How to map a patient’s social support network


Abstract
When patients are discharged from hospital they are dependent on the professional and social care delivered by healthcare staff and also on the support provided by lay carers, family and friends. This article describes a method for determining the quality and extent of lay care that may be available to older people to ensure that their discharge is more successful in the long term.

Aims and intended learning outcomes
The aim of this article is to provide a method for mapping the extent and quality of lay care that may be available to older people as perceived by the patient. Mapping here covers two things: a description of the social support available; and a representation of that (visually) which can then be discussed. As you will see later on in the article, the maps are a basis for discussion, not simply a record to file in the patient’s notes. The article suggests how this method can be used to plan for a more successful hospital discharge and one which alerts care professionals in the community to a patient’s possible needs. This is particularly helpful where the patient has a chronic illness and will need to continue rehabilitating in the community. The mapping of a social support network has been applied in a wide variety of contexts (Cohen et al 2000, Lewis et al 2000, Knoke and Yang 2008), but the lessons outlined here were learned through the author’s early work in cancer care.

By reading this article and completing the time outs the reader will be able to:

■ Use a simple social support network assessment tool to ascertain the extent and quality of lay support available in the community as perceived by the patient.
■ Discuss with patients the different patterns of information provided in such maps and identify those that suggest a promising supply of support for patients and those which signal possible difficulties ahead.
■ Use social support network map data to highlight concerns and needs to others, particularly where greater professional care may be required over a longer period: availability, continuance and expertise available as part of support are important here.
■ Explore with colleagues the advantages and limitations of mapping a patient’s social support network as a way of exploring the extent, quality and type of lay support that might be available.

Introduction
However imaginative and well-planned patient support is, the long-term success of measures supporting older patients may depend on the quality and extent of the social support networks that they draw on (Bennett et al 2006, Rocha et al 2009, Lund et al 2010). Patients being discharged from hospital to the community are not only dependent on professional and social care delivered by healthcare staff, but also on the support provided by lay carers, family and friends.

The needs of older patients may be considerable and extend for a lengthy period of time and they remain independent mainly because of the contribution from lay carers (Phillipson et al 2001, Aihara et al 2009). It is important to estimate what lay carers might provide because it might vary considerably and not remain constant (Klée 2009). First, the nurse needs to understand the extent and the quality of lay support networks that patients believe they have. This process can be started by creating a map of the network available, which can then be used as a discussion point with the patient.

Social support networks
Human beings are gregarious, albeit to varying degrees; that is, they enjoy the company of others and living in...
communities that provide a range of resources above and beyond what individuals provide for themselves (Delanty 2003). Social support consists of many factors but principally it is associated with:

- Managing activities of daily living, for example, securing food and maintaining the home, including keeping it warm and secure.
- Providing a sense of purpose as we benefit from the roles that we share with others (Breheny and Stephens 2009).
- Reviewing changes in circumstances by sharing stories of challenging or difficult events with friends and evaluating each other’s responses to them (Price 2010).
- Celebrating success and sustaining progress. Social support networks provide feedback to individuals by encouraging them and rewarding their efforts.
- The support of dignity. Living with illness is often a challenge and there may be no realistic prospect of a complete recovery. It is therefore important to learn that the efforts of living with a chronic illness are respected by others (Price 2004).

In these terms social support is often hidden and seemingly unremarkable, but it operates as a vital part of what sustains individuals, especially in those who are older (Phillips et al 2010). Because it is made up of many small acts, it is rarely recognised except by the individual who is supported. It can therefore be a volunteer resource that is not adequately connected to the formal services provided by health and social care.

Now do time out 1.

There is no set formula to describe what an individual’s social support network will consist of and who will provide it (Cohen et al 2000). Typically the network is influenced by matters such as:

- The gender of the patient; women often have richer support networks than men.
- The culture and community from which patients come.
- The location in which the patient lives, for example, some support may be far removed, as with families of armed service personnel.
- Whether the individual is a member of a club, an association or group.
- Whether the person continues to work; work colleagues sometimes help.
- The age of the individual; extreme old age can mean that significant others have died.
- The patient’s marital status/living arrangements; the profile of who provides help may be affected significantly when people live alone, are unmarried or divorced in later years.

It is unwise to assume that an individual will be supported by a partner or spouse, or that families will shoulder the bulk of support responsibilities. The willingness and ability of others to help may vary too, even if their support is cherished by the patient. People have different levels of expertise and confidence in supporting a patient in the community.

Relationships in old age are as varied as in younger age groups. Particular people may be selected as confidantes to suit current needs. For example, in an illness that seems intimate, patients’ chief confidantes may be people of the same sex, rather than a partner of the opposite gender. A best friend, rather than a spouse, might be the most influential supporter.

Now do time out 2.

It is valuable to realise that the social support network might be rich, with dedicated confidants, skilful supporters and individuals who are ready to help the patient to cope with illness or other change (Phillipson et al 2001). Each individual might only provide a small service or a little help, but the cumulative effect could be considerable. The social support network can be a fickle resource though as chronic illness makes great demands on lay supporters and it may consist of less knowledgeable individuals. For most nurses it remains a relatively unknown resource and the pressures of time and the need to attend to physical care needs sometimes distract them from gathering additional information that might
Continuing professional development

enhance the way in which they liaise with patients to identify sources of longer term support.

Preparing a social support network map
There is a case for mapping the perceived community-based social support of many older patients, at least those who are dealing with chronic illnesses, and who face challenges coping with them. This includes patients who have physical disabilities associated with eye sight or mobility, for instance, and those who might be challenged by mental illness, such as depression. What nurses know about the challenges of illness or disability has to be married with the range and quality of support. While such maps are assessments of perceived support, they remain helpful starting points for establishing who might assist the patient's problems. A discharge planning that assumes no lay support, or one which presumes more will be available than there is remains unhelpful or risky. The patient's success in the community, their satisfaction with how professional and sources of lay support tie together, may rely on nurses and other hospital discharge planners understanding lay support much better.

Figure 1 shows a simple map that can be used to help patients describe who supports them. It comprises a three circle target with the patient at the centre. The inner circle represents support that is intimate, detailed and confidential – it is here that patients share that which they find most difficult, challenging and worrying. It is the place where closest and best friends exist and where the individual feels that they could express the most difficult of matters. When patients identify a lay supporter here it is not the case that they necessarily believe that such individuals are confident counsellors, but that they are willing to confide in these individuals.

Explanations of the helper's ability, confidence and availability of time have to form part of the discussion surrounding the map. The middle circle shows close friendship – support that is sustained and dependable and which is flexible enough to deal with the ups and downs of change. A wide variety of people might operate here, including family members, friends, neighbours and associates from clubs or past work. The outer circle describes occasional or more superficial support. The individual sees this as an area where people will 'lend a hand' but where they might feel more circumspect about sustained assistance.

Presenting such a blank map to patients and helping them to fill it in can provide a rich source of information which assists with discharge planning. Because of the possibility that some patients may have a great deal of support, it is more advantageous if this is drawn as an A3-size diagram. A record of the completed map can then be kept with the patient's notes and used to alert community care professionals of what is understood, hoped for or believed by the patient at that time.

The mapping begins with explaining the planned use of the map and its potential benefits in helping the nurse to liaise with other supporters that the patient values. It is emphasised to patients that it is not mandatory, but that it may assist healthcare staff with arranging support for them when they are discharged. The nurse explains the meaning of each of the circles and explains that the person at the centre of the circle is the patient. It is important that the nurse uses terms that the patient finds accessible and understandable, so the inner circle might include ‘best friends’, the middle circle ‘good friends’ and the outer circle ‘acquaintances’.

The next step is to ask patients to insert, in the relevant circle, the initials of those people they know and trust and with whom they have a supportive relationship. It is important to emphasise that this could be a two-way relationship. Patients who are ill do not necessarily stop caring for others – even though their capacity to assist may be more limited. To assist with mapping it is usually better to group those individuals who know one another in the same quadrant of the map, for example, married couples will typically appear close to one another there.

Now do time out 3.

In the second step the patient is asked, with the nurse’s assistance, to draw arrows between individuals who support one another. The direction of the arrow indicates who supports whom. Many of these will connect with the patient at the centre of the map, but not exclusively so. Remind the patient that arrows can go in one or both directions because some individuals may be providing support to more than one person. There is often a web of social support with mutual
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assistance provided in different directions. To achieve this it is helpful to talk with the patient about the type of help that is represented by the arrows. For example, ‘she provides some help with shopping’ and ‘he is the wise friend when it comes to finances’. In this way, the map provokes discussion about the quality of support and the friend’s level of expertise and trustworthiness as well as the volume of support that can be provided.

now do time out 4.

reading map responses

having completed the social support network map it is necessary to interpret and to ask any supplementary questions that will assist you in alerting others to patients’ needs and aspirations. Maps are usefully interpreted in terms of the volume, richness and quality of available support. The reader should periodically refer to figures 2 and 3 for assistance with understanding this.

the volume of support consists of the number of initials that appear in the social support map and is understood best with reference to remarks made by the patient as arrows are then added, for example, ‘this person is lovely, but they have worries of their own, so sometimes they are distracted’.

some older patients have surprisingly sparse social support networks, either because their friendships have dwindled away over time, because of family disputes or because of the lifestyle they have led. Patients, for example, who have alcohol problems, who have been aggressive or unpredictable, may have alienated others. Low volume support networks are also sometimes associated with men. Men do not make the same number of friendships as women and may be especially exposed to risk if they lose a female partner who has brought her own friendships to the patient. The associates of a male patient may sometimes be located in the middle or outer circle, which suggests that the patient does not easily share issues, secrets and needs. It is necessary to discuss the volume of social support with a patient in a sensitive way, as the map may suddenly confront them with just how exposed they are.
Figure 2 is the social support network of a man called ‘Mr Farmer’ who lived in a rural location and who was trying to support his wife who had Alzheimer’s disease. The chief challenge for Mr Farmer was to draw in the support of people in the outer circle, those who had been his wife’s friends but who did not relate that well to him. Now do time out 5.

The richness of a social support network is indicated by the number of arrows between individuals indicated on the map, not just with the patient but with one another. In some instances, the map may suggest that a busy social life is led. Provided that relationships are constructive and that quality of support is reasonably constant, this can suggest an extremely supportive environment.

Figure 3 shows this type of social network. The woman concerned is dealing with multiple problems, osteoarthritis, debilitating tinnitus, failing hearing and chronic obstructive pulmonary disease, but she has a rich mix of associations linked to her membership of a craft circle and past work in a local factory. There are several close friendships with others, so she has the means to communicate with a wide variety of people, even if she does not see or talk to them regularly. Patterns such as this are often associated with large and close-knit families, where an older person plays several different roles with the generations of the family. It is a pattern that may be seen less often today as families move apart geographically.

It is important to hear as well as to read the map. The patient, in talking about the arrows added, may refer to matters such as mutual dependency, trust and the frequency with which people see one another. This then leads to the consideration of the quality of the social support. Even if there are a large number of people indicated on the map and arrows are recorded in many different directions, the quality of a network could still be poor if the nature of the relationships are fickle, tense or open to challenge from third parties. It is necessary to understand something of others’ capacity to support the patient. So, for example, an important other who appears in the inner circle, but who has arrows pointing out to many others indicating the direction of support might have a limited amount of time and energy to contribute to patient care. In addition, such ‘star individuals’ may or may not have the confidence to play pivotal roles if the patient’s illness or treatment seems complicated. Now do time out 6.

Talking about the interpretation of the map with the patient is as valuable as obtaining the data. Patients are sometimes surprised to see that they have focused nearly all the arrows inwards towards themselves and then wondered whether they are ‘selfish people’. This can prompt a discussion about perceived vulnerability and perhaps identify shortfalls in the patient’s knowledge or skills. One patient observed to the author: ‘This made me realise that I wasn’t that confident about managing my stoma. I wanted everyone else to understand but I didn’t have a clear idea as to how I could ask for help.’

Planning more coherent support
It takes time and effort to complete and interpret such a map with a patient. Such an investment may be too great as a routine hospital discharge planning measure. It might be better to reserve it for patients who we already suspect could be at risk. Perhaps there have been few visitors, perhaps the patient has already expressed doubts about coping or perhaps there is evidence of friction about future care responsibilities, as suggested by family or other carer contact. Where social
support network maps are used, several practical uses can be envisaged.

First, it is possible to spot ‘star individuals’, who in the patient’s estimation are influential and supportive of others. On the map, these are the people with a large number of arrows coming and going to them and who appear in the inner circle of the patient’s associates. Whether these people are also ‘star supporters‘ will depend on their time, energy and confidence levels to assist the patient with any particular problems or needs. For example, someone may be a star individual but may be squeamish about talking about bodily functions and especially ileostomies. It follows that while the individual is a general confidant, they might not be able to support the patient because they mull over concerns about stoma accidents. It is necessary to investigate further to establish how much help such a star individual might feel able to give. Patients do sometimes express too much confidence in such individuals, especially if they are eager to return home.

Second, where a map is rich in support and the quality of support is also high, it can be liberating for patients to realise that their circumstances are better than they imagined. Not all older patients are lonely as many continue to enjoy a varied friendship base, but may not have taken stock of this after falling ill. By discussing a map it may assist patients with celebrating their good fortune, staving off anxiety and enabling them to make plans about which supporter they share their progress with first.

Where networks are poor or weak, the nurse is alerted to the patient’s perceived vulnerability and can begin work early to connect the patient to support groups, the services of charities associated with an illness and to alert social or community care agencies of the patient’s possible needs. The map does not resolve problems of poor social support, but it helps colleagues to target support to those patients who are most in need. If the patient permits the nurse to share this information with other support agencies it can help them to describe the profile of support so that assistance can be customised to suit the patient’s circumstances and the agencies can even work with the patient’s trusted friends.

Conclusions

When social support network maps are used selectively and discussed carefully so that the patient’s privacy and wishes are respected, they potentially have a useful part to play in helping nurses to appreciate the perceived resources available to patients. By ascertaining who might support the patient and in whom the patient has confidence, nurses can work more sensitively to help patients with their transitions back home.

7 Reflection

Think back to the patient that you considered in time outs 1 and 2. Could a social support network map have helped you plan support differently with them? In particular, would you be clearer about who to talk to?

Some people may prefer to confide in friends of the same sex or from the same cultural background.
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Nurses can work with the star supporters who have plenty of time available and the confident ones to plan for post-discharge support that is sustainable and coherent. While social support network mapping can be applied widely, it is particularly relevant for the care of older people, an area where it may be unwise to presume that particular support arrangements are in place and one where patients are eager to remain independent. The maps themselves, however, have limited value unless the information is discussed with the patient as it is gathered and then reviewed. Such maps remain a perceptual representation of support and checks have to be made that the information provided is accurate.

The maps are powerful and require thoughtful use. It can be unsettling to discover that the social support network of an individual patient is limited. For this reason nurses receive great benefit from the experience of mapping their own support network before using them with patients. What nurses realise about their own social support network enables them to be more sensitive when using the tool with patients. This is not an instrument which can be used indiscriminately but it is a diagnostic tool that can help nurses and older patients identify any perceived sources of support and worries before hospital discharge. Where poor social support networks are identified, nurses have a responsibility to respond by working with the patient to identify new sources of assistance.

References


Practice profile

What do I do now?
■ Using the information in section 1 to guide you, write a practice profile of between 750 and 1,000 words – ensuring that you have related it to the article that you have studied. See the examples in section 2.
■ Write ‘Practice Profile’ at the top of your entry followed by your name, the title of the article, which is: ‘How to map a patient’s social support network’, and the article number, which is NOP470.
■ Complete all of the requirements of the cut-out form provided and attach it securely to your practice profile. Failure to do so will mean that your practice profile cannot be considered for a certificate.
■ You are entitled to unlimited free entries.
■ Using an A4 envelope, send for your free assessment to: Practice Profile, RCN Publishing Company, Freepost PAM 10155, Harrow, Middlesex HA1 3BR by March 2012. Please do not staple your practice profile and cut-out slip – paper-clips are recommended. You can also email practice profiles to practiceprofile@rcnpublishing.co.uk. You must also provide the same information that is requested on the cut-out form. Type ‘Practice Profile’ in the email subject field to ensure you are sent a response confirming receipt.
■ You will be informed in writing of your result. A certificate is awarded for successful completion of the practice profile.

1. Framework for reflection
■ Study the checklist (section 3).
■ What have I learnt from this article?
■ To what extent were the intended learning outcomes met?
■ What do I know, or can I do, now, that I did not/could not before reading the article?
■ What can I apply immediately to my practice or client/patient care?
■ Is there anything that I did not understand, need to explore or read about further, to clarify my understanding?
■ What else do I need to do/know to extend my professional development in this area?
■ What other needs have I identified in relation to my professional development?
■ How might I achieve the above needs? (It might be helpful to convert these to short/medium/long-term goals and draw up an action plan.)

2. Examples of practice profile entries
■ Example 1 After reading a CPD article on ‘Communication skills’, Jenny, a practice nurse, reflects on her own communication skills and re-arranges her clinic room so that she will sit next to her patients when talking to them. She makes a conscious decision to pay attention to her own body language, posture and eye contact, and notices that communication with patients improves. This forms the basis of her practice profile.
■ Example 2 After reading a CPD article on ‘Wound care’, Amajit, a senior staff nurse on a surgical ward, approached the nurse manager about her concerns about wound infections on the ward. Following an audit which Amajit undertook, a protocol for dressing wounds was established which led to a reduction in wound infections in her ward and across the directorate. Amajit used this experience for her practice profile and is now taking part in a region-wide research project.

3. Portfolio submission
Checklist for submitting your practice profile
■ Have you related your practice profile to the article?
■ Have you headed your entry with: the title ‘Practice Profile’; your name; the title of the article; and the article number?
■ Have you written between 750 and 1,000 words?
■ Have you kept a copy of the practice profile for your own portfolio?
■ Have you completed the cut-out form and attached it to your entry?