Care ensembles: examining relational aspects of care in the context of home care

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We adapt the concept of the ‘consumption ensemble’ to capture the nuanced collaborations between actors in the provision and receipt of home care. Data were from a ten-year study of home care clients, family carers and workers in selected Canadian provinces. Using the lens of the ‘ensemble’, we analysed interviews with 24 dyads (carers and clients) and reviewed findings of our previously published research. Evidence of agency as collective endeavour supporting client autonomy and of improvisation in the ensemble informed a revision of our previous interactive model of care, emphasising the bidirectional nature of care relationships.

Key words model of care • collaboration • interdependence • autonomy


Introduction

More than a decade ago, in the context of the project ‘Home Care in Canada: Working at the Nexus of the Public and Private Spheres’ (hereafter referred to as the ‘Nexus’ project), Sims-Gould and Martin-Matthews (2010) proposed a conceptual model of care to capture the interactive nature of care provision. This model of home care was developed in response to the literature’s limited identification of roles, responsibilities and relationship dynamics in the context of home care, where multiple individuals contribute to the care of an older person. Family care research to that date had mostly addressed the relationship between a carer (for example, wife or daughter) and a care recipient, and the stress and burden experienced by those caregivers. Our model, in contrast, identified and characterised the interactions between different actors involved in the dynamics of home care, including client, carer and home care worker.

The diverse perspectives and experiences of actors represented in the interactive model of care, as well as the relationships between them, have been captured in other publications (Sims-Gould and Martin-Matthews, 2010; Byrne et al, 2012; Sims-Gould et al, 2015). Some of our published findings showed that autonomy was preserved when home support workers collaborated with clients to help them ‘as much’ or ‘as
little’ as needed (Byrne et al, 2011). Yet, the conceptual model only partially captured care exchanges between client and carer.

Further applications of the ‘Nexus’ project’s findings and the interactive model of care have highlighted aspects of negotiation, partnership and coordination between formal providers and informal caregivers (Hautsalo et al, 2013; Truglio-Londrigan, 2013; Naganathan et al, 2016). Ris and colleagues (2019) expanded the model to include aspects of collaborative practice in the context of nursing home care. This adapted model showed home care nurses and family carers engaged in an interactive process to work with and for the care receiver. The work of Ris and colleagues is an example of emergent healthcare approaches that place patients and carers as co-producers of care (Hoffer Gittell, 2016). However, such approaches do not reflect the coordination between non-medical providers of home care, carers and clients (Weinberg et al, 2007). Additionally, and just as in our model, the specific role played by the client in this coordination is not always specified.

Illness-centred perspectives and Western conceptualisations of agency have focused on the functionality and activity of older people (Pirhonen and Pietilä, 2018; Romaioli and Contarello, 2019), while neglecting aspects of empowerment that recognise older people’s ability to define strategies to deal with their own problems (Turjamaa et al, 2013). The older person is generally described as the ‘care recipient’, which emphasises a passive role in care relationships. As a result, the relational and interdependent nature of care dynamics, and the more active role that older clients can play in such dynamics, remain unaddressed (Fine and Glendinning, 2005; Ray et al, 2009; Turjamaa et al, 2013).

In contrast, literature on dyadic partnerships in the context of chronic diseases stresses the role of the person with a chronic health condition as a partner in their own care, not just a passive care receiver (Bennett et al, 2017; Sebern and Whitlatch, 2017). Yet, the distinctions between formal (paid) caregivers, informal (unpaid) carers and care receivers used in these descriptions fail to capture the complex relationships and nuanced collaborations between multiple actors providing and receiving care at home (Bennett et al, 2017). Practical implications of the binary distinction between caregivers and care receivers include the development of policies and interventions based on models and conceptual frameworks that neglect interdependent dynamics of care and heterogeneous experiences of ageing (Gilleard and Higgs, 2010; Jacobs, 2019). These models also depict the older person in a binary fashion: either as vulnerable and dependent (for example, disengagement theory or the burden of care), or as healthy and autonomous (for example, active aging) (Grenier, 2012; Torrejon and Martin-Matthews, 2021).

This article brings together a decade-long period of data collection, analysis and publication of the ‘Nexus’ project – a multi-phased, multi-site programme of research (Sims-Gould and Martin-Matthews, 2010; Byrne et al, 2011; Sims-Gould et al, 2015; Martin-Matthews and Cloutier, 2017). We present the results of a qualitative meta-analysis of our published research findings to advance understanding of collective insights through the application of the concept of the care ensemble. We also report new data from our analysis of client–carer dyads. The analysis of these dyads enables us to better explore relational aspects of care, as clients and carers work together to coordinate contingent aspects of home care.

### Care ensemble

We use the concept of ensemble as a heuristic device, taking the elements foundational to collaboration and improvisation to analyse the roles of the various actors involved
in the dynamics of care and to capture both the relational nature of care and the contingent aspects of home care (Byrne et al., 2011; Martin-Matthews and Cloutier, 2017). The concept of ensemble was originally applied by Barnhart and Peñaloza (2013) in the context of consumption studies. For the authors, consumption is defined not only as the purchasing of goods, but also as an array of activities that include personal care, driving, doctor visits, managing medications, preparing meals and housekeeping, among others (Barnhart, 2009). According to Barnhart and Peñaloza (2013: 1134), the ensemble ‘improvises ways to continue the older person’s consumption as members participate consistently or intermittently and in various combinations, just as members of a jazz ensemble improvise the continuation of a tune’. In this manner, older persons add members to the ensemble to compensate for their inability to consume. In their research, the authors found that the ‘construction of identity in consumption discourse and practice fundamentally and paradoxically entails individual agency within a collective endeavor’ (Barnhart and Peñaloza, 2013: 1148). In this manner, the ensemble perspective aligns with relational approaches that address the interdependent aspects of care dynamics, involving collaboration and negotiation between different actors, including the older person (Heggestad et al., 2015; Dunér et al., 2019; Jacobs, 2019).

Two elements of the concept of ensemble interested us in Bernhart and Peñaloza’s work:

- The definition of agency as a collective endeavour. Here, the carer and home support worker support the preservation of the older person’s (that is, the client’s) autonomy by compensating for their decreased functionality. The members of the care ensemble collaborate with the older person to exert control over an array of daily activities that may or may not be directly related to home care tasks, as defined by the ‘care plan’ (a guide with a list of tasks to be performed by non-medical carers when in the home and the frequency and length of visits required as per the client’s assessed needs). Therefore, the carer and the home support worker play a central role in the construction of the client’s autonomy, which can be seen as the result of a ‘partnership of reciprocal responsibility’ instead of an individual ability (Jacobs, 2019: 1640).

- The notion of improvisation. The jazz ensemble metaphor, used by Barnhart and Peñaloza (2013) to define the concept of ensemble, is particularly appealing in order to study the routinised and yet improvised arrangements orchestrated by the older person as a client, by carers and by home support workers within the private space of the home and in the context of the home care system. Other approaches that capture interdependent aspects of care (for example, relational autonomy and relational coordination) do not specifically address contingent, situated and dynamic aspects of home care. As Martin-Matthews and Cloutier (2017) noted, care in the context of the home space includes workers adapting to unfamiliar environments and care situations, and learning and respecting clients’ particular circumstances and preferences. However, home care is also contingent on the interactions between those working and living in the home with other people and organisations that provide support and services to the household.

Informed by two elements of the concept of ensemble, the purpose of this article is twofold. First, to overcome the binary distinction between caregivers and care receivers that seems inadequate to capture the interdependent aspects of care dynamics. For
this, we apply the term ‘care ensemble’ to examine how older people as clients, carers and home support workers collaborate to achieve an appropriate care composition as they negotiate the situated and concrete practical contingencies of people’s lives to optimise the home care experience and its outcomes. Therefore, we depart from Barnhart and Peñaloza’s (2013) original attention to the dynamics of the ensemble in enabling consumption. Instead, we focus our analysis on the collaboration between the different actors involved in home care dynamics to help older clients exert control over daily activities. Second, we revise and refine the interactive model of care proposed by Sims-Gould and Martin-Matthews (2010) to examine more explicitly the complexity, nuance and collaboration of care coordination among members of the ensemble. We pay particular attention to the role played by the older person as client, and we stress the bidirectional nature of care relationships.

Original interactive model of care

The original conceptual model proposed by Sims-Gould and Martin-Matthews (2010) sought to improve the understanding of how paid and unpaid carers provide care to a care recipient and to one another. The model distinguishes between caregiving, direct care and assistive care (see Figure 1).

Caregiving refers to care provided by the carer (often, but not exclusively, a family member) to the older person (client). Direct care is used to indicate the care given to the older person by another carer, often via formal or paid care arrangements (for example, a home care worker). Finally, assistive care refers to the help provided from one carer to another carer with the aim of coordinating, facilitating and/or maximising the care provided to the client, for instance, a family member preparing a meal earlier so the paid carer can later heat up it for the client.

According to Sims-Gould and Martin-Matthews (2010), the assistive care exchange between two carers has two variants. In the first one, assistive caregiving is reciprocal, interconnected and bidirectional, and benefits both family carers and home support workers. A good example of this type of care is the family carer helping the worker to transfer the older client from the bed to the wheelchair. The second type of assistive care is more unidirectional in nature and is intended to ensure appropriate care of the older client. The family carer taking the role of care manager and teaching a succession of workers the needs and preferences of the client is a good example of this second type of assistive care.

Figure 1: Interactive model of care
The conceptual model partially recognises the bidirectional nature of care relationships among the different actors involved. However, in this model, care exchanges between the client and a carer are not clearly depicted, nor is a role played by the client in their own care. By contrast, the application of the concept of the care ensemble helps us to examine exchanges of different types of care in order to better understand how older people, family carers and home support workers collaborate to achieve appropriate care.

**Methods**

Data were derived from the ‘Nexus’ project – a ten-year study of older clients ($n = 82$) and family carers ($n = 56$) in British Columbia, Canada, and of home support workers ($n = 118$) in three Canadian provinces. This project was a mixed-methods study that examined the delivery and receipt of home support services from the varied perspectives of actors directly involved: home care managers, home support workers, older clients and family carers (Byrne et al, 2011; 2012). Qualitative and quantitative data were produced through in-depth semi-structured interviews. A generic qualitative research approach was used for the qualitative part of the study (Byrne et al, 2012). This approach focuses on how people interpret, construct or make meaning of experiences or events (Caelli et al, 2003; Kahlke, 2014).

A purposive sampling strategy was used to recruit care providers. Three home care agencies were selected to represent the spectrum of contracted agencies (two private and one not-for-profit). These agencies serve a mixture of both urban and rural clients in the study area. To augment low initial response rates, we also identified additional providers from the BC Government Employees Union (BCGEU Local 403). Eligibility criteria for home support workers included the ability to participate in an English-language interview and the provision of home support services through employment with a home care agency in the study area (Sims-Gould and Martin-Matthews, 2010; Sims-Gould et al, 2015).

Older clients over the age of 65 living at home or in an assisted living facility, and who were either currently using or were recent recipients of home support services (that is, within six months), were recruited using a purposive sampling strategy. They were reached through: newspaper ads; posters in local community centres, seniors’ centres, assisted living facilities and grocery stores; presentations to seniors’ groups; mailshots to provincial caregiver associations; and contacting five home care agencies in the study area (Sims-Gould and Martin-Matthews, 2010; Sims-Gould et al, 2015). Carers included in the study were family members or close friends who identified themselves as carers of an older person. The inclusion criteria for primary carers were people who were providing care to an older client who is or was (within the last 12 months) in receipt of home support services, and those with a recently deceased relative or friend who had received services (within the last 12 months).

Although the ‘Nexus’ project has examined the triad of older client, carer and home support worker at the heart of the home care experience, the different actors involved could not a priori be identified and interviewed as a triad due to privacy laws in Canada. However, where clients and family members identified this link to the research team, we were able to record and code this tie for subsequent analysis. We conducted a secondary analysis of 24 dyad interviews:
• five linked dyads (one friend–friend, two mother–daughter and two husband–wife), wherein the client and carer were interviewed separately but confirmed as a dyad, discussing one client case; and
• 19 dyads (16 husband–wife and three mother–daughter), in which the client and the carer had to be present and contribute to the interview.

These interviews were analysed using thematic analyses (Braun and Clarke, 2006). There were no specific questions in the interview guide that directly addressed the caregiving dynamics between the carer and the older client, as the study was not designed to address this. However, the topic emerged throughout the interviews. Consequently, the transcribed interviews were fully (re)read and then coded based on the topics mentioned by the interviewees at different points of the conversation. We used a three-step analysis that progressed from a general and descriptive organisation of the information using NVivo to an interpretive analysis. Although sometimes iterative and overlapping, the steps of our analysis can be related to what Richards (2009) calls ‘descriptive coding’, ‘topic coding’ and ‘analytical coding’. We analysed all matched pairs of dyad interviews and identified themes that addressed the relational aspects of giving and receiving different types of care, and the coordination of tasks between client and carer. This subset of interviews gave us a unique opportunity to examine joint care practices described by carers and older clients.

Additionally, we conducted a qualitative meta-analysis (Timulak, 2009) of the findings of our previously published research, informed by the lens of the ensemble, to examine the role of home support workers in care collaboration. We selected and reviewed published articles from the ‘Nexus’ project that addressed issues of coordination of care and home care services, collaboration in the home care setting, and the division of care tasks. Our approach to conducting the meta-analysis had a narrative and interpretive focus (Thorne, 2019), enabled by the first author’s constant engagement with the data for more than ten years. Using this approach, we analysed the selected literature through such questions as: ‘How is care coordination managed and negotiated?’; ‘How do different actors collaborate to establish a routine and react to the unexpected?’; ‘How are different types of care exchanged?’; ‘What is the role of the client in care dynamics?’; and ‘How are caregivers and carers facilitating clients’ autonomy?’.

Findings

Our findings present the results of the two methodological approaches (that is, the qualitative meta-analysis and secondary analysis of data from the dyad interviews) integrated throughout this section.

Agency as a collective endeavour

Other articles of the ‘Nexus’ project have identified elements of relational aspects of care. Sims-Gould and Martin-Matthews (2010) described how the carer and the home support worker ‘shared the care’, or cared together, through interconnected and bidirectional assistive care. The analysis of the dyads also supports these findings, indicating the coordination of tasks, shared care experiences and best practices to provide care to the client: “I think that’s just – I think you’re getting help with the
physical task, and I think – I think they’re very friendly. They’re kind of like my friends. They’re my support group. I call them my support group ‘cause we share the same things” (Celeste, daughter, carer). The secondary analysis of the dyads adds another dimension to this ‘shared care’: the contribution of the client to the dynamics of the care ensemble through different actions of self-care and assistance: “[He] sets the alarm for 20 to ten so that he can get up, go to the bathroom, get himself a glass of orange – he likes to be ready for them [the home care workers]. He doesn’t like to be caught in bed” (Clarissa, friend, carer).

Similarly, James stressed that his wife, Meredith, tried to carry out certain tasks and activities on her own, “so she does the things that she really wants to do … where possible”. James and Meredith also had well-defined housework and spaces that were their own responsibilities. They also assist the home support worker to achieve appropriate care services: “We did a limited amount of work, though, that uh … they never did our bedroom. We never asked them to do our bedroom. We only asked them to do this room, the hallway, the bathroom and the kitchen–dining room area. That’s all” (Meredith, wife, client and carer). The role played by the older client was also evident in interviews describing the way in which a daily routine was organised to optimise the services received. As Meredith indicates: “I always had a shower before the worker came. I guess that’s another way I helped.” Other clients mention similar strategies:

‘Usually, I’ve gone to the washroom before they’ve come [the caregivers], so they help me with dressing. I do my own teeth.’ (Sienna, client)

‘And uh … so, I – I’m always waiting there, so they don’t have to spend any time getting me ready or anything. And so, I – I’m ready to have the shower right there.’ (Hank, client)

The use of certain spaces and the performance of tasks at a specific time facilitate the routines and activities of the care ensemble:

‘Oh, well, she [the home support worker] usually knocks on the door, and we leave the door open, so she comes in. Usually, we’re having breakfast. So, if we’re having breakfast, she doesn’t disturb us. At that time, she does what she has to do and she goes and she makes the bed, [Yolanda’s] bed, she – we try and get his changed at least once a week, mine, and every couple weeks. ‘Cause it’s awkward to get in there to get around it to make it. So, I said, “Don’t worry about it, you know, as long as you just straighten it up or make it.”’ (Lorenzo, husband, client and carer)

In the example given by Lorenzo, the division of tasks enables a good flow of caregiving (making the bed) and non-caregiving activities (having breakfast).

In the original model proposed by Sims-Gould and Martin-Matthews (2010), the care dynamic between the client and the carer was described as a unidirectional type of assistive care. However, the reanalysis of our own data suggests a different relationship and dynamic between older client and carer. With our perspective framed through the lens of the ensemble and analysis based on the dyad interviews, we found that coordination between formal and informal systems of care is evident in more
subtle ways, as where, for example, a task is divided into stages so that the client can participate in their own care. Celeste, a family carer, explains how she and the home support worker set things up so that her mother can eat and have her medicine: “But she can eat on her own. She’s – her right hand’s in good shape. So, we’ll just set the yam or the apple sauce with the medicine in it and she’ll take it on her own.”

This type of collaboration and coordination of tasks was also described in another article when examining the collaboration between clients and home support workers (Byrne et al., 2012). This collaboration supported the autonomy of clients, as the workers helped them ‘as much’ or ‘as little’ as needed to perform certain tasks, depending on whether the client was having a good or bad day. Also, workers balanced and negotiated the need to get the job done with clients’ expectations and preferences in order to enable clients to have some social control over the conditions of their receipt of care. The secondary analysis of the dyad interviews helps us identify ways in which members of the ensemble coordinate their roles and activities. When viewed through the lens of the care ensemble, clients, carers and home support workers demonstrate interdependent aspects of care to support the preservation of the client’s autonomy. Our data also suggest subtle ways in which the client’s ability to exert agency is disrupted when such coordination is not achieved.

**Routine and improvisation**

The metaphor of the jazz ensemble is particularly useful to describe the collaboration and coordination between members of the care ensemble as they respond to contingent aspects of care and daily life. Care dynamics that maximise home care services and support non-care activities are the result of both routinised and improvised arrangements orchestrated by the client, family carer and home support worker within the private space of the home and in the context of the homecare system. A previous article from the ‘Nexus’ project argued that the care provided by home support workers fluctuates in response to changing circumstances (for example, health, personal networks and the availability of services), with medical and non-medical crisis episodes that can be predictable or unpredictable (Byrne et al., 2011). Similarly, Janssen (2014: 14) described providing care at home as requiring a ‘continuous anticipation of (un)expected changes in the situation of their care recipients’. These changes do not necessarily involve the decreased functionality of the client, but can also reflect changes in the regular functioning of the home and care routines:

‘Like, today, I had at the same time, the oxygen delivery came. And I have to go down and back and down on the elevator with them. Now, the Friday gal … I sensed that she was finished everything, but she waited ‘til I was finished that and came back to stay. Then she left. So, she works around our routines and supports them.’ (Salma, wife, client)

The dyad interviews highlight the positive impact of achieving a care ensemble on accessing other services and performing a variety of activities (for example, doctors’ appointments or meetings with friends). Samuel (client) and his wife (carer) described how their daily routine is supported and complemented by different systems: private workers, assistive devices and public and private systems (for example, transportation, recreation and meal preparation). Samuel has been in receipt of home support
for a year and a half, and has had only one home support worker. Despite health problems, Samuel has developed a routine to assist the home support worker and optimise the service received: he sits waiting in the bathtub with water warmed up and towels and clothes ready before the worker arrives. Samuel uses HandyDART – a public transportation service for persons who have a disability – to go to the chiropractor. Good coordination of the care ensemble is key for the use of such services as HandyDART, as the trips must be scheduled in advance unless considered a subscribed trip (that is, repeated trips that have been consistently scheduled and taken to and from the same locations at the same times).

However, the coordination between the formal and informal systems of care is not always smooth, and small changes can be consequential for the functioning of a care ensemble. That was the case for Meredith and her husband James (carer), who dropped out of services as changes in schedule and workers impacted their routines and ability to plan, “It wasn’t based on what we needed. It was based on rules.”

Our programme of research well demonstrates how the ‘bureaucracy of care’ and its episodic nature impact the tempo and rhythm of the ensemble (Martin-Matthews, 2010; Sims-Gould and Martin-Matthews, 2010; Johnson et al, 2018). This is not to suggest that bureaucracy is inherently negative and dehumanising (du Gay, 2000), as bureaucratic structures organising home care services enable workers to resist client or family demands for extra services (Sims-Gould et al, 2015). In the context of the complex and fractionalised Canadian home care system (Martin-Matthews et al, 2012), the policies and guidelines of the agencies represent bureaucratic structures that frame the interaction between the members of the ensemble. However, underlying these policies and guidelines are organisational issues that affect the quality of care, such as inconsistent work schedules, worker turnover and time pressures due to shifts based on time and not tasks (Martin-Matthews, 2010; Sims-Gould and Martin-Matthews, 2010; Johnson et al, 2018).

The members of the care ensemble have to accommodate and negotiate the temporal aspects of the formal care system, such as the amount of time, frequency and regularity of visits of home support workers (Byrne et al, 2011). The care ensemble somehow adapts to this situation through such strategies as optimising services, but for this to work, the care provided by the formal care system has to be consistent and continuous. These qualities are central to allowing the care ensemble to create and maintain routines of care that facilitate the active participation of the client in care dynamics.

For the client, opportunities to exert agency go beyond specific aspects of care. When we consider that most clients are homebound, keeping control of the activities to be performed and the timing of those activities is essential. Sienna’s husband decried the constant changes in schedule and their impact.

“They get you up and they put you to bed … it was supposed to be ten o’clock or between ten and 11 at night. And then all of a sudden, it became nine o’clock and eight o’clock that finally – I guess we blew our top when they come at seven o’clock and was going to put her to bed. And we said, “No, that’s okay. I’ll put her to bed.””

Erratic scheduling is similarly noted by Joseph (client) and Carla (Joseph’s wife and carer). Consistency in the arrival time of the home support worker is central to keeping control over Joseph’s preferences and activities:
Joseph: ‘They’re nine o’clock, ten o’clock.’
Carla: ‘Sometimes, it’s – it’s later. But mostly it’s eight.’
Interviewer: ‘So, when they come later, you have to stay in bed until they get here.’
Joseph: ‘I don’t like it ’cause I’m spending my whole life in bed. I’m not trying to be, you know, objecting.’

The routines of care help the adaptation of the client to new or increased situations of dependency, allowing them to perform tasks of self-care and exert control over daily care and non-care activities with the help of the care ensemble. Continuity and consistency of services are essential to developing a good coordination between carer and home support worker(s) in order to respond to routinised tasks, unexpected situations and changes. At the system level, good coordination of care activities that facilitate the active involvement of clients in care-related decisions enhances person-centred care.

Revised interactive model of care

We propose a revised model wherein the different types of care are better specified (see Figure 2). Direct care and caregiving are provided to the client by the home support worker and the carer, respectively. Assistance, instead of assistive care, is used to describe care relationships that supplement the other two, more intensive types of care. Furthermore, as noted throughout this article, the client assists the carer and home support worker through preparation in anticipation of home care services. Therefore, assistance represents the coordination between client, carer and home support worker to optimise home care services and care activities in general, and to facilitate other non-care activities that are important to the client’s daily life.

Figure 2: Revised interactive model of care
The revised interactive model of care stresses the interdependent dynamics of care relationships and the way in which each actor contributes to these dynamics. Its main contribution is its recognition of the role played by the client as an active member of the care ensemble by specifying care exchanged in the form of assistance.

The revised model depicts how the older client performs and contributes with activities of self-care, assistance and reciprocation. Under the right circumstances, interaction between the client–carer dyad and the home support worker helps to increase the autonomy of the client by enabling them to play an active part – to the best of their abilities – in the care dynamics by contributing with assistance.

This revised model makes visible relationships that are often neglected in the caregiving equation: the complementary role played by the members of the care ensemble, including the client. The heuristic device of the ensemble enables us to examine relational aspects of caregiving dynamics and to highlight increased attention to autonomy as the result of interdependent relationships, as opposed to the limited and constrained actions of a person with little or no autonomy or agency. Our findings regarding the development of routines of care support debates already present in the relational autonomy literature (Perkins et al, 2012; Jacobs, 2019). These routines of care are made possible through coordination and negotiation between different members of the ensemble, who thereby recognise and facilitate the client’s autonomy.

In this way, the model captures what Barnhart and Peñaloza (2013) refer to as agency as a collective endeavour, clearly showing the interaction and contribution of the members of the care ensemble. Additionally, the revised model raises awareness of the role played by clients to contribute to their own care and to optimise the work or activities of other members of the ensemble.

The ensemble lens also contributes to the relational autonomy literature by situating interdependent aspects of care in the particular context of home care. This approach stresses the delicate balance between routine and improvisation that supports an effective collaboration and coordination among the different actors and systems involved. Across Canada, policy and services relative to the provision of care at home assume the availability of family members and friends, but the recognition of their role as part of the care team is limited (Hoffer Gittell, 2016). Carers and clients contribute to the integration of systems ‘by default rather than by design’ (Hoffman et al, 2020), though their role is ever more crucial to coordinating care in a complex and fragmented delivery context (Martin-Matthews et al, 2012).

Continuity and consistency of formal home care enable the care ensemble to create and perform routines of care, and, at the same time, to provide a context that facilitates improvisation to respond to unexpected needs, crisis and changes. However, policy changes in home care delivery (shorter hours, the higher acuity of clients and the casualisation of the home care labour force) threaten the fundamental continuity and consistency central to this process. The provision of home care services tends to be driven by a concern with efficiency over the quality of care (Martin-Matthews and Cloutier, 2017), which directly impacts the functioning of the care ensemble.

Conclusion

We revised the interactive model of care by applying the perspective of the care ensemble to examine interdependent dynamics of caregiving relationships, stressing
the role played by the client. The analysis of the dyad interviews, which included both older people receiving home-based health/social care and their informal carers, enabled us to identify the subtle coordination and negotiation of care that supports clients’ autonomy. The updated interactive model of care enables us to advance knowledge of how complex systems of care (linking families and both private and public sector workers) influence dynamics between family carers and older clients.

By observing the dynamics of caregiving through the relational lenses of the care ensemble, and by acknowledging autonomy as a collective effort to support clients’ agency, we can understand the performance of care as enabling the older person as a client and the carer to perform their daily lives. As Milne and Larkin (2015: 8) indicate, community care policies have framed the home as a therapeutic space where the carer – and we emphasise here also the client – has to ‘negotiate a balance between protecting the private space of the home and engaging with the institutionalised infrastructure of formal care’. When complementary systems of care that intersect in the private space of the home work in unison, client and carer can perform their daily lives as individuals, as partners and as family members.

The main limitation of the present research is that matching older clients and carers was not planned from the beginning of the project. Therefore, no specific questions to compare and contrast their experiences were included. However, even with this limitation, our findings advance current understanding of the role of older clients in the dynamics of home care, as only few studies (Horowitz et al, 2004; Sebern, 2005; Samsi and Manthorpe, 2013; Torgé, 2014; Persson et al, 2020) have specifically analysed client–carer dyads to investigate this issue. Another limitation is the generalisability of our findings due to our specific sample. More research is needed to examine the dynamics of the care ensemble when clients experience more acute and/or specific health conditions.

Despite these limitations, our approach helps to identify the interdependent nature of care and the complex coordination required to support older people’s agency in the home space. It also opens opportunities for future research that seeks to examine complex interactions between private experiences of care and the home care system.

Our findings also contribute to discussions of the crucial role played by carers in the adequate functioning of the formal care system. The limitation – and even restriction – of visitors in long-term care facilities and hospitals during the COVID-19 pandemic has shown the interdependence between formal care providers and carers in providing safe and comprehensive services to clients. Together, the #morethanvisitors campaign and the change in language used to refer to carers as ‘care partners’ highlight the relevance of models that acknowledge relational care practices. While the examples pertain to long-term care, the implications are equally true for home care, where lockdowns and travel restrictions disrupted home care services and care provided by carers from different households. The fundamental importance of the care ensemble was never more apparent than when pandemic regulations altered or prevented the collaboration and improvisation core to its functioning.

Note
1 Home support workers are ‘unregulated workers’ who provide non–medical services in the form of personal assistance with daily activities and personal care (for example,
bathing, dressing and light household tasks) that help to maintain a safe and supportive home. The home support role may be defined differently across Canada and around the world. Other terms to describe this role are ‘home care workers’, ‘personal care workers’, ‘home helps’ and ‘homemakers’.

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**Conflict of interest**
The authors declare that there is no conflict of interest.

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