their sense of safety, comfort and self confidence and helped to calm them.

Physical touch as a concept and having the elements of physical, emotional, social and spiritual important needs to be treated in a holistic way and it is possible to enhance the significance and methods of physical touch in nursing so that its function may have effect that have positive impacts on patients well-being and comfort.

2.4.4. Meaning of Listening in Caring

Listening as described by Fredriksson (1999) is a deliberate and active behavior of being attentive to a speaker more than receiving sounds of words. It demands conscious effort of exploring the meaning and also fathoms what the speaker said. This therefore helps establish relationship. Listening is more than taking in what someone says; it entails analysis and understanding of what is said as well as giving back that understanding to the person talking. This phenomenon can be a step to connect with the patient or enter the world of the patient. However, hearing is not enough to achieve a connection.

We may only establish rapport, a working relationship. We are striving for more than closeness. We are attempting to participate in the inner feelings of another while remaining objective, to see the world from the other's perspective with as much understanding as possible. To go beyond closeness, to understand the lived experience of another, we must begin by listening. (Fredriksson, 1999 p1173).

Fredriksson (1999) also stated that silence and hearing on the part of the listener is very important for understanding of the message. The caregiver should be able to silence not only his mouth but also his or her own mind in order to listener to the talker. However, silence seems to be a difficult for nurses. Caregivers appear to be action orientated and the immediate answer to any problem is to do something even if the result is ineffective.

The result of listening comprises developing a relationship or contact with the patient, which embodies entering the patient's world. It also helps the caregiver to fathom a lived experience, to alleviate pain, fear or anxiety which enables patients to talk, to accumulate and unify information from the patient to enhance presence and to exhibit respect and advance self esteem (Fredriksson, 1999).

Sheila (2010) also agreed that, in order of the act of listening to become beneficial to the patient, the caregiver or nurse must be non-judgemental, respectful, and able to demonstrate empathy and compassion. It is thus essential to understand the underlying meaning of the patient's message.

However, in order to listen in a non-judgemental manner, the nurse must eliminate all preconceived beliefs, bias, and negative attitudes. This characteristic of communication includes understating the whole person and acknowledging that each patient is unique individual with distinct beliefs, lifestyles and cultures. Nonjudgemental listening conveys respect for each individual and results in an atmosphere of trust in which the patient feels free to openly communicate without fear of rejection (Sheila, 2010).

In order for effective listening to occur, Sheila (2010) explained that, the caregiver must make a conscious decision to be fully present and engaged in the patient encounter. The listener must be committed to hearing, sensing and understanding the patient's message to the fullest extent possible. This commitment requires the nurse to give total and undivided attention to the patient.

2.5 Holistic Needs of the Elderly

A research was conducted in England by Witton (2005) to ascertain the competence of care givers showered that the majority of caregivers to older people hold vocational qualification. The aim of the research was to identify the health and personal care needs of older residents and also to verify the adequacy of the contents of vocational qualification in offering holistic needs to older people. This qualification does not necessarily empower them to demonstrate the competence in all aspects of care. The qualification does not address the holistic needs of older people but based on providing basic care. This rise the question of whether an obtainment of vocational qualification will enable care staff to meet the care needs of older people or only basic needs. The researcher also argued that, the unit curriculum of vocational training does not address the holistic³ needs of older people.

Assessment is essential in understanding the functional ability of patients. Bathing a patient is an example of how a competence staff will detect the condition of the skin and texture and correlate this to nutritional status, continence and pathological conditions. Other assessments include patient's wellbeing such as muscles usage, posture, mobility and hygiene. Through interaction with the patients observation of any form of redraw could be made. By these observations a competence staff can assess a form of deterioration and assessment of this kinds are the short comings of vocational qualification. What these depicts is that, gaining a vocational qualification does not equate with exhibiting maximum skills because there would be incompetence in providing evidence of holistic care (Witton, 2005)

It is of the uttermost important that care staffs must take notice of not only basic needs but also social, emotional, physical and mental health needs of older people in the care home. According to Witton (2005), the training offered to vocational staffs is rooted in what is already known rather than training to enhance and acquire new knowledge and competence. If the vocational qualification as some of the interviewed trainers explained as being based on what is already known, then this depicts that it is mainly a means by which people gain a qualification rather than a

³ Holistic nursing care: focuses on healing the whole person through the unity of body, mind, emotion, spirit and environment.

way by which there is increased knowledge and understanding that would have a positive result on improving quality of care.

Willis (2002) refers to holistic care as being of the uttermost essential than ensuring patients is able to maintain their individual hygiene. Another element such as being aware and understanding the spiritual nature if patient care, should not be unnoticed. Willis stated that, providing holistic care would enforce developments of new skills and competence. Nevertheless, it is of no benefit unless patients perceive that they receive holistic care from their staff. Patients access care that exposes them to both clinical and non -clinical personnel's, however, Nurses are the frequent at the heart of patients receiving care and hence are able to influence immensely on patients perception.

3. Theoretical Framework

In this thesis, Katie Eriksson's Theory of Caritative Caring and Watson's theory of caring will be used. These two theories were chosen for this thesis because both theorists have caring as their central core.

Watson uses interchangeably the terms human being, person, life, personhood, and self. Watson views the person as a unity of mind, body, spirit and nature, (Watson1996, p147), and she described that personhood is tied to notions that, one's soul possess a body that is not confined by objective, time and space. The conception of the human being in Eriksson's theory is based on the axiom that the human being is an entity of body, soul and spirit. The human being is fundamentally a religious being and holy. This is related to the idea of human dignity which means accepting the human obligation of serving with love and exiting of the sake of others

Eriksson in Alligood (2010) Eriksson defined health as soundness, freshness and wellbeing and also stated that health is more than absence of illness but implies being whole in body, soul and spirit. It is a pure concept of wholeness and holiness, whereas Watson described health as unity and harmony within the mind, body and soul; it is associated with the degree of correspondence between the self as perceived as the self as experienced.

3.1. Katie Eriksson's Theory of Caritative Caring

Eriksson in Alligood and Tomey (2010) claimed the human being constitute an entity of body, soul and spirit and is able to experience phenomena. Therefore portraying the human being in terms of only the present needs is insufficient. The care delivered must constitute this essential phenomena's. Caritas according to her theory means love and charity, and by nature caritas is an unconditional love. This however creates that understanding that, the care delivered should aim at mediating faith, hope, love, tending, playing and learning. These essential elements are what drive motivation for care and thereby making something invaluable unique. Eriksson further stated that the caritas motive is what drives us to caring.

According to Eriksson as cited by Alligood and Tomey (2010), as caritative⁴ motive is characterized by love and charity, human beings by nature is love. Therefore it is by this that caring got it core fundamental. Exhibiting this phenomenon is humanistic by nature and constitutes the feeling that foster caring. Nevertheless caritas also entails not only love for a neighbor but for self, for every created thing, love for God and also God's love for mankind. The human being as described is a religious being that is dignified and this implies the element of love and caring for another.

Caring is a communion between the nurse and the patient and caring as stated exists in different categories. True communion and the awareness for the unique human being are central and important in caritative caring, and it also implies creating possibility for others. Genuine caring is not by feeling, behaviour or a state of being, but a way of living which makes being presence alone inadequate (Alligood & Tomey, 2010).

Eriksson's caritative theory of caring is based on nine principles. Among the principle the human being has been described as being fundamentally holy and as such human dignity means accepting the human obligation of serving with love, existing for the sake of others. In all nursing care, Holiness and dignity is always paramount in the human being. Holistic health seeks to help people reach and maintain a state of wellbeing in which self- healing capabilities of body, mind and soul can proceed

⁴Caritas is the latin expression for unselfish love that is expressed in action.

unhindered (Leathard & cook 2009). According to Eriksson's principles caring is something human by nature, a call to serve in love. Nevertheless caring is to alleviate suffering in charity, love, faith, hope and as such enables health and wellbeing.

Arman and Rehnsfeldt (2007) stated that suffering as a basic area of care is an idea that opens up to embody patients whole experience of life, health and illness in a physical, mental and spiritual manner. In a way, the contest of suffering occurs within human beings ontological dimensions. Whereas suffering violates human dignity and may bring forth loss and dying, it also creates the possibility of new life and reconciliation. Caritas as virtue, alongside hope and faith and the biblical narrative of the Good Samaritan brings out light on the phenomenon. The story of the Good Samaritan exhibits the inner meaning of caritas in a practical way, which entails unselfish charity and compassion for a fellow human.

3.2. Jean Watson's Caring Theory

This theory has evolved over the years but the basic principle remains unchanged. It emphasizes the humanistic aspects of nursing in combination with scientific knowledge. Watson designed this theory to bring meaning and spotlight to nursing as a distinct health profession. Watson believes that: "Caring" is an endorsement of professional nurses identity, medicines identity is that of "caring". (Vanguard Health System, n.d)

According to Watson, the nurse's role is to: establish a caring relationship with patients, treat patients as holistic beings (body, mind and spirit), display unconditional acceptance, treat patients with a positive regard, display unconditional acceptance, treat patients with a positive regard, promote health through knowledge and intervention, spend uninterrupted time with patients: "caring moments". Watson believes that through the nurse's attitude and competence, a patient's world can become: Larger or smaller, brighter or drab, rich or dull, threatening or secure. (Vanguard Health system, n.d)

Watson's theory consists of the following major elements: Transpersonal relationship, Carative factors and the caring moment.

3.2.1 Transpersonal Caring Relationship

According to Watson (1988, p.63), a transpersonal caring relationship implies a special kind of human care relationship-a union with another person-high regard for the whole person and their being-in-the-world. Caring in this sense is viewed as the moral ideal of nursing where there is the paramount concern for human dignity and preservation of humanity. Human care she says, can only begin when the nurse enters into the life space or phenomenal field of the care receiver, is able to detect the care receiver's, condition of being (spirit and soul), feels this condition within him/herself, and responds to the condition in such a way that the recipient has a release of subjective feelings and thoughts he or she has been longing to release. As such, there is an inter-subjective flow between the nurse and patient.

This caring relationship according to Watson depends on some principles: First of all, a moral commitment to protect and enhance human dignity, wherein a person is allowed to determine his or her own meaning. Secondly, the nurse's intention and will is to affirm the subjective significance of the person. Thirdly, the nurse's ability to realize and accurately detect feelings and the inner condition of another. Then the ability of the nurse to assess and realize another's condition of being-in-the-world and to feel a union with another and finally, the nurse's own life history and previous experiences and opportunities of having lived through or experienced one's own feelings and various human conditions, and of having imagined other's feelings in various human conditions. (Watson, 1988, p64)

Concepts such as responsivity, mutuality, intersubjectivity, expressitivity and engagement of nurse with the other, even in a spontaneous moment, become critical for a mature caring-healing profession. Within the model of transpersonal caring, the nurse will attempt to stay within the other's frame of reference, to join in a mutual search for meaning and wholeness of being, to potentiate comfort measures, pain control, a sense of well-being, or spiritual transcendence of suffering. Consciousness of new ways of being can give meaning to the experience of suffering while living.

The person is considered valid and whole regardless of illness or disease. That intact wholeness, the constant reintegration of mind, body and spirit, being fully immanent is paradoxically transcendent (Watson 1988, p65).

3.2.2. Carative Factors

According to Watson (2007), transpersonal caring is actualized and grounded through ten carative factors that characterize a human-to-human nursing caring transaction within a given caring occasion. These ten carative factors serve as a guide to the core⁵ of nursing and are not new to nursing; most nurses already use them in their practice but they are often named or seen. The carative factors, Watson claims provide a language structure for nursing education and practice.

In addition to providing a language for nursing phenomena, the carative factors help define nursing knowledge and practices as distinct from, but complementary with, curing knowledge and practices related to traditional medicine. These ten original carative factors remain the timeless structural core of the theory, while allowing for their evolving and emergence into more fluid aspects of the model captured by the ten caritas processes as shown in table 1.

These cores for nursing and it's practices proposes that nursing, individually and collectively, contributes to the preservation of humanity and seeks to sustain caring in instances where it is threatened. The carative factors and caritas processes serve as structure and order for a theoretical – Philosophical foundation for the discipline and profession of nursing. The moral ideas and caring factors and processes proposed foster the evolution and deepening of humankind and serve to sustain humanity (Watson 2007).

3.2.3. Caring Moment

Watson (2006) explained that, a caring occasion occurs whenever the nurse and another come together with their exceptional life histories and extraordinary fields in

⁵Core refers to those aspects of nursing that actually potentiate therapeutic healing processes for both the one caring and the one being cared for. The core of nursing is grounded in the philosophy, science and art of caring (which is posited to be intrinsically related to healing). Watson 2007.

a human-to-human deal: the coming together in a given moment than the occasion itself. It becomes inspiring when experience and perception take place, but the actual caring occasion has a greater ground of its own in a given moment. As such, the process goes beyond itself, yet arises from aspects of itself that become part of the life history of each person, as well as part of some larger, more complex pattern of life as portrayed by the figure 1.

An actual caring moment Watson claims involves an action and choice by the both the nurse and the individual. The moment of coming together in a caring occasion presents them with the opportunity to decide how to be in the moment and in the relationship, what to do with and during the moment. If the caring moment is transpersonal, each feels a connection with the other at the spirit level, thus it transcends time and space, opening up new possibilities for healing and human connection at a deeper level than physical interaction as the quotation below suggests.

"We learn from one another how to be human by identifying ourselves with others, finding their dilemmas in ourselves. What we all learn from it is self-knowledge. The self we learn about ...is every self. IT is universal - the human self. We learn to recognize ourselves in others; (It) keeps alive our common humanity and avoids reducing self or other to the moral status of object." (Watson in University of Colorado, 2008).

4. Methodological Discussion

Convenient samples of four groups and two individuals of home caregivers from six different localities in Österbotten region of Finland were selected with the assistance of the various heads of the various groups. The group varied from five persons to ten persons. The sampled participants included three groups of practical nurses and three groups of registered nurses. This we did with the aim of getting a broad sample with variations in the homecare situations. With informed consents of the heads of each group, we visited them each on different convenient day within a space of two weeks and informed them about the study both through verbal and written (see appendix 1A and 1B) communication.

The respondents used qualitative research method. Qualitative research as defined by Shank (2004, p.5), is a form of systematic empirical inquiry into meaning. By systematic Shank means, planned, ordered and public, following rules agreed upon by members of the qualitative research community. By empirical, Shank means that this type of enquiry is grounded in the world of experience. Inquiry into meaning says researchers try to understand how others make sense of their experience.

Denzin and Lincoln (2000, p.3) also claim that qualitative research involves an interpretative and Naturalistic approach which means that qualitative researchers study things in their natural settings, attempting to make sense of, or to interpret phenomena in terms of the meanings people bring to them.

Qualitative research seeks to understand a given research problem or topic from the perspectives of the local population it involves (Bulpitt & Martin, 2010). It is especially effective in obtaining culturally specific information about values, opinions, behaviors and social contexts of particular population.

The family health international (n.d) in their review of qualitative research method claims that, the strength of this research method is its ability to provide complex textual descriptions of how people experience a given research issue. They explain that qualitative research method provides about the human side of an issue- which is the often contradictory behaviors, beliefs, opinions, emotions, and relationships of individuals. The method is also effective in identifying intangible factors such as social norms, socioeconomic status, gender roles, ethnicity and religion, whose role in the research issue may not be readily apparent.

Although findings from qualitative data can often be extended to people with characteristics similar to those in the study population, gaining a rich and complex understanding of a specific social context or phenomenon typically takes precedence over eliciting data that can be generalized to then geographical areas or populations (Sandelowski, 1995). The advantages of this research method is that use of open ended questions and probing gives the participant the opportunity to respond in their own words, rather than forcing them to choose from fixed responses, as quantitative methods do (Family Health International, n.d.). Open-ended questions have the ability to evoke responses that are meaningful and culturally salient to the

participant, unanticipated by the researcher and above all they are rich and explanatory in nature.

Sandelowski (1995) also noted that, qualitative research methods are typically more flexible- they allow greater spontaneity and adaptation of the interaction between the researcher and the study participant. In addition, with qualitative methods, the relationship between the researcher and the participant is less formal than in quantitative research. Participants have the opportunity to respond more elaborately and in greater detail than is typically the case with quantitative methods. Sandelowski states another advantage of qualitative methods which is they allow the researcher the flexibility to probe initial participant responses- that is., to ask why or how.

Townsend et al. (2010) agree that, qualitative studies have offered explanations for unexpected or contradictory findings revealed by quantitative studies and shortcomings of a rational-choice decision-making model in seeking care and have identified unintended consequences of service development.

Qualitative research method has three major challenges. Foremost, there are no universal rules for analyzing qualitative date. The absence of standard analytic procedures makes it difficult to explain how to do such analysis, and how to present findings in a way that their validity is obvious. Secondly, it requires an enormous amount of work. Qualitative analysts must organized and make sense out of pages and pages of narrative materials. The pages must be read, re-read and then organized, integrated and interpreted. The final challenged comes in reducing data for reporting purposes. Quantitative result can often be summarized in a few tables but qualitative researchers by contrast, must balance the need to be concise with the need to maintain the richness and evidentiary value of their data (Polit & Beck ,2008 p.507).

4.1 Data Collection

Individual and focused group interview⁶ were using the semi-structured interview method. Open individual tape-recorded interviews based on the questionnaires (see appendix 2A and 2B) were conducted with the participants in their various offices.

For each question, we the interviewers encouraged the participants to narrate freely about their perceptions using follow-up questions when necessary. The interviews, which lasted between thirty and forty-five30 minutes, were conducted with each group individually and transcribed word for word. Notations of nonverbal expressions such as silence were made directly after the interview.

4.1.1. Semi- structured Interview

This kind of interview according to Morse (1991, p.189) allows a respondent the time and scope to talk about their opinions on a particular subject. The focal point of the interview is decided by the researcher and there may be areas the researcher is interested in exploring. The objective is to understand the respondent's point of view rather. It uses open-ended questions, some suggested by the researcher ("Tell me about...") and some arise naturally during the interview ("You said a moment ago...can you tell me more?").The researcher tries to build a relationship with the respondent and the interview is like a conversation. Questions are asked when the interviewer feels it is appropriate to ask them. They may be prepared questions or questions that occur to the researcher during the interview. The wording of questions will not necessarily be the same for all respondents.

Many researchers like to use semi-structured interviews because questions can be prepared ahead of time. This allows the interviewer to be prepared and appear competent during the interview. Semi-structured interviews also allow informants the freedom to express their views in their own terms. Semi-structure interviews can

⁶ The respondents are aware of the lack of similarities in the group and interview individual interview but there was almost nothing we could do about it. The participants on the interview day wanted to sit in groups since it made them more comfortable and each could complement the other. This anyway, turned out to be very useful since it enriched our results and gave us a broader opinion. About 50 pages of data was collected and analysed hence. This in our opinion, makes our results more reliable.

provide reliable, comparable qualitative data. On the other hand, this depends on the skill of the interviewer (the ability to think of questions during the interview, for example) and clarity of respondent. Other disadvantages are that the interviewer may give out unconscious signals / cues that guide respondent to give answers expected by interviewer, it is time consuming and the depth of qualitative information may be difficult to analyze, for example what is and what is not relevant (Morse 1991, p 192).

5. Ethical Consideration

Risks which are particularly relevant to participants in qualitative health services research include anxiety and distress; confusion of the research process with a therapeutic encounter, coercion; and the identification of need for further help and misrepresentation (Richards & Schwartz, 2002).

In order to minimize the risks of qualitative health service research, the respondents took the following precautions: In recruiting participants, special care was taken to avoid saying anything that could be interpreted as coercive. The voluntary nature of participation in the study was always emphasized in accordance with the Family Health International (n.d). Informed consent was also obtained and this involved clearly explaining the study to the participants.

The participants were also informed about the fact that they could opt out of the research at anytime without any consequences. The autonomy of participants which encompasses an acknowledgement of agency and respect for the participants 'priorities, experiences and motivations was our topmost priority as pointed out by Townsend (2010).

In relation to confidentiality, participant's identity will not be disclosed. Participants are vulnerable to being misinterpreted. This is because the researcher co-constructs the interview with the participants and analyzes and interprets the talks and questionnaires, the potential to misrepresent the individual is always present (Townsend 2010). For this reason, we the respondents carefully followed all the

appropriate and necessary steps of the content analysis process in order to minimize the risk.

Lastly, the participants were assured that the answers they provided will not be used against them in anyway. They will also be made aware of the results if they want to know. Ethical, rigorous and useful qualitative research involves being accountable to research participants (Richards & Schwartz, 2002).

6. Data Analysis

Content analysis was used to analyze the results that were obtained. At the first step, the researchers read through all the interviews and tried to underline phrases and derived meaning from what the participants said. The researches reflected on what the participants meant rather than on what in fact they said. It was thus a matter of reading the material over and over again and at the same time stopping at it and extracting the meaning of the answers the participants gave. The answers from different participants were grouped under the same categories. The researchers did this to find out the similarities in the answers they obtained from the same questions and how each participant responded.

Content analysis is a method of analyzing written, verbal or visual communications (Cole in Elo & Kyngäs, 2008). Content analysis as a research method is a systematic and objective means of describing and quantifying phenomena (Sandelowski 1995). It allows the researcher to test theoretical data. Through content analysis, it is possible to distil words into fewer content related categories. Sandelowski believes that, when classified into the same categories, words, phrases and the like share the same meaning.

According to Elo and Kyngäs (2008), content analysis is a research method for making replicable and valid inferences from data to their context, with the purpose of providing knowledge, new insights, a representation of facts and a practical guide to action. The aim of content analysis is to attain a condensed and broad description of the phenomenon and the outcome of the analysis is concepts or categories describing the phenomenon. The authors further on claims that, despite its critiques,

content analysis has an established position in nursing research and offers researchers several major benefits. One of which is its content sensitivity method. The other is its flexibility in terms of research designs.

Cavanagh (1997) also points out that, content analysis is much more than a naïve technique that results in a simplistic description of data and can be used to develop an understanding of the meaning of communication and to identify critical processes.

To Elo and Kyngäs, content analysis is concerned with meanings, intentions, consequences and context and it is extremely suited to analyzing the multifaceted, sensitive phenomena characteristics of nursing. An advantage of the method Elo and Kyngäs say is that large volumes of textual data and different textual sources can be dealt with and used in corroborating evidence. Especially in nursing research, content analysis has been an important way of providing evidence for a phenomenon where the qualitative approach used to be the only way to do this, particularly for sensitive topics. The disadvantage of this kind of analysis relates to research questions that are ambiguous or too extensive. In addition, excessive interpretation on the part of the researcher poses a threat to successful content analysis (Canavagh 1997).

7. Results

Originally, the themes areas that emerged were grouped into 14 categories, which is also the number of questions that were asked. This number reduced as the researchers distilled the material. After further analysis of the material, the number reduced and six themes were created under different categories. Finally, the researchers identified the meaning of each significant answer obtained and formulated meanings into themes. The themes are:

Being at home as long as possible

In the perspective of being in need of help by the elderly at home and the goal of homecare, most of the participants had a perception that any elderly person's dream is to care for themselves or have their spouses care for them. But if this does not become possible for some reasons beyond their control and they tend to be in need of help or care, then their heart desires are to receive this care in their own homes.

".....When a patient is in the hospital he or she doesn't have much to do but in the home, they do the dishes, make food, wash clothes and do all kinds of things. Usually it better to be home. They are motivated to do something at home rather than in the hospital. In the hospital they just lay down and the nurse do everything for them but in the home we tell them, No you have to do things yourself and it easier to go outside and visit friends and friends can visit them when they old......"

".....People want to stay and die in their own homes......"

In describing the goal and future of homecare, the participants expressed their concerns about the lack of resources and personnel in the field of home care. These, they feared might bring home care to a standstill if nothing was done about it.

"It (homecare) is good but we have a lot of patients. We don't always have the resources to give what the patients needs. If someone is sick, like the nurses, we don't get any replacement so sometimes we need to take care of our own patients and the patients of the sick nurse, so we do two tasks at the same time. This is not good for the future of homecare......"

".....the main goal is that the patient can stay home as long as possible with someone coming to help them and that the patients feel safe in their own home. So the goal is that in Vaasa, don't remember but 80% of the patient above 80 years should be taken care of at home......then we need more nurses, now we have shortage of nurses or home care nurses. To make this possible we need more."

Maintaining the self and being cared for with dignity and respect to the end

A dominating theme for the best home care was interpreted by the participants and this concerned maintaining the self and being cared for with dignity and respect no matter the circumstances. The desire to be treated as a unique person and to maintain the self was important, no matter the illness, state of mental health or living situation as expressed by the caregivers. It seemed that as this becomes more important, the more in need of care and the more vulnerable the elderly became.

".....there are those kinds of situations, for example, I have this patient who has dementia, and she never wants me to take her blood sugar. We talked, I made coffee and warm pan cake, and then I could take it. I try to explain why I had to take the blood test. She is 94 years old, quite old."

From the caregivers' perspective, maintaining the dignity is also about allowing the elderly to decide for themselves about their care and making the center of the care.

"The clients themselves decide, they have the right to do so. We treat them according to their needs, not as we like but as they want; their opinions and not that of their relatives. Sometimes we have to tell them it is the best for them but if they say no, then no it is."

"I think that keeping and maintaining patient's dignity is one of the most important things we consider in our care."

".....for me I consider the fact that part of keeping the patient's dignity is making them decide on what kind of care they want. Sometimes we can't allow them to take the whole decision so we come to a compromise and we are very effective at that. Sometimes the patient may not be able to ask for help because they feel they should be able to do it themselves so then we try to tell the patient that they are still valuable even though they are not able to take care of themselves any longer. We also tell them that we can learn from them also. Then they too feel comforted by our presence."

"You have to respect them and ask what they want if they don't want something you can only advice them not force them to do something, it's their right to decide on what they want and what they don't want......we can only advice them, you have

to give them space in their home and not be all over them and go to rooms they don't want you to go to or go to places they don't want you to go to, you give them privacy in their homes, we don't fight them when they say no even if they are demented or have Alzheimer's or are mentally retarded but if it is emergency case for example going to the hospital and they don't want to go we try to persuade them to go......."

For some of the caregivers, the driving force of maintaining dignity is the feeling of doing unto others what you want them to do unto you.

".....I try to think about if from the patient's perspective. I imagine how I would like to be treated if I were in their shoes. I am very careful and thinking about what I write about the patient because it would be attached to the patients for the rest of their lives....."

"The issue of respecting the patient's home and being aware that it is their own territory was also a significant part of maintaining the self and the dignity of the elderly."

"......if the patient does not want us to come, we don't go there......"

"In this home care, it is very important that you respect the territory of the patient and you behave decently. You should respect the patient. When you work in the hospital it's like your territory but when you go to the patients home, that is their territory. The most important thing is that when you go home to a patient you also have respect for the home, for the things that they have and that you are entering their home and you have to take that in consideration and behave in a way that is appropriate. And is the patient who decides......"

When all these are fulfilled, then and only then can the feel safe in their own homes and then they can comfortably ask for the help they need and also feel comfortable around the caregivers.

The elderly-caregivers' relationship

The relationship between the elderly and the caregivers are central to the elderly satisfaction as pointed out by the caregivers. This sets the tone for the care giving experience and has a powerful impact on the elderly patient's satisfaction. They experience better health when all their needs are fully considered in the relationship.

In order to build this relationship, the participants acknowledged that trust and good communication are essential ingredients.

In building trust, the caregivers talked about the essence of time and secrecy.

"...It takes time for them to trust you, it takes few visits for them and then they count on you and tell you things."

"...... For some people it takes longer to get trust in you....."

".....We come into their homes and they trust us that we are not spreading their personal matters to other people."

This is how one of our participants described the beginning of this trust relationship:

"I believe the moment they give out their keys to you and let you into their homes, they establish a trust relationship."

Another also thought of this relationship as rewarding;

"In home care, the job is not so physically tough but mentally tough. It is rewarding when I see that the patient trusts me in all things. We build upon the relationship of knowing and trust each other."

When asked about the relationship existing between them and the elderly, most of the described it as being good and even being friends

"If you have the same patient for many years, you get quite close to the patient..."

"..... The patient can become a friend....."

"There is a good relationship between us and the patients. We can have some problems at times, but mostly the relationship functions well. But we need to have a lot of understanding...."

".....I have one I have been helping for 10 yrs already so we are almost friends. We know them and they know us, we share with them what we have been doing for example travelling. We feel that it makes the patients more comfortable..." There were a couple who also thought keeping a distance was safe and enabled them do their jobs well. The participants explained that, although there must be a patient nurse relationship which sets the tone for the care experience and also creates the care satisfaction, there must also be limited as to how for this relationship must goes.

"There should be a distance; we cannot be the very good friends....otherwise they do not really allow us do our jobs....."

"I have better relationships with those who are demented. I have to put a boundary between us and assume the role of just doing what I am supposed to do."

What makes all these possible are the concept of communication? They explained that being able to communicate both verbally and non-verbally was important. Also, one needs to have the ability of listening and being patient in this line of care.

"If the patient has had a bad day you know. You know exactly how the patient feels by non-verbal action if you've known the same patient for years. You get need to open the door to the patients home and you feel it in the air."

"With experience we learn to judge if a person is sad, depressed or faking happiness etc. We try to be sneaky to get the info we need. We also try to show we care, be gentle, hug them etc."

"We communicate with them nicely, talk to them in their mother tongue, they cry sometimes if they have a problem, we hug them sometimes, they are very sweet sometimes, we talk to them when they need somebody to talk to."

Rendering day to day care to the patient at home

On having specific or special routines on the visits to patients, most of the participants responded negatively. The participants explained that, although they have specific area of care needs for each patient, they also attend to other needs that is not in the original plan or why they went to the patient. They also engage in caring conversation to know the needs of the patients and if there is anything specific they want to talk about and also monitor their general living condition.

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Furthermore, the participants pointed out that, they don't treat patients differently; they have the same standard for each patient. They ensure that, each of their patients receives quality care and if there are any other services they require, they arrange it for them. The participants stressed that, although sometimes time allocation for the visit to each patient is most times not enough, they try to give the desired care as required.

".....We do not have routines but work according to the needs of the patients."

The participants noted that, there are patients who only need wound care, or medication, upon their visit, they would probably attend to those first and if there is anything else the patients needs, they take care of that. They interact with them and ask about things and if there has been something significant. They don't have routines but take care of the patients according to their needs. Furthermore, they don't impose things on their patients if they don't want to. For instance, if the patient had had a bad day or have something worrying them that could be clearly noticed, they the participants don't interfere unless the patients is willing and ready to talk about it.

However, they do their best to ask if everything is alright and ask if there is anything the patients wants them to do for them. The participants disclosed that, they patient is always right, they don't try to argue with them but reason with them and provide quality care as much as possible.

".....We don't have any routines but we try to do customer service. We don't impose on them; we do whatever the patient needs. For instance if a patient wants to sleep till 10 am in the morning, we will visit after 10 and some wakes at 7 we will visit earlier. "

Being cared for as a whole being

According to the participants caring for only the specific needs of their patients at home is literally not enough. They also take into account other aspect that is not really outlined in the day to day care of the patient. Caring for a patient holistically to them means caring with a view toward healing the whole person and this involves body, mind and spirit. The participants affirmed that in caring for a patient, you must also take note of how the person is actually feeling, if they have something specific bordering them that is not actually physical. It could be spiritual distressed, social issues, financial issues, etc. They try to take care of their patient as a whole being and not ignoring other essential elements that contribute to the totally healing of their patients.

"....It not just the wound we take care of, but also the whole person. Therefore if we see that there is something wrong with the psychological and social health, then we have cooperation with others like that who take care of them......"

To the participants, taking care of only the medical issues forgetting that the person is an entity consisting of different areas of needs is not ideal. The participants aim to care for their patients so they could achieve maximum well-being, where everything is functioning the very best there is possible. Caring for the patient in totality enables them to feel safe in their home. The participants explained that most of their patients live alone and when they go to care for them, they are eager to talk about so many things and share the company of another.

"We do not care just for the little sore but from head to toe. For example, if they have food, medicine or feel safe. A lot of them are lonely and are eager to talk when we haven't been there for a long time about every day stuffs."

This brings out the fact that, just attending to the wound, taking blood pressure or going to inject insulin is not enough. Although the participants treats each individual patient with the type of care they need when they need it, rendering assistance to other needs such as spiritual issues and other issues when it deemed needed helps the patients achieve wellness that helps them keep healthy and whole.

"...We contact the deacon workers if needed or the social worker and say the patients need this help. We refer them to somebody else who come talk to them. There are some priests who are visiting the patients from home to home..."

"We try to see the whole person and all their needs, body, mind and spirit. For us, it is not just about the practical things but we do other important stuffs for them as well. Example going to the cemetery with them etc. We sometimes feel like we more than practical nurses to them but more of a close companion. Sometimes from the patient point of view, they consider us as relatives It is also important to keep some distance and bear in mind we are the caregivers. We contact the priest on behalf of the pat if there are no relatives that can do that."

In order for a patient to achieve total well-being every aspect of need must be addressed. A person should treat not only the illness but the whole self to reach a higher level of wellness. Combining other important aspect of the patients' issues could help attain a feeling of total wellness, spiritually, physically and mentally.

"..... often when we go to a patient, we go to measure blood pressure but when you are there for example, you need to notice the house, if there is food in the fridge, the whole situation, the condition of the home, is it unclean? Can the patient take care of him or herself, hygiene, social status, money etc. You need the person as a whole; even if you go there to do something specific but at the same time see the whole situation......We make it possible for the person to have the best situation at home....."

Caring for a person in as a whole focuses on healing the whole person through the unity of body, mind, emotion, spirit and environment. More than caregivers, the participants believe in addressing the other areas of need of their patients help the whole body and bring balance.

Caring needs of elderly

Elderly patients living in their own homes seem the best option. They feel comfortable in their own environment as explained by the participants. They are rooted from the home they lived in and loved.

The participants explained that, most of the patient they visit at home have the average age of ninety and mostly, live alone. There are those who live with their children, whilst others have their families elsewhere like Sweden. There are others who don't have any one at all. Each of their patients has a specific need of care. The underlying illness of their patients includes Alzheimer's, dementia, psychiatry, alcoholics, and disables, patients who have mobility issues, and also patients who don't have different illness or disease.

The needs of each of their patients varies, as some needs only basic care, others need both basic and medical help such as wound care, injections, catherizaion,

medications, removing surgical stitches etc. Elderly care or taking care of patient at their own homes is the fulfillment of their special needs both medical, emotional and all the other aspect that helps maintain the total wellbeing of the patient. The participants also fulfills the requirement that are unique to them should the need arise.

"...Laboratory test, wound care, injections, check-ups for mental issues, catheterization, insulin, medicines, but most of the insulin and the distribution of medication are handled by the home help who are practical nurses. ...We take blood pressure, Kidney dialysis, insulin, medications, If the medication is finished then they come to us. There are also different problems."

"...They mainly need ADL and sometimes we just talk to them. Also medications...."

The participants explained that, they worked with other units such as the home help, and the practical nurses in order to taking care of the everyday care needs of their patient. They explained that the requirement for such care, being homecare is increasing and it is important that there is understanding of the needs of the elderly patients.

The elderly should have each of their caring needs cared for both medically, emotionally, spiritually, and also basic needs met. It is important that, the elderly person is treated just as a unique person with thoughts and needs, although there may be difficulties with communication, understanding or challenging illnesses. The participants stated that, although some of their patient's illness such as dementia might hinder them from remembering or clearly stating their desired care needs, they try to take care of their needs in totality. Whereas they nurses care for the medical and other essential care needs, the home help and practical nurses also ensures that other basic aspect of care is not ignored.

The participants affirmed that through the caring process they get acquainted with their patients individual care needs. The care they provide is centered on getting to know the patients, their like and dislikes, understanding their illness and caring needs. These fundamentals are what the elderly person should be entitled to and it should be done in a skilled manner in order to deliver quality care where patients are treated and cared for as special being. The home helps and practical nurses are also available to satisfaction the needs of the patients at home. For example, take them for walks, shopping and enabling their wishes met.

8. Critical Review

The respondents will follow the guidelines outlined by Streubert and Carpenter (1999) when critically reviewing this study. The conduction of the study will be examined in all. It's credibility, audibility and fittingness will also be addressed.

According to Streubert and Carpenter (1999, p66), when conducting a qualitative research, the concept of interest has to be visibly defined and the reason why the concept requires a qualitative research design must be explained. The philosophies underpinning the study must also be clarified. The purpose of the study and it's significant to nursing must also be stated.

The objective of this thesis was to gain more knowledge and to shed additional light on the concept Holistic Home care for the elderly within the home setting from the perspective of the care givers. The study was conducted to explore the nature of the care relationship within the home setting between community nurses and elderly people to examine the impact of care relationship on the way care is provided in this setting. Qualitative research design was used to get a thorough picture of the caregivers' experiences and capture them entirely. The study was based on Eriksson's theory on caritative caring and Watson's theory on caring. The results of the study can useful in recognizing holistic care as an important component of caring and influencing caregivers way of caring.

The mode of data collection according to Streubert and Carpenter (1999, p66) must be compatible with the purpose of the study and must address the concept of interest. The study must be conducted according to the process described. The selection of participants and their suitability must also be described.

The purpose of the study was to describe the concept of holistic care in the homecare setting from the caregivers' perspective. The respondents chose individual and focused group interview using the semi-structured interview method.

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This was done because the respondents wanted the participants to express themselves in their own words in order to get a richer and fuller perspective of the concept of interest. The respondents have tried to follow the plan of conduction and developed it when needed. The participants were selected from the departments of homecare, both nurses and practical nurses.

The data collection mode according to Streubert and Carpenter (1999) must focus on human experiences. The strategies for the collection must be described and the participants must be protected. When analyzing the data, the researcher has to describe the strategies used and must remain true to the data and also make the reader understand the processes used for the analysis.

The respondents focused on the experiences of the participants regarding caring. Open individual tape-recorded interviews based on open ended questionnaires were conducted with the participants in their various offices. The collected data was transcribed word for word and analyzed using content analysis. The meaning of the data was searched for and categorized.

The informants were informed about the purpose of the study both orally and written. They were made aware of their right to redraw from the study at any point. They voluntarily consented to participate under guaranteed anonymity. Confidentiality and privacy have been maintained throughout the study.

The researcher must address credibility, auditability and fittingness of the collected data when analyzing the data. Credibility refers to confidence in the truth of the data and their interpretation. It means the participants can recognize the experiences as their own and the findings reflect their experiences. Auditability means the reader can follow his or her thinking and the researcher also needs to document the research process. Fittingness means that the findings should be applicable outside the study situation; the results should also be of significance to individuals who are not involved in the study (Streubert & Carpenter 1999, p67).

The credibility of the study has not been fully addressed in the analysis. Fully addressing the credibility would mean that calling all the informants and getting a suitable time for them in order to confirm that if findings reflected on their view on holistic care and if they can recognize them as their own.

The data has been described and analyzed in such a way that they would remain intact. The information has been referred to as it is. Nothing that was not found in the data from the interview was added. The results of the study have been described according to the aim that was outlined for the study. The categories have been described such that the reader can understand the results.

The theoretical framework and literature review are relevant to the study. The findings of the study can be used in the context of describing caregivers pespective of holistic care for the elderly. The study is significant for understanding the importance of caring for the elderly as whole human being with body, soul and spirit. Future studies on this field may be meaningful and the concept of holistic acre can be further explored.

9. Discussion

The aim of our study was study to explore the nature of the care relationship within the home setting between community nurses and elderly people and to examine the impact of care relationship on the way care is provided in this setting. The main theme was interpreted as Patient centered care.

Whatever the circumstances were, the caregivers agreed on a common theme: the elderly patients should be treated with dignity and respect to the end. Especially in situations with bodily and intellectual impairments; when they are alone with no family, friends, or a healthy spouse. The results indicate that, the perceived possibility of being treated with dignity and respect is closely connected to how the caregivers cared for their elderly patients. In addition, caring for the elderly in totality or the choice of holistic care is also the paramount desire of most of the participants. Van-Manen (2002) claims that, reciprocal care is something that most people have experienced from close relations. The human care, he claims involves someone to belong to and someone who can prove that you are important, loved and a very special person.

In the literature, caring for the elderly was based upon diagnosis and treatment of diseases relating to aging. However, the attention has shifted in recent times and

studies of gerontology has advance in a way that attention is being drawn to enhancing the health of the aged holistically. Tabloski (2010, pp. 3-5). The caregivers agreed that, addressing only the medical needs of their patients is not enough. Every individual is unique and as such have different areas of needs and in order for the elderly to be in total health, this individual needs outside medical treatment must not be over looked. Health is more than an absence of disease so they try to care for their elderly in totality in order to enhance their total well-being.

Eriksson in Alligood and Tomey (2010) laid emphasis on the human being as an entity comprising of body, soul and spirit and portraying the human being in terms of only the present needs is inadequate. Caritas according to the authors signifies love and charity this is by nature; unconditional love. This explains the fact that the care delivered should aim at mediating faith, hope, love, tending, playing and learning.

Watson (1996) in her model of transpersonal caring points out that the there must be a special kind of human care relationship, a union with another person, high regards for the whole person and their being in the world. The caregivers explained that, having a patient for quite a long time helps in developing the caregiver and patient relationship. Through the course of the care, they learn to trust them. Although relationship between the care giver and the patient is essential for quality care, it takes time for this to develop. This however, does not limit them from caring and helping the other attain their well-being in the world.

Communication has been identified as one of the essential element of nursing elderly people. According to Caris-Verhallen et al. (1997), it is a valuable tool in providing and assessing the tangible needs of elderly patients and thereby enhancing care that is tailored to individual patients needs. Communication can be conveyed by touch, facial expression, eye contact, posture, gesture, physical appearance which is non –spoken, etc. Fredriksson and Eriksson (2003), laid emphases on caring conversation depicting that caring conversation addresses caring and what nurses ought, may, or should not do. These essential components as the authors stated are vital in caring to enhance well-being.

The nature of qualitative inquiry as pointed out by Harrefors et al (2009) is that the results are difficult to generalize and have to be judged from a specific context. However, we selected the participants in a way that will enrich the variations in the

home care situations here in Österbotten. Another aspect of context is that the interviews reflect the perception the caregivers had at the time of interview. It is possible that these perceptions and the homecare situation in Österbotten may change over time. Despite these limitations we think that the perceptions of holistic care among those caregivers that participated in the study provide an important contribution to the understanding on the phenomenon of holistic care: caring for the body, soul and spirit and how the home caregivers view and incorporate this into their day to day care.

The caregivers in the study made it clear that making the elderly the center of care is their top priority. This they think defines the elderly and gives them identities. Not making them objects of routines, respecting their territories and allowing them be part of the decision making process was seen in the result as a key to making the elderly feel safe in their own homes.

We think more knowledge and education should be given to homecare givers whether registered nurse or practical nurse. And the importance of this to the elderly must be stressed and not underestimated. This is the only way the elderly can be in the center of the care they receive and their wellbeing will be promoted to enhance a high quality of life no matter their circumstances.

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Table 1

Box 1 – 10 Carative factors and caritas processes. (Watson 2006)

Original 10 Carative Factors, juxtaposed against the emerging <i>Caritas Processes</i> /Carative Factors	Caritas Process		
1. Humanistic –Altruistic Values.	1. Practicing Loving-kindness & Equanimity for self and other.		
2. Instilling/enabling Faith & Hope.	2. Being authentically present to/enabling/sustaining/honoring deep belief system and subjective world of self/other.		
3. Cultivation of Sensitivity to one's self and other.	3. Cultivating of one's own spiritual practices; deepening self-awareness, going beyond "ego self".		
4. Development of helping-trusting, humancaring relationship.	4. Developing and sustaining a helping- trusting, authentic caring relationship.		
5. Promotion and acceptance of expression of positive and negative feelings.	5. Being present to, and supportive of, the expression of positive and negative feelings as a connection with deeper spirit of self and the one-being-cared- for.		
6. Systematic use of scientific (creative) problem solving caring	6. Creatively using presence of self and		
process.	all ways of knowing/multiple ways of Being/doing as part of the caring		
	process; engaging in artistry of caring-		
	healing practices		
7. Promotion of transpersonal teaching-learning.	7. Engaging in genuine teaching- learning experiences that attend to whole person, their meaning; attempting to stay within other's frame of reference.		
8. Provision for a supportive,	8. Creating healing environment at all		
protective, and/or corrective mental,	levels (physical, nonphysical, subtle		
social, spiritual environment.	environment of energy and		
	consciousness whereby wholeness,		

	beauty, comfort, dignity and peace are	
	potentiated.	
9. Assistance with gratification of human needs.	9. Assisting with basic needs, with an intentional, caring consciousness of touching and working with embodied spirit of individual, honoring unity of Being; allowing for spiritual emergence.	
10. Allowance for existential- phenomenological spiritual dimensions.	10. Opening and attending to spiritual- mysterious, unknown existential dimensions of life-death; attending to soul care for self and one- being- cared- for.	

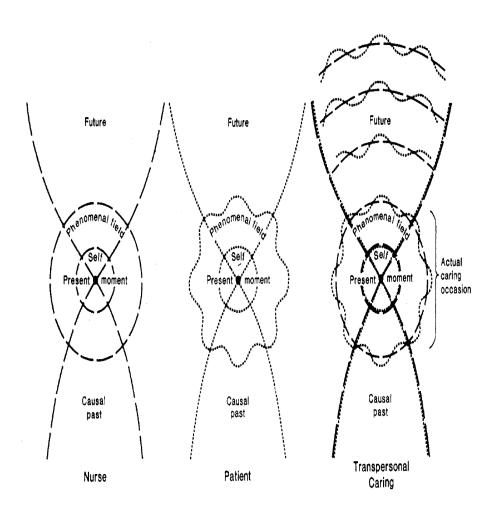


Figure 5. Dynamics of human caring process, including nurse-patient transpersonal dimension. (Illustration by Mel Gabel, University of Colorado, Biomedical Communications Dept.)

In Watson, J., Nursing: Human Science and Human Care, A Theory of Nursing (1985/1988) p. 59

Watson in University of Colorado (2008).

Appendix 1A

Questionnaire in English

- 1. How much time is allocated for each patient? In your honest opinion, is this time enough for one visit?
- 2. How many patients do you visit in a day?
- 3. Can you please describe what you do during this visit?
- 4. How many times a week do you visit them?
- 5. What is the age range of your patients?
- 6. Please describe the physical and mental status of your patients in overall.
- 7. Can you please describe the main needs of your patients in overall?
- 8. What are the routines you normally have on your visits?
- 9. How would you describe the relationship that exists between you and your patients?
- 10. What is the overall living conditions of the majority your patients?
- 11. Dignity and respects are important concepts in elderly care. How are these manifested in your care?
- 12. What is your opinion on the concept of communication in the care of the elderly?
- 13. Could you please state and explain the goal of care in the home setting?
- 14. What is your opinion on the phenomenon Holistic care? Can you please describe how it is manifested in today's nursing care?

Appendix 1B

Questionnaires in Swedish

- 1. Hur mycket tid reserveras för varje patient? Enligt din ärliga åsikt, räcker denna tid för ett besök?
- 2. Hur många patienter besöker du på en dag?
- 3. Kan du beskriva vad du gör under detta besök?
- 4. Hur många gånger i veckan besöker du patienterna?
- 5. Inom vilken åldersgrupp befinner sig dina patienter?
- 6. Beskriv i allmänhet dina patienters fysiska och mentala tillstånd.
- 7. Beskriv i allmänhet dina patienters huvudsakliga behov.
- 8. Hurudana är dina rutiner under ett normalt besök?
- 9. Hur skulle du beskriva relationen mellan dig och dina patienter?
- 10. Hurudana är i allmänhet dina patienters levnadsförhållanden?
- 11. Värdighet och respekt är viktiga begrepp inom äldrevården. Hur syns dessa i ditt vårdarbete?
- 12. Vad innebär enligt dig begreppet kommunikation inom äldrevården?
- 13. Kan du definiera målsättningen för vård i hemmamiljö?
- 14. Vad innebär enligt dig fenomenet holistisk vård? Hur syns det i dagens sjukvård?

Appendix 2A

Informed consent in English

Permission and Confidential letter for the search

Dear Informant,

We are two nursing student from the Novia University of Applied Sciences (Yrheshögskolan Novia), Vasa and we are conducting a research on Holistic care for the Elderly receiving home care.

The need for homecare might continue to increase over the next decade as the elderly population is increasing and people are finding reasons to take care of their aged at home. As the location of care continues to move closer to home, it is crucial that the implicit qualities that are valued within the nurse-patient relationships in this context are recognized and made more definite at both the organizational and policy level. Therefore the aim of our research is to gain more insight on the phenomenon, holistic care of the elderly within the home setting from the perspective of the caregivers.

To get a good result from this study, it is important you cooperate with us and help us out by answering the questions we ask you and also by sharing your sincere and honest opinions and thoughts. Everything you say will be handled anonymously and total confidentiality will be held. We hope that you will not feel uncomfortable with any of the questions but if you do in any way at anytime, you are free to withdraw your participation and answers at any time.

The interview will be recorded and the results will be analyzed and published in our final thesis, which will be found in the library of our school. The thesis will be in English, but there will also be a short summary in Swedish.

Thank you so much for your participation in our study.

Sincerely yours,

Hagin Joan and Bamfo Esther.

Appendix 2B

Informed Consent in Swedish

Tillstånd och konfidentiellt introduktionsbrev för undersökningen

Kära respondent,

Vi är två sjukvårdsstuderande från Yrkeshögskolan Novia i Vasa och vi utför en undersökning om holistisk vård för äldre patienter inom hemvården.

Behovet av hemvård kan komma att öka inom det närmaste decenniet eftersom andelen äldre i befolkningen ökar och människor finner anledning att sköta sina närstående äldre i hemmet. När vårdarbetet alltmer utförs i hemmen är det livsviktigt att de implicita egenskaperna som värdesätts i relationen mellan vårdare och patient definieras och klargörs både på organisations- och policynivå. Målsättningen för vår undersökning är därför att få mer insikt i detta fenomen: holistisk vård av äldre i hemmamiljö ur vårdarens perspektiv.

För att få användbara resultat av denna undersökning är ditt samarbete och din hjälp viktiga för oss. Du kan hjälpa oss genom att svara på frågorna och dela med oss dina uppriktiga tankar och åsikter. Allt du säger behandlas anonymt och absolut konfidentiellt. Vi hoppas att du inte kommer att känna dig obekväm med någon av frågorna men om så är fallet är du fri att avbryta ditt deltagande i undersökningen när som helst.

Intervjun kommer att spelas in och resultaten analyseras och publiceras i vårt lärdomsprov som kommer att finnas tillgängligt i skolans bibliotek. Lärdomsprovet skrivs på engelska men innehåller en kort sammanfattning på svenska.

Många tack för att du deltar i undersökningen.

Vänliga hälsningar,

Joan Hagin och Esther Bamfo

1. Enhet/avdelning, organisation, adressuppgifter Necklothous project 2. E-mail adress 3. Projektets syste och innehåll Choosing Holithé care for the elderly The ain of the Shiely is to explore the nathure of the co reledionship within the hone softing bothween rammunity nu and cholerly people to exermine the impact of care related on the way care is precided in this setting.		ESTÄLLNING AV I	LÄRDOMSPROV	HADB41
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* separat avtal uppgörs vid behov.

Appendix 3B

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UPPDRAGSAVTAL MELLAN STUDERANDE OCH UPPDRAGSGIVARE

Namn_ (Trayeur Trecusturina
Namn Travelit Mechibilinia Kontaktperson <u>yronne Hill</u>
Kontaktuppgifter_/yronne, hillig to pole, fr
Studerande Namn <u>Fether Bambo och Joan Hagnn</u> Kontaktuppgifter <u>Cinorettababy@yabua.com</u> Utbildningsprogram <u>Nursing /05</u>
Handledare
Uppdragsgivaren: Namn Kontaktuppgifter
Yrkeshögskolan Novia: Namn <u>fika. Lery</u> Halmbury Onvera.f.
Examensarbetet Syfte The aim of the study is to gain more knowledge and shed light on the phenomena Holistic Home care for the Arbetsrubrik The home setting from the perspective of the Upplägg och tidsdisposition
Upphovsrätt Upphovs- och äganderätten till examensarbetets resultat tillhör alltid den/de studerande. Uppdragsgivaren ges med detta avtal oinskränkt rätt att använda examensarbetets resultat Ja <u>Y</u> Nej
Övriga villkor Uppdragsgivaren betalar antingen Yrkeshögskolan Novia eller den studerande för examensarbetet Ja <u>Nej X</u>
Uppdragsgivaren har för avsikt att utnyttja resultaten i sin verksamhet $Ja _ \checkmark$ Nej

Uppdragsgivare

Ettor (Soan Heigin)

Studerande

PA/representant YH Novia

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