

Pitfalls on the path of rehabilitation – Client centeredness and adherence

This abstract is based on the following research reports and articles.

Research reports of The Central Union for the Welfare of the Aged:

Pitkälä K, Savikko N & Routasalo P. Pitfalls on the path of rehabilitation. Research and development project on geriatric rehabilitation, report no 10 (In Finnish). The Central Union for the Welfare of the Aged. Gummerus, Saarijärvi 2006.

Other publications:

Pitkälä K, Savikko N. Only half of patients adhere to their treatment (In Finnish). HS Vieraskynä 2.9.2006.

Savikko N, Pitkälä K. The importance and challenge of adherence to care (In Finnish). Tabu 2006;5: 4-7.

Background

Certain pitfalls have been identified in the rehabilitation processes of older people. By intervening these pitfalls, the effectiveness of rehabilitation might be increased. The importance of adherence to and patient-centeredness of care in rehabilitation were recognized as central research topics in our Research and Development Project on Geriatric Rehabilitation. In the project, adherence to and patient centeredness of care emerged as risk factors for effectiveness of group rehabilitation for older lonely people: according to previous research literature, poor adherence to and dropping out of group rehabilitation are common for lonely people. However, active involvement and having a possibility to influence the contents of group rehabilitation increased its effectiveness. In our qualitative Home Together research, the service system was found to offer services in a bureaucratic ‘from top to bottom’ manner that weakened families’ willingness and opportunity to respond positively to the offered help. In addition, in the KuntoValtti project at Seinäjoki many problems occurred in client centeredness related to older peoples’ rehabilitation process. These problems were examined more closely in this research project.

Objectives

The objectives of the research were based on previous literature and different data sources to examine

1. how the client centeredness is defined in previous literature?
2. how does client centeredness appear in the rehabilitation path?
3. what does adherence to care among older people mean and what factors are related to it
4. the importance of adherence to rehabilitation and professionals’ possibilities to support it
5. the impact of healthy life style and compliance to drug treatments on mortality of older people with vascular diseases
6. In addition, an objective was to develop an adherence measure to identify clients’ adherence to care that could be also used as a basis for professional-client discussions in clinical settings.

Methods

The methods of the research included a literature review (client centeredness and adherence) and examination of legislation concerning the rights of older people in rehabilitation (client centeredness). In addition, factors affecting adherence of participants to group rehabilitation for lonely older people were explored using group leaders' diaries as data for qualitative analysis. A survey research was carried out among older people who participated in one of the three different forms of rehabilitation (clients of a fall-prevention clinic, people with vascular diseases, and WWII veterans in rehabilitation). An adherence-to-care measurement was developed and its validity and reliability was studied appropriately. The data of the KuntoValtti project consisted of interviews with older people in rehabilitation as well as with their relatives and professionals, observations at rehabilitations meetings and activities, professionals' self-evaluations and diaries, and different other documents (to find out how client centeredness is achieved in rehabilitation processes). These were used as material for qualitative analyses.

Results

1. According to research literature, client centeredness, client orientation, patient centeredness and patient orientation have several definitions that are partly specific for the scientific discipline in question (social research, nursing research, medical sciences), partly cultural (Anglo-Saxon, Finnish), and partly determined by the particular function under scrutiny (organizational level, practical level, interaction between professionals and clients) Social sciences have examined client centeredness mainly at the level of organization, nursing science at the level of practices and medical sciences at the level of interaction between physicians and patients.

During the last decades, the relationship between professionals and clients or patients has changed to a more equal companionship based on negotiation. Long historical change in values and practices are influencing on the background there. However, at present the nature of this companionship and responsibility given to clients depend on the context. The relationship between health care professionals and clients is always asymmetrical, which is clearly visible in acute care situations. Yet, in chronic diseases and in rehabilitation process people should have a firm and active role in order to support a successful care.

Client centeredness is usually studied by examining structures and resources at the organizational level, by observing meetings between clients and professionals, by studying professionals' views of their working methods, and by asking clients about their experiences of meetings with professionals. According to international research findings, client centeredness is still achieved poorly at different levels of health care system.

2. Also according to our own studies, client centeredness is achieved poorly in the service system and in rehabilitation. Protection of and caring for older clients are strong professional values that in practice may translate as knowing better than clients what is best for them. The qualitative part of the KuntoValtti project as well as the observations made in the Family Care Project revealed that older people are easily treated as passive bystanders and recipients of care. It was also realized that for older people adhering to receive services may actually mean a partial loss of autonomy.

In the KuntoValtti project, the poor attainment of client centeredness appeared at the level of organization (limited time resources in implementing a client-centred way of working; inflexibility, fragmentation and delay of services; problems in collaboration, problems in organization of actions and flow of information), at the level of practices (level of professionalism; predomination of the biomedical perspective in rehabilitation; predomination of professional objectives and their implementation in rehabilitation; rehabilitation plan for professional use only, not for clients) and at interactional level (older people in rehabilitation

fear becoming subjects for the exercise of power; leaving the clients' own wishes unheard and them without information).

Client centeredness can greatly enhance the effectiveness of rehabilitation, as was shown in our group rehabilitation for older lonely people and in the Family Care as Collaboration intervention research in our Research and Development Project on Geriatric Rehabilitation. Adopting a client-centred way of working may even decrease the costs of care.

3. According to research literature, adherence to care has been mainly studied as compliance indicating a client's obedience in the process of treatment. However, what adherence to care should actually mean is that the client has a more active role in the realisation of his or her care and that he or she should be able to negotiate the objectives and means of carrying out the treatment with professionals. Adherence to care is very important in treating chronic illnesses, since only 50% of people use medication as prescribed, 30% take exercise according to recommendations and 10% are able to lose weight or stop smoking in a long run. Adherence of the client to care is not related to age, socio-economical status, education or personality characteristics. However, issues that do have an effect on adherence include the complicated nature of care, short-term advantages and disadvantages of care, illness symptoms, side effects of care, and support and information given by professionals. In addition, the client's values and attitudes, level of cognitive functioning, functional ability, level of sensory functioning, and eligibility of services are related to adherence. It can be difficult for professionals and clients to talk about adherence to care because they are involved in a power relationship in which the client may feel inclined to please the provider of care. Professionals may view poor adherence to care as critique for themselves. Then again, if the client is not allowed to tell about the problems to adhere to the care, this may easily provoke white lies. Only client-centred working methods, a non-judgemental atmosphere, as well as mutual respect and trust can make way to talking about the client's own values, objectives and agenda that should be taken for the basis of the care plan. In any case, clients always make the final decisions concerning their own care. Long, continuing and confidential care relationships are the best arenas for discussing the objectives of care and for creating care and rehabilitation solutions for each client individually.

4. According to research literature and this study on pitfalls of the rehabilitation process, adherence to care is very important in the rehabilitation of slowly developing functional disabilities and frailty. In an acute loss of functional ability such as a hip fracture or a stroke functional skills and muscular strength are not lost suddenly. This is why it is possible for a competent rehabilitation team to restore a person's skills and abilities quickly. However, when frailty and functional disability have developed slowly the restoration of functional status also takes time and requires the client's long-term adherence to the rehabilitation objectives.
5. In the Geriatric Rehabilitation Project, older lonely people adhered very well to the group rehabilitation, since only 2% of them dropped out. Dropping out from a group can have a traumatising effect on the remaining group members, which may weaken the effectiveness of their rehabilitation. In the qualitative analysis of the group leaders' diaries, the issues promoting adherence to the group included leaders' professional skills (ability to listen the group members and to act in client-centred ways; knowledge of group processes; reflective thinking), factors related to the activity itself (goal-oriented groups; group structures; members' possibilities to have an influence on the group activities; versatile program), factors related to controlling the situations (leaders' skills in facilitating the groups; equitability in the groups), and other factors (e.g., supporting togetherness).
6. Among older people who have vascular diseases, active interest in taking care of oneself, attitudes towards and, on one hand, suspicions on medication and, on the other, adherence to medication have a strong impact on the prognosis of their mortality and institutionalisation.

Adherence to care can be evaluated quite sufficiently by an unhurried, patient-centred consultation.

7. The scale detecting clients' adherence to care was developed step by step so that factors influencing adherence were identified through research literature and by using a professional panel. Survey questions were then operationalised accordingly. The questions were tested in three different populations to examine their discriminatory power, reliability, internal consistent and construct validity. Factor analysis revealed four charged factors that were named "sense of control over one's own care", "goal-orientation in the care", "influence of professionals" and "experienced support, advantages and disadvantages". Finally, a 22-item measurement was developed and compared to an evaluation of adherence made by professionals. The adherence measurement had good validity and reliability and measured aspects that had not been included in earlier measurements. However, even at its best the measurement can only serve as a screening method through which the most adherent or non-adherent clients can be identified. The measurement can be used in clinical practice as a basis for professional-client discussions of adherence to care.

Developing the measurement produced data that can be used in supporting clients' adherence to care. Different symptoms of illnesses have a strong impact on clients' ability to follow care instructions. From this, it is possible to draw conclusions that by easing the symptoms, e.g. pain, also a client's adherence to care can be supported. Information and support given by professionals as well as their positive attitude influence a client's adherence to care greatly. Experiencing disadvantages in care weakens adherence, and fear in particular correlates negatively with adherence to care. An indirect conclusion of this could be that uses scaring as method of health promotion is not an effective way to influence on clients' adherence.

Conclusions

Client centeredness and adherence to care have strong impacts on the effectiveness of rehabilitation. However, both are poorly achieved in the current health care system. Clients are seeking to fulfil their own goals in rehabilitation, which should be approved as a basis of their rehabilitation plan. Only this way it is possible to support clients' adherence to care.